VimoSEWA
India

CGAP Working Group on Microinsurance
Good and Bad Practices
Case Study No. 16

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Good and Bad Practices in Microinsurance

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1. A **series of case studies** to identify good and bad practices in microinsurance
2. A **synthesis document** of good and bad practices in microinsurance for practitioners based on an analysis of the case studies. The major lessons from the case studies will also be published in a series of **two-page briefing notes** for easy access by practitioners.
3. **Donor guidelines** for funding microinsurance.

The CGAP Working Group on Microinsurance

The CGAP Microinsurance Working Group includes donors, insurers and other interested parties. The Working Group coordinates donor activities as they pertain to the development and proliferation of insurance services to low-income households in developing countries. The main activities of the working group include:

1. Developing donor guidelines for supporting microinsurance
2. Document case studies of insurance products and delivery models
3. Commission research on key issues such as the regulatory environment for microinsurance
4. Supporting innovations that will expand the availability of appropriate microinsurance products
5. Publishing a quarterly newsletter on microinsurance
6. Managing the content of the Microinsurance Focus website:
   www. microfinancegateway. org/section/resourcecenters/microinsurance

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Denis Garand

Acronyms

AP	Annual Pay
BPL	Below Poverty Line
CA	Chartered accountant
CCA	Canadian Cooperative Association
CEO	Chief Executive Officer
CIA	Central Intelligence Agency
COO	Chief Operation Officer
FD	Fixed Deposit
GDP	Gross Domestic Product
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit GmbH
IBNR	Incurred But Not Reported Reserve
ILO	International Labour Organization
IRDA	Insurance Regulatory and Development Authority
JBY	Janashree Bima Yojana
LIC	Life Insurance Corporation of India
MI	Microinsurance
MIS	Management Information System
MoF	Ministry of Finance
MoU	Memorandum of Understanding
NGO	Non Government Organization
NIC	National Insurance Company
PPP	Purchasing Power Parity
Rs	Rupees
SEWA	Self-Employed Women's Association
SHG	Self Help Group
STEP	Strategies and Tools against Social Exclusion and Poverty
UIIC	United India Insurance Company
US$	United States Dollar
WHO	World Health Organization

Executive Summary

Under the guidance of Ela Bhatt, the Self-Employed Women's Association (SEWA), a trade union for female informal sector workers, was registered at Ahmedabad, India in 1972. Despite contributing significantly to the Indian economy, self-employed women remain invisible, unrecognized and uncounted. SEWA's main goals are to organize women workers for full employment, so they can obtain income, food and social security. Besides forming a union, SEWA has created a bank, childcare co-operatives, a training academy, other co-operatives, a health programme—and has developed VimoSEWA to provide insurance benefits. In Gujarati, Vimo means insurance, and the pronunciation of SEWA means service.

VimoSEWA began in 1992 as a "trust" operated by the SEWA union. It provides a voluntary, integrated insurance product, which is the most challenging type of microinsurance. It is open to all members, whether or not they have a loan, and provides life, accident, health and asset protection to a group that has higher risks and lower incomes than the "normal" insurance market. The challenge of managing a smaller operating margin with higher claims costs requires a very skilled organization.

In the beginning, VimoSEWA partnered with public insurance companies. As this was a new market for the insurer, policies, claims reimbursement delays and procedures were inadequate to meet the needs of the SEWA membership. To solve the service problems created by the insurer, and to increase sensitivity to its clients, VimoSEWA began offering some of the coverage on its own. The Gujarat Earthquake in January 2001 demonstrated that covariate risk with inadequate reinsurance can create a large financial strain on the organization. The liberalization of the Indian insurance market in the late 1990s permitted VimoSEWA to dream of forming a member-owned insurance company to serve the informal economy. The later two events were the catalysts in developing a business plan in October 2001, with the goal of establishing a viable microinsurance scheme.

This case study focuses on the evolution of VimoSEWA since the development of the business plan. Following the earthquake, the number of insured increased dramatically from 30,000 to 92,000. The business plan assumed that VimoSEWA had found an effective means of reaching members and could scale up to 300,000 insured within 7 years to reach viability. By January 2005, however, membership was below targets and viability remained 7 years away, with low renewal rates as the principal cause. There have been, however, some important evolutions of understanding within VimoSEWA:

- There is now a clear concept of the risk of insurance and the requirement to protect the scheme from major catastrophic events.
- Developing a good management information system is a necessary element to manage the microinsurance scheme actively.
- VimoSEWA's management team now has the skills, vision and knowledge to reach the goal of viability.

- The business plan was an important tool to set critical benchmarks; in addition, periodic reviews of goals permitted VimoSEWA to make adjustments to methods and procedures in order to reach new goals amidst frequent catastrophes.
- Management and staff teams used reports to actively manage the organization.
- Developing capacity of each staff person was difficult as microinsurance is new and no clear solutions have been developed. GTZ provided an experienced insurance person from UIIC for the period 1999-2001 for capacity building, however there is a need to cultivate experienced *micro*insurance personnel.
- The assistance of an outside actuarial and management consultant helped the team to recognize problems, and to realize that solutions had to come from within the organization.
- Product development must always consider the ability of members to pay for benefits.
- Obtaining a high renewal rate may be difficult, as the widely dispersed membership requires an understanding of insurance and solidarity, facilities to pay premiums, access to health care providers, and methods to obtain reimbursements.
- Adequate accreditation standards for health facilities covering appropriate treatment protocols, as well as health education programmes aimed at the target population, are necessary to keep health claims costs from spiralling out of control.

Developing a voluntary integrated insurance scheme takes time, dedication and a highly effective organization. VimoSEWA is still 7 years away from reaching viability. If VimoSEWA can succeed, its approach may be a model for other community-based insurance schemes.

Creditor insurance remains the easiest type of microinsurance to implement, however it is not effective in covering the basic needs of the low-income community for health and life insurance. VimoSEWA's product and delivery channels represent an alternative that is harder to manage, and takes longer to achieve viability, but in the end is likely to achieve a significantly greater development impact.

1. The Context

India's diverse economy encompasses traditional village farming, modern agriculture, handicrafts, a wide range of modern industries, and a multitude of services. Services are the major source of economic growth, though two-thirds of the workforce is employed in agriculture. The government has committed to furthering economic reforms and developing basic infrastructure to improve the lives of the rural poor and boost economic performance. The economy has posted an excellent average growth rate of 6.8% since 1994, reducing poverty rates by about 10 percentage points. India is capitalizing on its many well-educated people skilled in the English language to become a major exporter of software services and software workers. Despite strong growth, the World Bank and other international organizations are concerned about the combined state and federal budget deficit, running at approximately 9% of GDP. The huge and growing population is the fundamental social, economic, and environmental problem.[1]

Table 1.1 Macro Data

GDP (US$ Billions) 2003	600.6
Population (millions) July 2005 estimate	1,080.3
Population density per km2	329
Percentage urban / rural population	28/72
GDP/Capita (US$) 2003	$564
GDP Growth Rate, 2004 estimate	6.2%
Inflation, 2004 estimate	4.2%
Exchange Rate (current, X Currency per US$1)[2]	45.3
PPP GDP per Capita, 2004 estimate	3072
Infant Mortality (per 1000 live births), 2002	56.3
Under Five Mortality (per thousand) , 2002	90 F/ 85 M
Maternal Mortality (per 100,000 live births), 2000	540
Access to improved water sources (% of population)	84%
Health Expenditure as % of GDP (public/private/total), 2002	1.3%/4.8%/6.1%
Health Expenditure per capita (US$), 2002	$30
Doctors per thousand people	0.48
Hospital beds per thousand people (urban/rural)	0.8
Literacy rate (male 70%, female 48%)	60%

(sources: World Bank, WHO and CIA Factbook)

1.1 Role of the State in Insurance

In 1999, India liberalized its insurance sector by promulgating the Insurance Regulatory and Development Authority (IRDA) Act, which supplemented the Insurance Act of 1938. The new legislation opened up the insurance market to private insurers, permitted limited foreign ownership, set a minimum capital requirement of Rs100 Crore (US$22 million) to form an insurance company, and separated life and non-life business. Foreign companies are allowed an ownership stake up to 26% (proposed to increase to 49%) in Indian insurance companies.

[1] CIA The World Factbook
[2] This exchange rate will be used in all calculations of current figures in this paper.

The IRDA has the dual role of regulating the insurers and promoting the development of the insurance market. To promote its development role, in 2002 the IRDA adopted minimum requirements for insurers to serve rural areas and persons below the poverty line (BPL). To fulfil their requirements, each private life and non-life company must insure 25,000 low-income lives by the end of the fifth year of operations. The public insurers must increase the number of insured every year. Failure to meet the regulations results in financial penalty.

In late 2004, IRDA posted a "Concept Paper on Microinsurance," a regulatory framework which requires non-governmental organizations (NGOs) and self-help groups (SHGs) to provide insurance only in collaboration with regulated insurance companies through the partner-agent model. The concept paper also modified the education requirements of microinsurance agents compared to the requirements of the "high income" insurance market and generally added flexibility to facilitate the provision of microinsurance. However, it also added some restrictions on amounts paid to NGOs, policy design and other issues. The concept paper has not been finalized at the time of this writing, and interested parties have had discussions with IRDA to improve the overall microinsurance regulations to both encourage its development and to ensure protection of the consumer. India is to be applauded for its proposed policy framework for microinsurance.

The concept paper recommends recognising microinsurance agents/NGOs based on MoUs signed with insurers, who would be expected to carry out due diligence as per the requirements of the Act and regulations. This is a departure from the existing system of licensing. For popularizing the products and increasing the general awareness, insurers would be required to print the policy literature in simple local language. The NGOs would employ specified persons, with the prior approval of the insurer, to carry out their insurance activities. These persons would be trained about insurance in the local vernacular at the insurer's expense. The NGO can receive commissions from the insurer for services provided at 20% of life premium and 7.5% of non-life premium.

The Government has also constituted a Consultative Group on Microinsurance to examine insurance schemes for the rural and urban poor under the existing regulatory framework. The Consultative Group was set up to develop an enabling framework for developing and promoting microinsurance initiatives. The Group has since submitted its Report on the "Viability and Capital Requirements for Microinsurers."

The overall regulatory impact on microinsurance includes the following:

- Capital requirements are punitive for microinsurers that want to become a regulated company.
- Insurer's social obligations provide a ready market for the partner-agent model, although the private insurance sector mostly views the requirement as a cost of doing business; with a few exceptions, insurers have not pursued the BPL sector as a viable market and in some cases stop issuing policies when they have fulfilled their obligations.
- Unions and not-for-profit entities can use a "trust" to provide microinsurance to their members and, curiously, are not subject to IRDA regulations. Besides VimoSEWA,

Yeshasvini, the largest microinsurance plan in India, has been formed as a trust.[3] Maintaining the discipline of regulatory requirements is in the interest of the trust, and this option should not be used to escape regulatory provisions.

- Mutual and co-operative insurance and other forms of microinsurance will not be permitted even if these models have been successful in other countries.

Microinsurance policies are subject to a service tax; the recent Union government budget plans to remove the tax on qualified microinsurance plans.

The largely underdeveloped Indian private health insurance market faces many challenges. Cost of services varies widely across the country and by rural and urban settings. State insurers provide subsidized coverage, the medical profession and health facilities lack uniform accreditation standards, and limited data is available for pricing products. In this environment, insurers have not achieved profitability in the Indian domestic health market.

Supervision of companies is premised on the optimum amount of self-regulation consistent with prudent regulations. For example, an insurer can "file and use" a microinsurance policy that it has developed. The regulator calls for information (in prescribed forms), undertakes inspections, conducts enquiries and investigations, including audits of the insurers, intermediaries, and other organizations connected with the insurance business.

It is believed that, with transparency and proper regulations, the insurance sector can become an important contributor to the economy.

Table 1.2 Insurance Industry Basics

Issues	Observations
Name of insurance regulatory body	IRDA
Key responsibilities of the regulatory authority	Licensing, supervision and the development of insurance
Minimum capital requirements for insurance	Minimum capital is 100 Crore or 22 million US$ each for Life and Non-Life companies
Other key requirements for an insurance license	Financial strength to inject capital as required, sound management team
On-going capital requirements	74% of life premium required as capital
Other key requirements for regulatory compliance	Fit and proper management and regular filing
Minimum capital requirement for reinsurer	Minimum capital is 200 Crore or 44 million US$ each for Life and Non-Life companies
Number of regulated private insurers	13 Life 8 Non-Life
Value of annual premiums of private insurers	0.7 Billion US$ Life 0.5 Billion US$ Non-Life
Number of regulated public insurers	1 Life 4 Non-Life
Value of annual premiums of public insurers	13.9 Billion US$ Life 3.3 Billion US$ Non-Life
Number of re-insurers (if any)	1 Public re-insurer

[3] See Radermacher et al (forthcoming), "Yeshasvini Health Scheme, India," Good and Bad Practices Case Study.

Issues	Observations
Value of annual premiums of reinsurers	N/A
Unregulated organizations that offer insurance	Trust funds, premium unknown
Certification requirements for agents	Minimum educational requirements for regular insurance, and agents trained by NGO for microinsurance

(Source: IRDA 2003-2004 Annual Report)

1.2 Role of the State in Social Protection

There is very little health insurance protection for the Indian population; 78% of health care cost is covered by individuals. Public schemes, such as those summarised in Table 1.3, only reach a small percentage of the population. Experts in the industry estimate that only 10 to 20 million persons have health insurance.

Table 1.3 Public Health Insurance Schemes in India

State Scheme	Number covered
Employees' State Insurance Scheme	340,000
Central Government Health Scheme	4,000,000
Railways Health Scheme	1,200,000
Public companies BPL Scheme	1,200,000

1.3 Brief Profile of Microinsurance in India

A recent survey by the ILO[4] has provided an inventory of 83 microinsurance products in India, including life, disability, accidental death, health care, asset protection and accidental expense. A single product is offered by 46 schemes, while 37 schemes offer two or more products. The number of providers is increasing yearly; however, it is difficult to estimate the number of people covered. Probably less than 5 million BPL are covered by microinsurance.

The public insurance companies offer life and health insurance products to the BPL at subsidized prices. Life Insurance Company of India (LIC) has Janashree Bima Yojana (JBY), which provides Rs 20,000 ($440) life insurance and Rs 50,000 ($1100) accidental death insurance for Rs 200 ($4.40) a year, subsidized up to 50% by the Government. Four public non-life insurers offer the Universal Health Scheme covering up to Rs 30,000 ($660) of hospital expense for annual premium of Rs 365 for a single person, Rs 547.50 for a family of 5, and Rs 790 for a family of 7. Persons below the poverty line receive a subsidy of Rs 200 for an indivdiual, Rs 300 for a family of 5, and Rs 400 for a family of 7.

These and other government insurance products are useful in extending coverage; however, the prevalence of public subsidies may strain the efforts of private insurers in expanding coverage to the BPL population. In addition, the product design of these subsidised schemes may not be particularly suited to the sector's need as the contract is complicated, with many exclusions. The BPL population may not know how to access service relying on cumbersome reimbursement procedures with long delays in claims processing. Even with the subsidies, the premium is still beyond the capacity of the majority of the target population.

[4] "Insurance products provided by insurance companies to the disadvantaged groups in India," ILO/STEP.

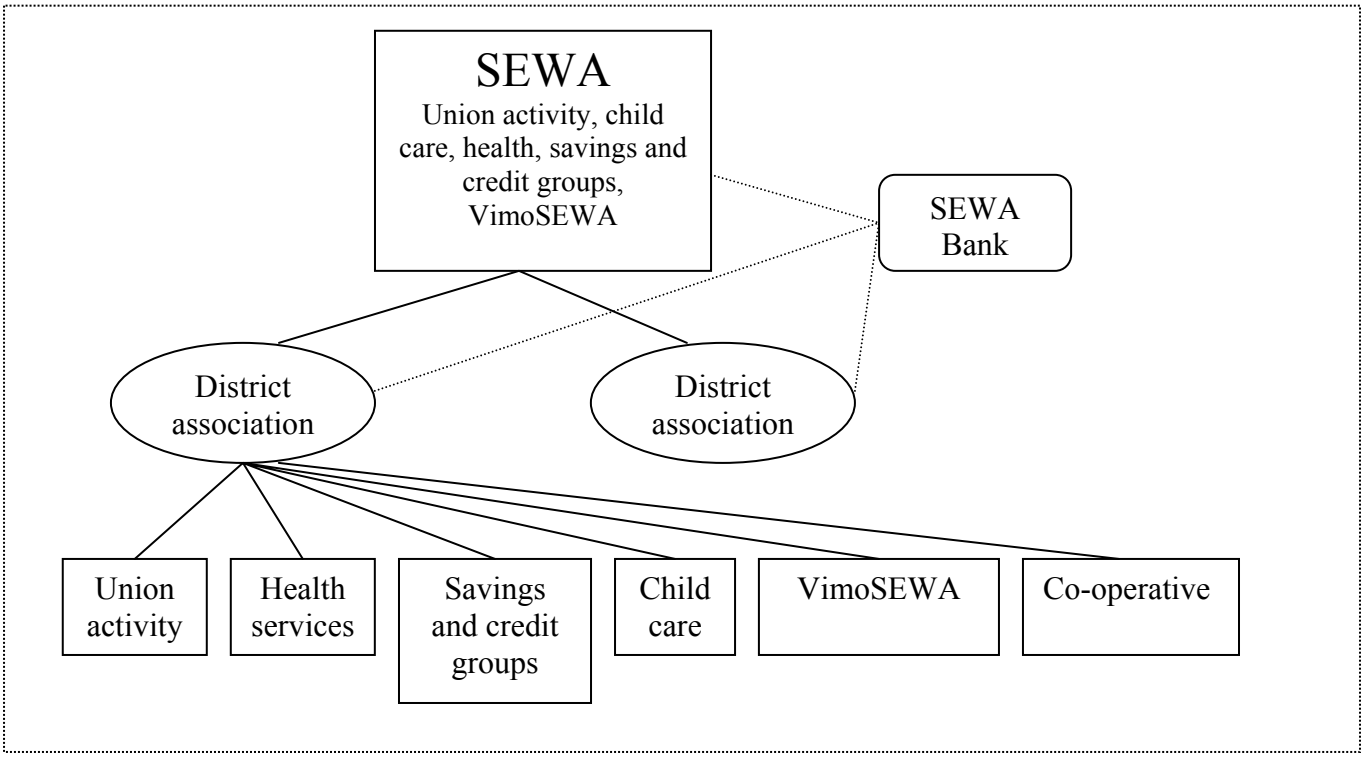
2. The Institution

2.1 History of the Institution

Overview

The Self Employed Women's Association (SEWA) was founded by Ela Bhatt in 1972 as a union for rural and urban workers in the informal economy. By December 2004, SEWA had almost 700,000 members. Several services have evolved as part of the union, including a separately registered bank in 1974, health co-operatives and a health service unit, and childcare co-operatives. In 1992, an Integrated Social Security Scheme was developed, which has now become VimoSEWA.

Figure 1: Overview of SEWA



The main activity of SEWA is a union for self-employed workers. Within the union there are several "divisions" providing a variety of services. SEWA Bank is a separate legal entity, having a democratically elected board from SEWA's membership. SEWA functions via district associations that are responsible for providing services.

In the matrix structure depicted in Figure 1, VimoSEWA is integrated into the SEWA family, for better or for worse. VimoSEWA benefits significantly from its links with other departments, such as preventative services from SEWA Health, financial transactions with SEWA Bank, and distribution assistance from the union. In addition, VimoSEWA benefits from credibility in the low-income market because it is associated with the union's strong

brand. However, since it is not independent, VimoSEWA is not particularly agile. Broad organizational discussions are required to change procedures, such as offering incentives for sales promoters or recognizing depreciation in financial statements.

The health service provided by SEWA to members is a particularly important resource for VimoSEWA's health insurance. SEWA Health has worked to improve the skills of midwives and the formation of health workers, having a direct impact on reducing maternal and infant mortality. In some districts, a pharmacy service provides low-cost, generic drugs to members. The health promotion and education activities can be used as a risk mitigation strategy for the health insurance. Attempting health insurance without knowledge of diseases, health facilities and risk mitigation strategies will likely doom a scheme to failure. VimoSEWA has benefited from the experience of SEWA Health by better detecting fraud by members and providers, directing members away from inappropriate and expensive treatments, and by providing health promotion activities and information to insured members.

The Advent of Microinsurance

In the first year of operation in 1992, membership in the insurance programme was mandatory, resulting in 50,000 members insured for life and accident. Premiums were automatically deducted from savings accounts in SEWA Bank. However, this resulted in a backlash as members did not understand why money was taken from their accounts and many did not want insurance. The following year, the social security plan became voluntary resulting in a plunge in enrolment to 7,000 insured.

The public life insurance partner, Life Insurance Corporation (LIC), was providing subsidised coverage with a claims ratio of 200% for the life coverage. While this was beneficial to members, it was not a long-term viable model.

In 1994, health and asset protection were added via United India Insurance Company (UIIC), which had no previous experience with below poverty line markets. This was a period in India when the public insurance companies had a monopoly, so VimoSEWA felt that it had little room to negotiate required changes, even though the product and processes were inappropriate for the realities of the BPL market.

For example, the contract stated claims would only be paid if the hospital had 10 or more beds. VimoSEWA found that there were quality facilities with less beds near to members, yet these claims were rejected. Qualified facilities often required members to travel, adding transportation costs and inconveniences. The minimum coverage available in the policy, 5,000 Rs ($110), was unaffordable for the majority of SEWA members. The ratio of claims rejections was high and reimbursements took 2 to 6 months— a real problem for BPL households with severe cash flow constraints. Any delay in claims reimbursement could result in members borrowing from moneylenders, adding to their burdens.

Consequently, VimoSEWA began offering in-house health insurance in 1996, and then added asset insurance in 1998.

In these early years, for coverage that was offered with insurers, premiums paid by the clients covered the premium charged by the state insurers, who in turn provided subsidised coverage.

Investment earnings on an endowment fund provided by GTZ covered VimoSEWA's administrative expenses. This financing model worked reasonably well as long as the client base was below 30,000. However, once VimoSEWA grew, the investment earnings on the endowment fund could not cover the administrative expenses. In addition, the declining interest rates reduced the capacity of the endowment fund to cover administrative expenses.

There were additional subsidises built into the institutional arrangements. From 1992 to 2001, the sales campaigns were the responsibility of the local union leaders, known as Aagewans, appointed by the district association. The cost of these sales effort was borne by SEWA, with no cost allocated to VimoSEWA. In 2001, a separate Vimo Aagewan roll was created with expenses borne by VimoSEWA. The annual sales campaign is still aided by all Aagewans, however it is the primary focus of the Vimo Aagewans. Outside of the campaign period, Vimo Aagewans are occasionally called on to assist SEWA with other services.[5]

During the period from 1992 to 1999, there was no significant effort to increase the insurance skills of the administrators of the program. In 1999, GTZ funded the collaboration of an experienced insurance person, who helped develop greater management and insurance capacity at VimoSEWA. The concept of VimoSEWA began to shift from a welfare fund providing aid to distressed persons to an insurance scheme that pooled risk. These changes were important developments for VimoSEWA as it amassed the skills required to run an insurance operation.

The opening of the insurance market in the late 1990s loosened the monopoly of the state companies. The entry of private companies increased the willingness of all insurers to look at innovative methods to reach a larger market. The increased flexibility helped VimoSEWA, as real dialogue could now take place to find mutually acceptable solutions. Around this time, VimoSEWA started thinking about establishing a regulated microinsurance company.

Earthquake Risk

For several years, VimoSEWA's transition from UIIC to self insurance had positive financial and service benefits. However, when the January 2001 earthquake struck Gujarat**,** over Rs 3,400,000 ($75,000) was required to satisfy claims, causing a severe financial strain. Prior to the earthquake, annual payouts for asset protection were below Rs 30,000 ($662). This experience helped VimoSEWA appreciate the need for reinsurance.

Insurance companies buy catastrophe insurance for major events or potential claims that far exceed the average anticipated payout. Careful analysis of reinsurance is required. In some cases, reinsurance is not necessary, such as when claims have a high probability, low severity and have no covariate risk. In other cases, like earthquakes, floods and communal violence, the covariate risk is high, resulting in claims far exceeding expectations of an average year and therefore requiring reinsurance. Reinsurance programs should be developed by whoever is responsible for the risk, e.g., the insurer in the partner-agent model. There should always be reinsurance for catastrophes, unless such risks are excluded—but such exclusions would mean that the target market would not receive coverage when they need it the most.

[5] In 2005, there were approximately 1000 Aagewans, of which 120 were Vimo Aagewans.

Following the disaster, VimoSEWA went back to the partner-agent approach. Since it was not a licensed insurer, it could only access reinsurance if an insurer held the primary risk. In 2002, VimoSEWA retained National Insurance Company (NIC) to insure the health and asset benefits. But now there was competition among insurers for agents like VimoSEWA, and it had a better idea how to use its size and experience in the negotiations with insurers. For example, during the self-insured period, VimoSEWA formed claims committees to establish claims protocols and adjudicate claims. In the new arrangement, NIC allowed VimoSEWA to process claims following its existing infrastructure and protocols.

New Directions

Following the earthquake, insured membership increased to 90,259. The large spike in membership, the liberalization in the regulatory environment, dissatisfaction with services of current insurers, and the desire to eventually become an insurance company combined to cause VimoSEWA to develop a business plan to reach financial viability. This business plan was built in consultation with a group of donors who met in October 2001. The large jump in membership also pushed the organization to substantially improve its capacity. The huge volumes helped VimoSEWA realise that it needed significant upgrades for its information systems to manage client data, greater training for staff, and more reliable claims service.

The October 2001 plan focused on the development of an insurance programme for the poor run on sound insurance principles, financial viability and policy action (direct government contributions and a suitable regulatory environment for microinsurance). Reaching viability would take 7 years and depended on a substantial increase in the number of insured—a task subsequently found more difficult to achieve than anticipated.

VimoSEWA's model is based on providing insurance for the wider community on a voluntary basis over the long term. While a link to microcredit activities is used, it is not the exclusive distribution channel. For health coverage, VimoSEWA uses the knowledge gained from SEWA's health activities. VimoSEWA takes on all distribution, product development, administrative and claims activity on behalf of the insurance companies. As the insurance company outsources these activities to VimoSEWA, the commercial insurance market would call VimoSEWA a Third Party Administrator; however in India that term has a specific connotation and cannot be used.

As part of its sustainability strategy, in 2001VimoSEWA introduced a new insurance package, Scheme III (see Appendix 1), which featured higher benefits, higher premiums and greater operating margins. The expectation was that Scheme III profits from this "richer" target market would be the road to sustainability. However, members found the multiple coverage options confusing, and the new product distracted the focus of VimoSEWA. The numbers enrolled remained low and it quickly became evident that marketing Scheme III would require a different distribution method. To maintain focus on achieving viability in the BPL target market, Scheme III was dropped for the 2005 campaign.

VimoSEWA's 2001 business plan assumed that it had built momentum in reaching members. After all, membership increased from 29,000 to 90,000 in one year. In fact, this increase was a "false jump" because the insurance campaign coincided with SEWA's disaster relief effort. This meant that members who obtained post-earthquake relief, readily joined insurance

without fully comprehending the concept and its benefit. This resulted in significant dropouts, which were exacerbated by poor service following communal violence in 2002 (see Box 1). Low renewal ratios have continued to impede VimoSEWA's efforts to achieve viability. Now VimoSEWA has increased efforts to improve renewal rates by ensuring that members clearly understand their policy, how to access benefits, and even what is not covered.

Box 1. Communal Violence

As the business plan was being implemented, Gujarat was hit with communal violence starting in February 2002. Stability was reached only by July 2002. The dangerous environment had an impact on the quality of services as VimoSEWA's team could not provide timely responses. Further, the crisis delayed the hiring and training of staff, and increased work loads with a flood of claims even before VimoSEWA was fully prepared to deal with a crisis of such proportions. All of this led to dissatisfaction among the members and consequently some dropouts. In addition, the violence and the consequent tense and dangerous atmosphere set VimoSEWA back by half a year in terms of its total plan. The effect was longer than expected and had an impact even on the 2003 campaign. This unfortunate incident illustrates that microinsurers have to be prepared to deal with disasters.

In 2002, the annual campaign was changed to a calendar year from a July 1 policy year. It was anticipated that members would have a greater ability to buy insurance prior to the New Year when harvests are collected. In practice, the change in campaign period had no significant effect.

VimoSEWA feels that it is important to have a member-owned insurance company, since this would increase the dignity and self-reliance of its client base, as was demonstrated with the formation of SEWA Bank. If regulatory constraints on capital could be overcome, VimoSEWA desires to become a registered insurance company. (However, capital is not the only barrier; VimoSEWA would also have to demonstrate fit and proper management and a sound business plans.)

Table 2.1 VimoSEWA Chronology of Major Changes

Year		Event
1992		Mandatory life and accidental death insurance with LIC
1993		Voluntary life and accidental death insurance
1994		Added asset and health insurance
		Added spouse life insurance
1996		Self insured health
1998		Self insured asset
1999		Added health insurance for spouse
2001		Gujarat earthquake
		Developed business plan to scale up operations
		Added Scheme III
2002		NIC insures health and asset
		Period of communal violence
		Changed annual payment and insurance from July 1 to Jan 1
2003		Child health insurance added
		ICICI Lombard provides health and asset
2005		Eliminated Scheme III
		AVIVA becomes life insurance partner

Table 2.2 Insurance Organization Basics

Issues	Observations
Legal structure	Union Trust Fund operating within SEWA as an insurance programme administrator; risk maintained by insurance company
Registration status	Not registered
Regulation status	IRDA permits an NGO to administer benefits provided an MoU exists between parties.
Start of corporate operations (year)	1972
Start of microinsurance operations (year)	1992
Core business	Integrated insurance package, with life, health, asset, accidental death, maternity and other minor coverages
Target market – core business	Informal economy workers
Target market – insurance business	Members of SEWA and other similar organizations
Geographic area of operation	Principally Gujarat with expansion into other states commencing
Development, marketing, or servicing policies with other institutions	Links with SEWA Bank, union, SEWA Health and childcare
Reinsurance	No direct reinsurer; using partner-agent model with insurer retaining all the risk

Table 2.3 Insurance Organization Basics – Trends (US$)

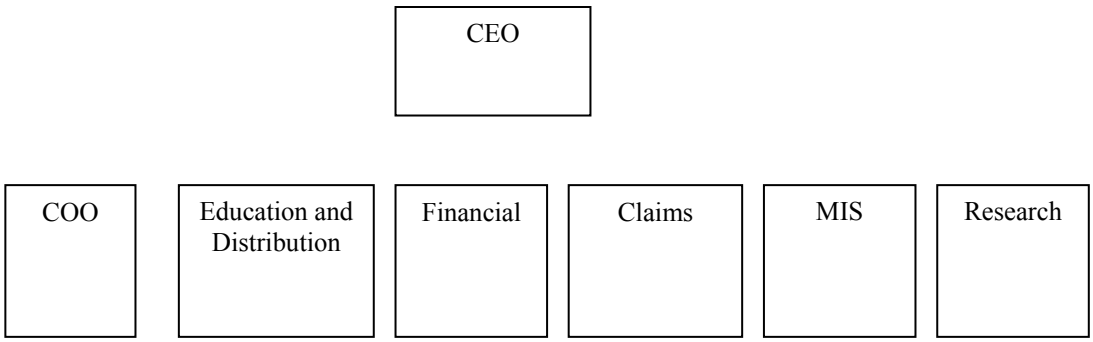
	2004	2003	2002
Total assets	2,064,000	1,825,000	Not available
Annual budget (administration expenses)	245,000	163,000	117,000
Total capital	971,000	768,000	662,000
Number of sales promoters (Vimo Aagewans)	110	Unknown	Unknown
Total number of microinsurance policyholders	105,000	110,000	93,000
Total number of microinsurance insured lives	110,000	112,000	93,000
Number of microinsurance staff	175	176	149
Staff turnover (%)	11%	20%	27%
Number of policyholders / microinsurance staff (%)	600	625	625
Microinsurance marketing (and distribution) costs	65,000	36,000	23,000

2.2 Organizational Development

VimoSEWA has a mission "to provide social protection for SEWA members to cover their life cycle needs and the various risks they face in their lives, through an insurance organization in which they themselves are the users, owners and managers of all services." As VimoSEWA is a part of SEWA, it falls under the union's democratic structure. The overall operations rest with the management team of VimoSEWA (see Figure 2).

The CEO, Mirai Chatterjee, has direct responsibility for overall functioning of VimoSEWA, and reports to the general secretary of SEWA. The COO has responsibility for the execution of the insurance operations. This position, previously held by someone with insurance company experience, is currently vacant.

Figure 2. Organizational Structure of VimoSEWA



Increasing the overall skills of the staff is an important goal for VimoSEWA. The Education and Distribution Coordinator is responsible for ensuring that all employees have suitable training plans and that training takes place. The Education and Distribution Coordinator is ultimately in charge of all sales promoters or Vimo Aagewans.

The front line staff, the Vimo Aagewans, are responsible for enroling members, collecting premiums and assisting in submitting claims. They ensure that members understand the benefits of insurance. In Ahmedabad City and for four decentralized districts (Anand, Boroda, Sabarkantha and Ahmedabad District), VimoSEWA has direct control of the Vimo Aagewans. In all other districts, the district association directs the Vimo Aagewan and the effort for VimoSEWA.

Support departments are critical for the success of VimoSEWA. An experienced chartered accountant (CA) heads VimoSEWA's financial operations. She is responsible to maintain proper accounts, internal audit, investment policy management, and produce the appropriate financial management reports. The claims coordinator is in charge of claims processing and record keeping. MIS produces the software for insured and claims activity, maintains the accuracy of the data, and provides reports required by management.

Research at this stage is conducting studies to find effective strategies to improve access to benefits, as well as understanding why insured lapse their coverage. In the future, the research coordinator should develop pricing recommendations.

In addition to the VimoSEWA team, an external auditor reviews its accounts, and CGAP engages a consulting actuary to provide periodic assistance to management.[6]

VimoSEWA is ultimately governed by the SEWA board.

Insurance Expertise

From 1999 to 2001, GTZ funded an experienced insurance person from UIIC to provide coaching to all staff and assist in developing an administration system, in collaboration with

[6] The consulting actuary is the author of this paper.

other consultants. Prior to this upgrading of record keeping, VimoSEWA systems were inadequate for the crucial task of providing meaningful information to manage the scheme.

From 2001 to the spring of 2005, VimoSEWA had a COO with experience in the insurance industry, but she recently emigrated from India. The previous claims coordinator also had many years of insurance company experience. An outside actuarial consultant was engaged to enhance the team. Since the initial donors meeting (2001), training programmes plus the occasional outside intervention have resulted in the coalescing of a mature microinsurance management team.

Insurance training has enhanced skills; however, it is inadequate in assisting the VimoSEWA team in meeting the needs of microinsurance management. There is a great need for pedagogical information on microinsurance, such as publications by the ILO.

Training and Compensation

Training plans have been developed for each staff member with the assistance of an outside expert, DD Trivedi. The process was to map current versus needed skills, and then prioritize needs for each individual. The Vimo Aagewans had particular emphasis placed on product knowledge, claims process and sales skills.

Performance of Vimo Aagewans is reviewed annually; those who are unable to meet sales targets are replaced. The average salary of the Vimo Aagewan is Rs 1,700 ($38) per month in urban areas and Rs 1,350 ($30) per month in rural areas. VimoSEWA will experiment with some incentive compensation in 2005 based on the renewal ratio, sales targets and the number of family packages sold.

In general, compensation is low for professional staff as well, creating some turnover as staff seeking better paying jobs. However, as a women's organization, human resource policies are sensitive to the needs of employees, of which over 99% are women, permitting flexibility in working hours should the need arise to deal with family issues. In the last three years, the staff turnover rate has decreased.

2.3 Resources

Financial resources are derived from premiums, investment income, donor support, insurance company subsidies and expense allowances, and a contribution to capital by members. The premiums charged by VimoSEWA cover the cost of the premiums paid to the insurance companies, and are providing a small margin towards administrative expenses. Investment income derived from donor grants has contributed to a positive financial result.

The business plan anticipated donor support to scale up operations, and this investment in additional staff and distribution capacity is expected to impact future years' operations. Support from GTZ and Ford Foundation covers administrative expenses, research, as well as endowment of Rs 50,000,000 ($1,100,000) from which investment earnings can cover future administrative expenses. CGAP has funded an external actuarial and management consultant to assist VimoSEWA from 2002 to 2004. ILO STEP has funded research on renewal rates. The Canadian Cooperative Association (CCA) provided a grant to allow SEWA to offer an

interest free loan for members that want to borrow money to purchase the fixed deposit (FD) premium paying method (described in Section 4).

The donors' support has been important expanding access to microinsurance, however the lack in coordination in the donors reporting requirements added to the cost and effort of VimoSEWA, taking it away from the primary task of achieving viability.

The current regulatory environment requires insurers to cover BPL populations. Since private insurers are interested in the large middle- to high-income population, they are willing to sell insurance to the BPL population at a loss, providing a hidden subsidy to VimoSEWA. In addition, public insurers receive funds from the government to provide subsidized coverage for life and health insurance.

Finally, members of SEWA have contributed Rs 330,000 ($7,285) to capitalize the fund.

2.4 External Relationships

VimoSEWA works within the general framework of SEWA. VimoSEWA has direct relationships and a signed MoU with SEWA Bank for the management of the fixed deposit method of paying premiums. SEWA Bank contributes the earnings on the FD accounts to VimoSEWA to provide coverage to members insured with this premium payment method.

VimoSEWA also has a long history of partnering with a variety of different insurance companies. Initially, the principal partners were public insurers: LIC for life from 1992 to 2004, UIIC for health and asset from 1994 to 1998 and NIC from 2001 to 2004.

For the 2003 policy year, VimoSEWA insured part of the life insurance portfolio with OM Kotak, as it provided more favourable rates than LIC and promised greater flexibility. The complete life portfolio was not moved as VimoSEWA did not want to leave LIC until it was sure that the new partner would be better. However, OM Kotak was not sufficiently familiar with the BPL market and the relationship ended after only one year.

Still, delays with LIC's claims settlements were unacceptable, often taking 1 month or more after VimoSEWA submitted all the documentation. Therefore, VimoSEWA kept exploring alternatives. Aviva became the life insurer starting in 2005 as it permitted VimoSEWA to pay the life claims, reducing reimbursement time to 1 week.

For health and asset insurance, the private, non-life insurer ICICI Lombard became the partner in 2003, providing improved conditions, such as a fund to reimburse claims. This partnership has continued to date.

VimoSEWA has MoUs with Aviva and ICICI Lombard outlining the duties of each party and the term of the agreement.[7] These agreements delegate distribution, premium collection, recordkeeping and claims payment to VimoSEWA, with the insurer bearing the risk.

[7] The MoU for ICICI Lombard is included in Appendix 3.

The relationship with insurers has changed since the liberalization of the insurance market. VimoSEWA has chosen insurers that are more willing to work on improved speed of claims payment and the flexibility of documentation requirements for claims. In addition, more favourable financial terms have been negotiated with current partners. The evolving insurance market in India has created conditions for more appropriate microinsurance arrangements.

In 2003, VimoSEWA started partnering with NGOs to expand the distribution of insurance coverage; these partnerships are expected to increase with time. There are two categories of partners. The first category enrols members, pays claims and provides health information or services; they receive an allowance for this work and are provided with training and materials by VimoSEWA. For example, Nidan, one of the first NGOs to join the VimoSEWA scheme, works with street vendors in Patna, Bihar, providing some health services. The second category is smaller NGOs that facilitate information to their members and are contacted and serviced by Vimo Aagewans.

2.5 Risk Management Products

VimoSEWA provides life insurance, health insurance, asset protection and accidental insurance. In the event of earthquake, communal violence or other disasters, SEWA has been a distributor of relief. In addition, SEWA Bank provides loan and savings facilities, and SEWA Health delivers low cost pharmaceuticals, trains midwives and provides other medical services.

SEWA believes that the state has a role in the social security of informal workers and should provide a direct contribution towards their social security benefits. The union has been involved in policy action to achieve this goal. In part, this work may have contributed to the proposed reduction in taxes on insurance products provided to BPL populations. In the long term, SEWA would like comprehensive social security coverage for BPL populations.

2.6 Profit Allocation and Distribution

VimoSEWA has a “trust” philosophy; profits, if any, should be distributed for the benefit of the current and future beneficiaries. To date, no profits have been distributed; based on the future business plan, there is no expectation of profits for the next 7 years. Given this situation, the issue has not been discussed; however, VimoSEWA will have to develop a formal policy within the next 5 years.

2.7 Investment Policy

VimoSEWA has no regulatory requirements imposed on the investment of assets. An investment policy has been developed and accepted by SEWA and is in the implementation stages. The investment committee includes the CEO of VimoSEWA, SEWA senior management, the managing director of SEWA Bank, the external auditor and the finance coordinator. The entire portfolio of assets is invested with SEWA Bank in fixed deposits. In the mid-90s, SEWA had diversified investments to government bonds; however, these financial instruments were in default for a period, leading to VimoSEWA’s current

investment position. In addition, the return on investment with SEWA Bank is superior to that of private banks by 1 to 2%. However, it is important for VimoSEWA to start diversifying its investments, as it is too concentrated in one financial institution.

A principal reason for failure of an insurance company is the illiquidity of assets; for this reason, the investment portfolio has to be diversified in the types of financial instruments, and matched to projected cash flow needs. VimoSEWA has implemented a cash flow plan to manage the timing of investment maturity with cash requirements. In diversifying assets, the real estate asset class should be limited to not more than 10% of invested assets due to its lack of liquidity.

Finding suitable investments to provide sufficient diversification continues to be a challenge to all microinsurance organizations in developing economies.

2.8 Reinsurance

With the use of the partner-agent model, almost all the risk is borne by insurance companies; hence, VimoSEWA has little risk. The ability to change partners due to the dynamic nature of the Indian insurance market has been useful in negotiating flexible arrangements in terms of price, coverage provisions, claims settlement practices and reimbursements for marketing expenses.

Should VimoSEWA form an insurance company, an appropriate reinsurance programme will have to be developed. A reinsurer will only deal with an organization that has a credible business plan, knowledgeable management and an understanding of the risk faced by the organization.

3. The Members

3.1 Social, Economic and Geographic Conditions

VimoSEWA operates principally in Gujarat and is expanding services to other states. The primary target market is the members of SEWA, both urban and rural women, working in the informal economy, such as home-based workers, producers, vendors, manual labourers, and agricultural workers. VimoSEWA's membership is 66% rural, with service provided via the district associations, and 34% urban, receiving services directly from Vimo Aagewans. While the number of SEWA members continues to increase—700,000 in 2005—the urban-rural mix has not. These workers have no fixed employer-employee relationship. They are self-employed and do not have protective legislation, nor do they have statutory social protection. At the same time, they are the poorest and most vulnerable of workers in India. Many SEWA members earn less than $1 per day.

In addition, VimoSEWA works with other NGOs to distribute insurance products elsewhere to similar target markets.

The original business plan intended to serve higher income clients with the goal of using the profits from this segment to subsidize the lowest income segments. As the programme evolved, the organization realised that a higher income segment was difficult to reach by the current distribution system. VimoSEWA decided instead to concentrate on improving its service to the current SEWA members before going upmarket. A higher income market requires a different sales promoter with an understanding of this higher income market.

Table 3.1 Client Information Table

Issues	Observations
Intended target groups/clients	Members of SEWA, other BPL or near poverty line population and other NGO members
Actual clients	Actual is the same
Exclusions of specific groups	Women are the only ones who can be insured, spouses can be covered if premium is paid for them
General economic situation of clients	Members are near or BPL
Key economic activities of clients	Home-based workers, producers, vendors, labourers, agricultural workers, and other informal economy workers
% of clients in the informal economy	100%
Social characteristics of clients	Women near or BPL working in the informal economy
Geographic characteristics	Throughout Gujarat and expanding to other states
Nature of membership	Insured are encouraged to become members of SEWA, but that is not a prerequisite to obtaining insurance
Methods of recruitment of clients	Sales promoters called Vimo Aagewans publicise the insurance product, links are established with SEWA Bank, union, SEWA Health, childcare, savings and credit groups and other NGOs

3.2 Major Risks and Vulnerabilities

Informal economy workers face many risks with little protection. The insurance plan started in the early 1990s as a means of social solidarity. With continuing informal surveys of members needs, coverage has expanded. The initial coverage included life insurance on the member, widow insurance in the event of the spouse's death, and accidental death. These were expanded to include asset protection, health insurance, maternity coverage and most recently, health insurance for children. Members have indicated an interest in cattle and crop insurance as well; however, these are currently beyond the means of VimoSEWA members.

Without this insurance package, traditional approaches are used, such as borrowing from savings group/bank savings, moneylenders, aid of relatives, pawning and selling of assets to meet expenses.

3.3 Relationship between Risks and the Institution's Services

The insurance package is provided first to women, to which they can add life, health and accidental insurance for their husbands, and health insurance for their children. The main work of SEWA is to organise and unionise women, making them aware of their rights and their contribution as important vehicles in the informal economy of the country. SEWA also helps members develop income-generating activities, access health services, childcare and housing services, as well as financial services from SEWA Bank. SEWA views social security as one critical piece in the poverty alleviation puzzle.

The recent period of communal violence (2002), the earthquake in 2001, and floods in 2003-04 demonstrated the positive impact of VimoSEWA. Insured members received funds to replace the loss of equipment and huts, enabling them to return to productive employment quickly. Asset insurance is a much used product line and a service that is difficult to manage due to its complicated calculations.

3.4 Familiarity with Insurance

Education of members on the concept of insurance requires considerable effort, as target clientele cares only for its day-to-day earnings without a thought to adversities/risks to their families or themselves. Familiarity with insurance terminology is only through posters and billboards of insurance companies.

VimoSEWA explains insurance as: "all contribute to a common pot; those who have faced the prescribed risks can take from the pot as per the rules and regulations decided by all." It is important for members to see this as their programme in order to reduce the incidences of moral hazard. To communicate the insurance plan, a one-page illustrated policy (Appendix 4) is given to members at time of purchase. In addition, VimoSEWA has developed pamphlets, posters, street plays, short videos, and many other methods to communicate the insurance plan.

4. The Product

VimoSEWA offers integrated insurance products covering multiple risks. Once a member has bought her coverage, she can also insure her husband and children. The coverage amounts and price have evolved overtime; Table 4.1 illustrates the current coverage in force.

Table 4.1 Coverage and Price in Rs, Jan 1, 2005

Scheme 1	Member	Spouse	Children	Family
Natural Death	5,000	5,000		
Health	2,000	2,000	2,000	
Asset & Loss	10,000			
Accidental Death	40,000	25,000		
Spouse Accidental Death	15,000			
Premium: Annual Pay	100	70	100	250
Premium: Fixed Deposit	2,100	1,500		
Scheme 2	**Member**	**Spouse**	**Children**	**Family**
Natural Death	20,000	20,000		
Health	6,000	6,000	2,000	
Asset & Loss	20,000			
Accidental Death	65,000	50,000		
Spouse Accidental Death	15,000			
Premium: Annual Pay	225	175	100	480
Premium: Fixed Deposit	5,000	4,000		

- New members (and spouses) have to be between 18 and 55 years old; renewing members and spouses can remain until they are 60
- Persons who pay premiums via the FD method receive additional coverage:
    1. Maternity benefit: Rs 300.
    2. Reimbursement of denture expenses: Rs 600.
    3. Reimbursement of hearing aid: Rs 1000.
- Child coverage for health care is only available through the annual pay method. A Rs 100 premium covers all the children in the family
- Claims for pre-existing conditions are denied for the first 6 months of coverage for new insured members
- There is a Rs 20 discount if woman, husband and children (family package) are covered

Scheme 1 is the most popular package and is affordable to the majority of members. All coverage is voluntary with an annual payment for a one-year term. The policy year runs from January 1 to December 31 for annual pay members; those that complete a fixed deposit can have coverage commencing the first of the following month. Members with FD coverage have a few additional benefits as illustrated above to encourage this payment option. Child coverage is available only on an annual pay basis and covers all children in the family up to a maximum of Rs 2000 for hospitalization. To encourage covering the whole family, VimoSEWA discounts the combined woman, husband and children premium by Rs 20.

Members have two ways of paying for coverage: 1) annual payment (AP), or 2) fixed deposit (FD). This latter method requires members to make a fixed deposit with SEWA Bank, with the interest on the fixed deposit paying for the insurance coverage. This creates a semi permanent premium payment method. The FD amount is changed as little as possible as it is a difficult process to approach members to increase the deposit. The number of insured with this method has remained relatively stable over time.

The FD premium method minimises VimoSEWA's premium collection costs, maintains a high renewal ratio and creates a semi permanent client. The disadvantage appears when the FD amount has to increase due to an increase in premium or declining interest rates; members have to be convinced again to contribute. With the most recent increase in funding requirement, over a 1000 members cashed in their FD accounts. The other disadvantage is that the required FD amount is quite large and difficult for the BPL market to amass. When the child health coverage was added, VimoSEWA did not even include an FD premium payment option because it was felt that members would not be able to pay the premium in that way.

The integrated package includes:

- one-year term life insurance for death from any cause,
- health insurance covering hospital stays up to the maximum amount on a reimbursement basis,
- asset protection for hut and contents, and
- accidental death coverage

Many of these benefits have been added over the years in response to feedback from SEWA members (see Appendix 2 for a history of product changes). For example, the original policy was for members only; based on requests from members, VimoSEWA added the option to buy insurance for husbands. The same process happened when health insurance for children was introduced. Most recently, VimoSEWA negotiated with the health insurer to cover pre-existing diseases, for a premium loading of 25% extra on the basic health premium. This new coverage excludes only first-year members for 6 months for any claim due to a pre-existing disease.

Important factors in making the decision to change the product are: an assessment of the members' ability to pay for the coverage; VimoSEWA's capability to manage the product; the cost of adding the benefit; and the probability of viability. For example, members desire livestock insurance, yet this has not been added as it would be too costly for clients and too difficult for VimoSEWA to manage.[8]

To reach viability an increase in premium is required to ensure that all claims and administrative expenses are covered. VimoSEWA plans to close the viability gap by increasing premiums every two years—it was felt that annual increases would be difficult to

[8] Although VimoSEWA's insurance offers many benefits, they are all integrated into two products with additional options for spouses and children. Livestock insurance, however, could not be just another benefit of its existing product, but would rather have to be a separate product since it would only be appropriate for a portion of VimoSEWA's membership. Consequently, it would require a significant change to the administrative systems.

explain to members. To make the increase palatable, VimoSEWA also introduces a small increase in the benefit amount, however below the cost of providing the increased benefit. For example in 2005, the life insurance sum assured for Scheme I increased from Rs 3,000 ($66) to Rs 5,000 ($110), while the premium increased by Rs 15 ($0.33). The actual cost of the benefit increase was Rs 8, leaving Rs 7 to cover administration costs.

Table 4.2 Product Details

	Product Features and Policies
Microinsurance Type	Integrated coverage for woman, plus husband and children
Group or individual product	Group
Term	1 year
Eligibility requirements	Women between ages 18-55, renewal to age 60
Renewal requirements	Continuing premium payment under age maximum
Rejection rate	Determined at time of claim if had pre-existing condition
Voluntary or compulsory	Voluntary
Product coverage (benefits)	Life, Health (hospitalization), Accidental Death, Asset (see Table 4.1)
Key exclusions	Pre-existing condition for 6 months
Pricing – premiums	See Table 4.1
Pricing – co-payments and deductibles	No co-payment or deductibles; health benefit is based on being hospitalized for 24 hours

4.1 Partners

Initially, VimoSEWA partnered with public insurance companies. The insurance companies created constraints that required dialogue and exposing the insurance administrators to the reality of SEWA's members. Initial dialogue improved some aspects of the claims administration. Larger improvements followed over time. The organization now has an MoU with life insurer AVIVA permitting VimoSEWA to administer all aspects of the life policy, even paying claims. Similarly, VimoSEWA and ICICI Lombard, which covers health, asset and accidental death benefits, have an MoU outlining the division of tasks (see Appendix 3).

VimoSEWA has the responsibility of settling claims for partners. The insurers provided the initial training, and then dialogued with VimoSEWA on processes to use for BPL populations. VimoSEWA submits reports to insurers of claims settled and are reimbursed. Occasionally, the insurers reject a claim that VimoSEWA feels should be paid. VimoSEWA assumes the liability for these extra-contractual claims. Besides these minor payments, VimoSEWA also retains the risk for the extra benefits provided to FD premium members (i.e., maternity, dentures and hearing aids).

The willingness of the insurance partners to dialogue with VimoSEWA has increased with the introduction of private insurance companies and the fact that the regulatory regime requires all companies to have a certain percentage of business in the social sector. In addition, VimoSEWA has worked with IRDA and others in developing policy forums to openly discuss issues with all the players. Finally, VimoSEWA held an exposure dialogue in October 2004 where various insurance leaders lived for two days with SEWA members to understand the realities of their lives and how insurance can address their needs.

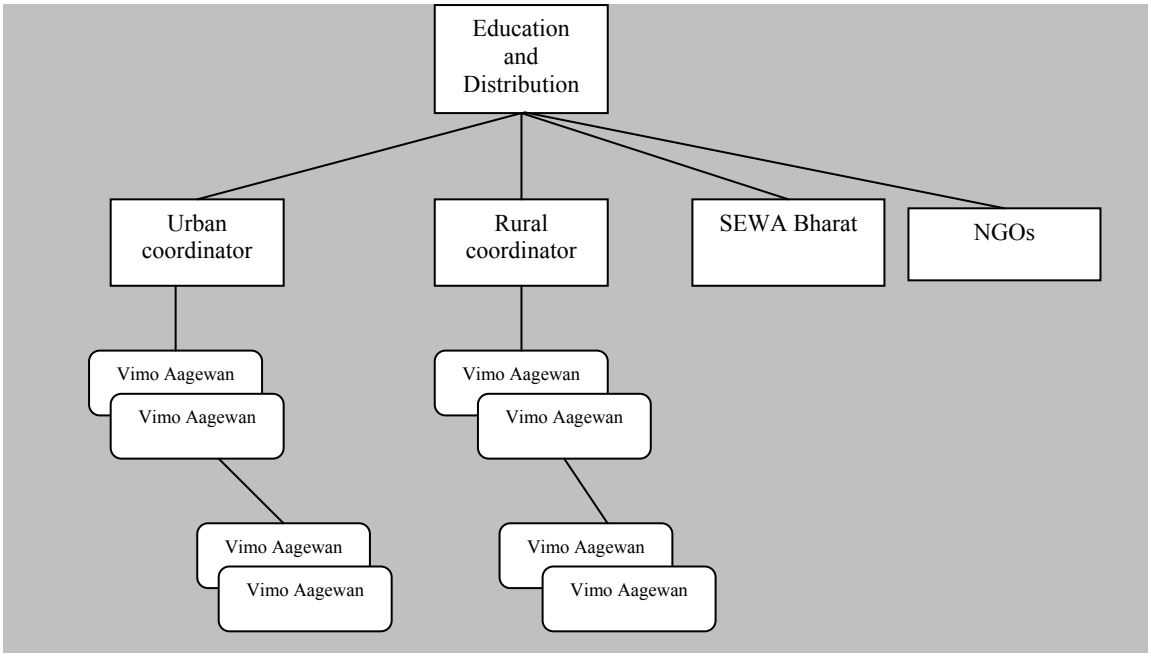
It seems that creating understanding has been the most successful method in developing understanding between insurers and VimoSEWA, especially in finding appropriate methods to adjudicate claims.

4.2 Distribution Channels

Until 2000, VimoSEWA relied on the SEWA organization to manage its annual mobilization campaign to distribute products. Since 2000, Vimo Aagewans have been the primary method of distribution. The prior method was done without any cost reflected to VimoSEWA, resulting in a hidden subsidy. To increase transparency, better reflect cost, improve members' understanding of the insurance programme and enhance customer service, the Vimo Aagewans were added. By specializing in insurance, it is expected that the Vimo Aagewans would be more effective than generalists.

A Vimo Aagewan is a community leader trained on the subject matter of insurance, and taught how to sell and service the insurance product. The distribution is split into three areas, urban, rural and SEWA Bharat (outside of Gujarat). Under all coordinators there are a total of 125 Aagewans. VimoSEWA may have to consider adding staff positions to deal with the growing number of NGOs that are partnering with it. Partnering with NGOs started in 2003, and represents less then 5% of insured members.

Figure 2. VimoSEWA Distribution System



The initial impact of the business plan was an increase in distribution cost. In 2002, distribution cost was Rs 11 per insured adult; by 2004, this had increased to Rs 28. With time and increased effectiveness, the distribution costs should decrease. Effectiveness is measured by number of insured per Aagewan (average 800 in 2004) and by renewal rates.

Renewal rates may indicate the attachment members have to the insurance programme. The Fixed Deposit method of paying premium results in 100% renewal; the annual premium method has experienced an increase in renewal rates in recent years (see Table 4.3).

Table 4.3 VimoSEWA Renewal Rates

Effective Date	Premium Paying Method		
	Annual Premium	Fixed Deposit	Total
01-Jan-03	22%	100%	48%
01-Jan-04	30%	100%	51%
01-Jan-05	41%	100%	59%

Even the improved renewal rates fall far short of expectation. The low renewal of AP members is the principal reason outreach targets have not been reached. In the last campaign, certain districts had close to 50% renewal rates. The better performing districts have maintained links with SEWA Health, savings and credit groups and other SEWA services. To reach viability, VimoSEWA will have to increase renewal rates; better use of links with other SEWA services will help achieve this.

The FD method of payment has closures when members require the cash for emergencies. The recent increase in amount required for FD has resulted in approximately 125 closures per month in 2004.

In 2003, VimoSEWA implemented a new initiative in which the Vimo Aagewans establish contact with both AP and FD members between campaigns to re-explain coverage, ask if they have been hospitalized and assist in claims submission, and provide health information. These visits also have a marketing purpose as the Vimo Aagewans establish new contacts and develop new areas for membership growth. Vimo Aagewans are assessed annually on performance and replaced if required. Sharing information with other micro insurers with voluntary distributions systems may assist in developing an approach to achieve higher renewal rates.

4.3 Benefits

The VimoSEWA mission is to provide integrated social security to members. Access to the benefits is through women who can choose either Scheme I or II; once chosen, she can also add her husband in the same Scheme, and finally she can add her children. She would not be able to choose coverage for herself and her child if she has a husband; she would not be able to cover her husband and not herself—the priority is to cover women as SEWA is a women's organization.

Underwriting

The Vimo Aagewans ensure that members who are over the age limits are not enrolled. In addition, they advise members with pre-existing conditions that they will not be covered. However, the primary underwriting control is to sell an integrated package and to ensure a large participation from the target community and across benefit lines. This is demonstrated in the life insurance coverage. When membership in the programme stayed around 30,000 in

the 1990s, the mortality rate was near 10 per thousand. Since July 2000, the mortality rate decreased to around 4 per thousand. It is assumed that the previous low participation attracted only the members that believed they would use the benefits, i.e. anti-selection.

If the distribution method can capture a large part of the community, the risk of adverse selection decreases. Providing integrated packages is an additional way of reducing risk by removing choice.

Life Insurance

A basic life insurance benefit of Rs 3,000 initially provided in Scheme I was increased to Rs 5,000 due to the improved claims experience, a demand from members for higher coverage and to compensate for inflation. For Scheme II, life insurance benefit increased from Rs 5,000 to Rs 20,000, principally to match the level of insurance under the government-subsidised programme of JBY.

Accidental Death Insurance

In 2001, this benefit provided Rs 40,000 to members and husbands in Scheme I and II. The only change was to increase the benefit in Scheme II to Rs 65,000. There has been some discussion of dropping this benefit to use the premium for a higher health insurance maximum; the argument for keeping the accidental death cover is that the benefit is useful in marketing the whole package because the large sum assured is quite attractive.

Health Insurance

In 2000, the member was reimbursed up to a maximum of Rs 1,200 for hospitalization expenses; this maximum is currently Rs 2,000 for Scheme I. In Scheme II, the maximum went from Rs 5,500 to Rs 6,000.

The health cover is the most utilized benefit. Based on an analysis of the 2004 claims database, which captures information on total expenditures submitted[9] versus reimbursement, the average submitted claim is Rs 2,670 with an average reimbursement of Rs 1,574, with 51% of claims reaching the maximum benefit. However, for Scheme II, the average submitted claim is Rs 3,702, with average reimbursement of Rs 2,958 and only 17% of claims exceeding the maximum. It appears that Scheme II provides greater security to the member and family.

Child Health Insurance

The business plan included the addition of child health insurance, effective Jan 1, 2003, providing a reimbursement up to a maximum total benefit of Rs 1,000 to any child of the family that was hospitalized. The current maximum benefit is Rs 2,000. It was important to cover all children in the family to avoid insuring only male children. Recently a family discount of Rs 20 has been provided to encourage an integrated family insurance package.

[9] Additional cost to the claimant such as transportation, lost wages, etc. are not captured. VimoSEWA's system only captures receipts submitted.

Asset Insurance

The member was reimbursed up to a maximum of Rs 5,000 and Rs 10,000 for Schemes I and II, initially, which has now been doubled. There was a large payout for this benefit following the communal violence in 2002, which assisted members to re-establish themselves.

4.4 Premium Calculation

Prior to 2000, the premiums set by insurance companies consumed all of the premiums collected from members. VimoSEWA covered operating expenses from investment earnings on a fund provided by GTZ. In addition, the premiums charged by the public insurance companies did not cover all of their insurance costs. LIC has received funds from the state to provide subsidized coverage for the BPL population.

With the assistance of the CGAP actuarial consultant, pricing has been reviewed annually since 2001. VimoSEWA now has a strategy to increase premiums periodically to cover all of the costs of providing insurance. VimoSEWA feels changing premiums every two years is acceptable to members as long as benefits also increase.

Claims Expense

Premium charged to members should cover at least two components: administration and claims expenses. As of 2005, there is sufficient premium to cover the claims component for the life, accident and asset[10] coverage. Health premiums, however, have not covered the claims cost over the past few years. Table 4.4 compares the actual claims cost with the premium charged by the insurance company.

Table 4.4 Health Benefit Premium Paid to Insurers, Actual Claim Cost (All Schemes)

Period	Insurance Premium	Claims Cost
CY 2002	Rs 12	Rs 14
CY 2003[11]	Rs 18	Rs 40
CY 2004	Rs 18	Rs 59
CY 2005	Rs 39	Rs 77 (projected)

Health claims have increased in recent years. Initially, many members were not aware of all the benefits, how to access health services, and the procedure to receive reimbursement. In 2004, a greater effort was made to increase awareness of benefits and reimbursement procedures, which has contributed to the higher claims. It is also possible that the plan may be experiencing some adverse selection. The current high claims could also be a function of higher cost for urban members (where there is greater access to health facilities) and general increases in medical expenses.

The long-term solution to manage health care cost is to direct members to accredited hospitals that have an agreement with VimoSEWA. This accreditation should set tariffs,

[10] In prior years, the asset protection premium was not sufficient in covering earthquake and flood claims. There remains a risk of catastrophic claims in this line of business.
[11] Benefit increased 50% from prior year.

define quality of care, define member access, and establish appropriate treatment protocols. Secondly, it is important to coordinate with SEWA Health to promote wellness and disease prevention. Thirdly, increasing the percentage of the population insured in a community will reduce adverse selection. Combined, these three measures should control claims cost to ensure long-term viability.

All other benefits—life, accident and asset protection—have a claims expense of Rs 35 in 2005, with premium paid to insurance companies of Rs 35, a break-even price for the insurers. The life experience mortality went from 10 per thousand to 4 per thousand once the scheme covered more than 30,000 members. In this case, the growth of the membership helped reduce claims cost due to marketing that attracted greater number of younger members.

These experiences demonstrate that there is an important link between price, member knowledge of coverage, and insuring greater numbers of target population. Setting prices should never be based on one factor. Price setting must consider how the plan is marketed, whether voluntary or compulsory membership, links with other products, communication of benefits, access to benefits and many other factors.

VimoSEWA is an administrator for insurance companies that take the risk. After having experienced the Gujarat earthquake in 2001, VimoSEWA "reinsures" the majority of the risk with insurance companies. It does retain the risk when the insurer rejects claims that in VimoSEWA's judgment should be covered, and for a few minor benefits such as maternity benefits for more than two children.

Administration Expenses

The business plan called for an increase in outreach effort, decentralization, developing a strong database, improved business processes and professional staff to manage the microinsurance business. This required a scaling up of effort, which initially increased administrative expense (see Table 4.5). As outreach effectiveness increases, that unit cost should decrease over the next 5 years.

Table 4.5 Administration and Distribution Expense per Insured Adult

Period	Administration Expenses	Distribution Expenses	Total Expenses
CY 2002	Rs 46	Rs 11	Rs 57
CY 2003	Rs 52	Rs 15	Rs 67
CY 2004	Rs 78	Rs 28	Rs 106
CY 2005	Rs 75	Rs 30	Rs 105

The premiums charged to the insured have a margin to cover some of the administrative expenses. In addition, the insurance carriers reimburse part of their premium to VimoSEWA as a commission. As a result, in 2005 VimoSEWA has Rs 25 per insured adult to cover Rs 105 total expenses. Increased distribution and administrative efficiency is required to reach viability. It is estimated that total administrative expenses will have to decline Rs 40 per adult before reaching viability.

The shortfall in administrative expenses has been covered by donors from 2001 to 2005. After this, VimoSEWA will be responsible for its own costs, and it will be in its interest to achieve viability as soon as possible. The returns on investment from the endowment should contribute an additional Rs 25 per insured in the near future. To increase productivity, VimoSEWA has increased efforts to analyse productivity and have found that by increasing concentration, i.e. the percentage of families' insured in a particular community, administrative expenses per adult decrease.

Currently, neither the Vimo Aagewans nor any other distributors receive commissions. VimoSEWA may consider some performance bonuses in the future based on achieving superior results in the number of insured and renewal rates.

Pricing Summary

To reach viability, claims and administration expenses have to at least equal the premium charged to clients. VimoSEWA has made improvement in most claims costs, with the exception of health care. Administration expenses will also have to improve to reach viability. Greater effort to increase the concentration of participation and the overall number of insured will bring the plan to a viable position. Grants from donors have assisted the expansion of the insurance plan since 2001, but the business plan expects several years of deficit prior to reaching viability.

4.5 Premium Collection

As mentioned above, there are two methods of paying for the insurance coverage: annual payment, and fixed deposit. With the latter method, the insured deposits a sum of money in an account at SEWA Bank, with the investment earnings paying for the insurance premium. With this method, once the balance reaches the intended amount, coverage commences on the first of the following month. The member has the right to withdraw the FD; however, insurance coverage stops at that time. This method has the advantage of ensuring continuous coverage and minimising administrative costs; the disadvantage is that occasionally the deposit amount has to increase as interest rates decline or insurance premiums increase. It is also difficult for the BLP market to amass such large amounts.

To encourage the FD method, additional minor benefits are provided, including a maternity expense reimbursement. In addition, a new programme was started in 2004 where members can get an interest free loan from SEWA Bank to buy the FD. This is targeted to lower income members and is funded by the Canadian Co-operative Association.

For the annual payment method, premiums are paid in the last quarter of the year for coverage starting January 1. When Vimo Aagewans collect premiums, they ask about pre-existing conditions and issue receipts. The receipt books are controlled by administrative staff to ensure that the funds are collected and all receipts are accounted for.

In 2003, VimoSEWA experimented with two enrolment periods to determine if this would increase participation. The second marketing campaign added 8,000 insured. As administration systems were not adapted and overall preparation was inadequate, the results

were not satisfactory. In the future, when its administrative systems are ready, VimoSEWA believes it will have more frequent marketing campaigns.

The advantage of the annual campaign is simplified administration for the balance of the year and staff can be motivated for one big enrolment push. In addition, once-a-year enrolment provides some underwriting control. Moving to a rolling enrolment period would require a change in the MIS system and training staff to deal with a different selling environment. The disadvantage is that it creates a peak workload period for staff. Plus, members missing the campaign have to wait a year to get insurance.

The payment of an annual premium can be problematic for many members who may not have sufficient cash on hand. VimoSEWA has targeted savings and credit groups to enable members' periodic savings to accumulate to pay the annual premium. This method has been easier to implement with new savings and credit groups, as old groups find the additional required weekly savings a burden.

4.6 Claims Management

With the jump in insured members, followed by communal violence, VimoSEWA's time to reimburse hospitalization and asset claims increased to 3 months in 2002-2003. With improved focus and planning, the service levels have improved significantly. For health claims, an insured can expect to be repaid within 10 days. In addition, the Vimo Aagewans now assist claimants in obtaining the appropriate documentation, speeding up the process.

Ideally, health claims should be reimbursed when the member is in the hospital. VimoSEWA should move to a cashless health benefit as soon as it is practical. In 2005, a change in life insurer permits VimoSEWA to reimburse death claims, improving the speed of reimbursement significantly. Procedures have been developed to reimburse asset claims with less waiting time by the claimant.

The claims process attempts to reimburse only legitimate claims, but there has been some fraud by both members and health care providers. Member fraud is lowered by getting information from the local community. VimoSEWA has blacklisted health care providers known for inflating claims costs. Claims are rejected for a variety of reasons, such as having no insurance, pre-existing condition and fraudulent hospitalization papers. To lessen the impact of a rejected claim, VimoSEWA has improved its communication to members and the community through visits from the Vimo Aagewan accompanied by staff members to explain the reasons for rejection.

As poor claims reimbursement service had negative impacts on the marketing campaigns, improved service removes a barrier to purchasing insurance. Further decentralization, with appropriate controls, will improve service even more.

Claim Investigation Cell

Since 2003, health insurance claims have been on the rise mainly because members are thoroughly informed about the benefits and claims procedures. But high claims are also due to abuses. For example, since hospitalization is the criteria for claim submission, members

were admitted to hospitals even though they could have used domiciliary treatment, e.g., oral dehydration instead of IV drips in case of diarrhoea.

Abuses also occur with the asset coverage. Following the communal violence and floods, many members made asset claims. It was observed that the costs of housing and contents were inflated, and it was difficult to settle claims in the absence of correct information.

To deal with these irregularities, in 2004 VimoSEWA trained three office staff on claims investigation techniques. The cell was trained by the COO for discreetly procuring correct ground level information from hospitals, doctors, nursing staff, relatives/neighbours of the claimants, for bill analysis, medical terms and information of claimants' income, work and family, depending on the details of the claim. Investigation results are discussed only with the claims coordinator and COO along with the CEO for final decisions.

Claims Procedure

For **life claims**, the following documents are requested:

- Death certificate
- Wood purchase for cremation/burial ground receipt
- Photocopy of ration card
- Photo of the deceased
- Medical papers of treatment taken before death

The Vimo Aagewan assist in collecting the information to submit to the office. Once received, the office verifies that the person was insured, verifies papers, and then submits them to the claim committee. Documentation of the wood purchase receipt can be used to verify a claim because Hindus, constituting the majority of the population, cremate the deceased. The claim committee includes Vimo Aagewans, head office staff, as well as Aagewans of the union, health, bank and childcare teams. If the claim is accepted, a cheque or cash is sent to the beneficiaries via the Vimo Aagewan. The payment is carried out in front of the community if possible.

Early on, it was found that issuing a cheque could be problematic for members if they could not access banking facilities; therefore, cash is issued when necessary. Occasionally official documents are not forthcoming, as the local officials request "speed money." In these cases, Vimo Aagewans intervene to ensure that the document is procured without additional cost.

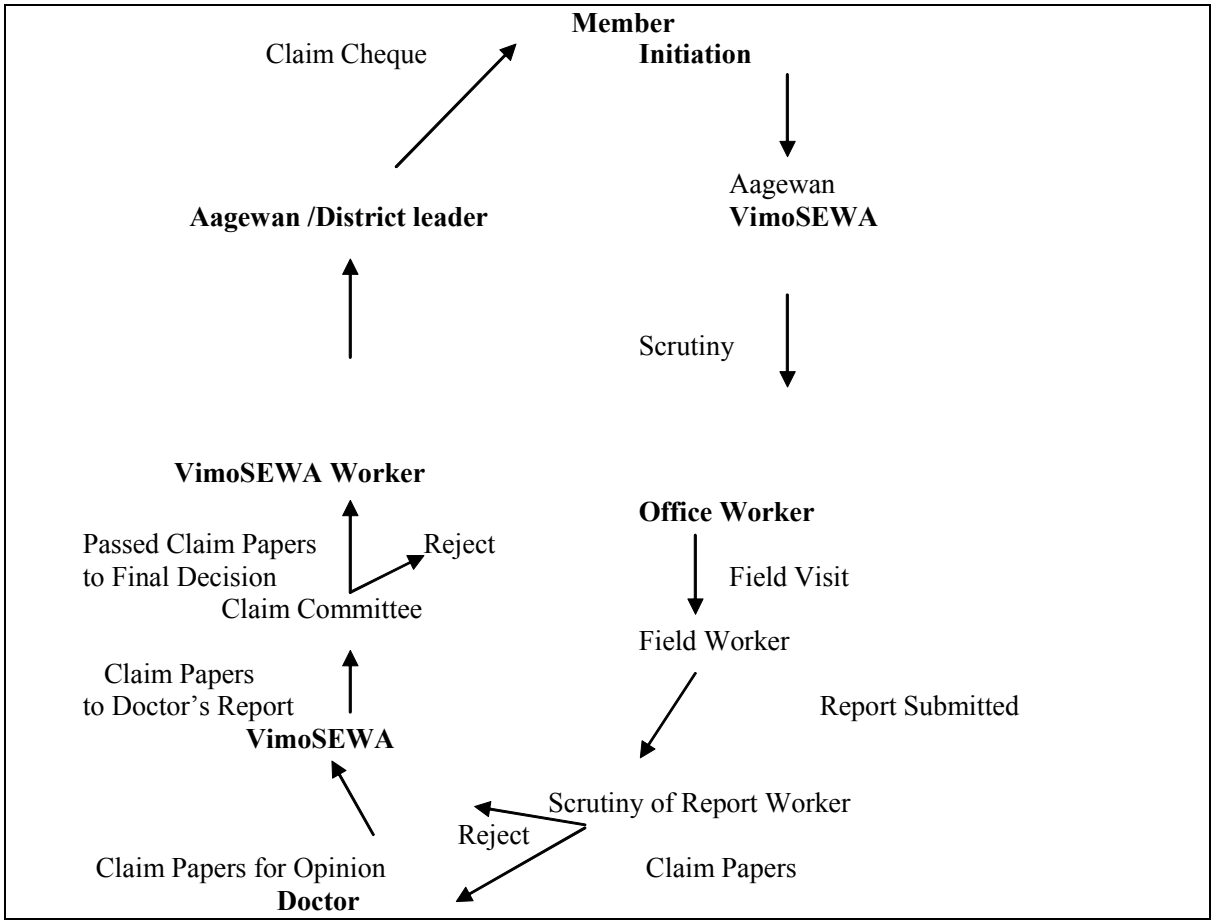
A claims register records the following information:

Claim No.	Date	Name	Age	Date of death	Insurance Receipt No.	Reason for death	Nominee's name	Cheque amount/ date	Sign

The insurance receipt number creates a link with the electronic premium data file, which contains additional demographic and coverage details.

Claims for **accidental death** have similar documentation requirements, plus the need to determine the cause of death via post mortem and police reports that verify the accidental death details.

Figure 3. Processing Diagram for Heath Claims



Following the procedure outlined in Figure 3, **health claims** require the following documents:

- Insurance receipt
- Medical bill with prescription
- Doctor's certificate stating date of admission/discharge and illness
- Hospital bill
- Investigation reports and bills if any

To improve the service associated with the health benefit, the VimoSEWA research team is testing two different methods of servicing members who have health claims:

- Prospective reimbursement
- After sales service and supportive supervision

The first method provides the member with an ID card; the member calls a Vimo Aagewan when hospitalized. The Vimo Aagewan visits the member within 24 hours and collects information from the hospital to estimate the claim amount. Based on this cost estimate, a partial reimbursement, up to 80% of the estimated claim amount, is provided on the spot, with the balance provided on discharge when all the required documentation is received.

The second method includes house-to-house visits to insured members where the scheme and claiming procedures are explained to them. They are also given a wall piece as a reminder of their membership. The wall piece has the name of the Vimo team leader and the district office's address and phone number to make it easy for the member to contact the office. Each member is also given a pre-stamped and pre-addressed postcard, which she can mail to the district office in case she needs an Aagewan to visit her regarding her insurance. VimoSEWA expects that this intervention will make it easier for members, particularly poorer members, to submit claims.

Asset claims follow similar procedures to the process outlined in Figure 2. However, the adjudication of asset claims by nature is more difficult. For example, for Scheme I the maximum benefit is Rs 10,000 ($220); VimoSEWA allocates up to a maximum of Rs 2,000 for occupational equipment and material, and the balance for the dwelling. The value of the dwelling is divided into ceiling, walls and furnishings. After investigating a claim, reimbursements are provided up to the maximum allocated for that category. If a cyclone destroys a member's roof, she would receive a maximum of Rs 1,500.

Box 2. Claims Committee

VimoSEWA has negotiated with insurers for claims management. A committee of 8 persons is formed to settle claims. It consists of head office staff, Vimo Aagewan and Aagewans from the health, union, childcare and bank teams. The committee meets three times a week and a doctor visits the committee if there are complicated health claims. He also builds the capacity of the committee by imparting information on diseases, medical terms, and reports.

Representation of various Aagewans is essential for fair practice of claim settlements. It helps the committee gain knowledge on insurance and practices, and they carry the message of unbiased claim settlement to their members and teams. The committee also assists in providing information on claims sent for investigation as needed.

All the claims are processed through the claims committee, as described in Box 2. There is a grievance procedure when members do not agree with the committee. The Vimo Aagewan passes on the verbal complaint to the VimoSEWA district team leader. The coordinator of claims reviews the evidence with the claims committee to provide a final decision.

Table 4.6 Claims Settlement Details

Issues	Observations
Parties involved in claims settlement	Beneficiary, Vimo Aagewan, claims committee, doctor
Documents required for claims submission	Receipts for health claims, proof of deceased person
Claims payment method	Cheque or cash disbursement after documents submitted
Time from insured event to claim submission	10 days (health), 10-15 days (life), immediate (asset in urban), 8 days (asset in rural)
Time from claim submission to decision	Health: 4 days urban, 4 days rural Life: immediate
Time from decision to payment	Health and life 3 days urban, 10 days rural
Claims rejection rate	N/A

4.7 Risk Management

Fraud and Moral Hazard

For a large part, moral hazard and fraud is controlled by the connection VimoSEWA has with the community. When members feel that the insurance programme is theirs, VimoSEWA perceives that there is less abuse of the scheme.

The Vimo Aegewan's field visit helps identify fraudulent claims. In one situation, a physician charged Rs 2000 to a vulnerable member for health care that was not provided, which the Vimo Aagewan discovered when discussing the claim with the member. The same Aagewan confronted the physician and demanded that he reimburse the member, which he did.

The claims committee also plays an important role detecting fraud and moral hazard. The claims committee includes knowledgeable people, including a physician who is particularly helpful in assessing which caregivers are providing expensive or unnecessary treatment. VimoSEWA has blacklisted physicians that do not give appropriate treatment. For health insurance, cost can be contained if appropriate treatment protocols are adopted by the health care facilities. For example, the WHO has guidelines on appropriate situations for hysterectomies; one hospital was found exceeding the number of such procedures on women less than age 35. Following notification from VimoSEWA and meetings with physicians, the procedure has approached the WHO guidelines.

Adverse Selection and Cost Escalation

Measuring adverse selection is difficult. As mentioned above, the life insurance claims declined dramatically with an expanded insured population. Health insurance claims costs, however, increased from Rs 14 per insured in 2002 to a projected Rs 77 in 2005. The increase could be due to:

- increase in benefit level in 2003 by approximately 50%
- general inflation in the Indian economy
- efforts by VimoSEWA to ensure members understood benefits and claims procedures
- greater use of private health facilities, which have a higher cost than public facilities
- inappropriate and/or expensive treatment
- inattention or inability of members to adopt preventive measures to maintain health
- members buying coverage when they feel they have a greater propensity to use the service (adverse selection)
- Frequent cerebral malaria outbreaks in the rural areas that require hospitalisation

VimoSEWA is monitoring health claims and it will implement actions to reduce adverse selection, such as increasing the percentage of enrolled households. Health care can have a large cost escalation due to the factors cited above. One solution is to establish links with health care providers to provide quality care and controlled costs to insured.

Covariant Risk

VimoSEWA has experienced covariant risk with the Gujarat earthquake in 2001 and the communal violence, which have impacted all lines—life, health and asset. The organization

is now managing this risk by maintaining relationships with insurers, which are likely reinsuring covariant risks. The expansion of its client base to other states also helps spread the risk over different geographical areas.

A disaster team is preparing for a spike in claims in the event of an earthquake or other crisis. The communal violence in 2002 happened prior to having staff sufficiently trained and systems in place. The immediate result was slow service, which in turn affected renewals for 2003. VimoSEWA wants to make sure that it is better prepared next time.

Other Controls

The base of controls is to ensure that proper procedures are followed by educating the staff. Receipts are issued and cash collected by one person, and the office reconciles both the receipts and the cash. Likewise with claims, proper documents are obtained, the claims committee scrutinizes the claim, and disbursements are done with appropriate procedures.

Cash flow is monitored and controlled by the finance department to ensure funds are available and the optimum investment returns are achieved. Investments have to be approved by senior management with a committee overseeing the investments. The finance department conducts periodic internal audits to ensure funds are used appropriately. External auditors review accounts and report findings to SEWA. Management reports and reviews are also an important control for proper use of funds.

For business disaster recovery, the MIS and finance department maintain a physical backup of data in an external bank vault. Further preparations will be finalized in the future.

4.8 Marketing

Sales activities are primarily undertaken by the Vimo Aagewans, women selected from the local community to promote the integrated insurance package. To assist in promotions, VimoSEWA has used various techniques, including “torans” (banners to hang on your doorway), street plays, short videos on the use of insurance, piggy banks, auto rickshaws with loudspeakers, district meetings, and the presence of senior VimoSEWA staff during enrolment campaigns. Marketing expenses range from Rs 11 to Rs 30 per insured.

Since 2003, sales targets are set for each district; better performing districts and agents with high volumes are studied to see how to improve the next campaign.

Selling insurance to this target market requires a period of education and sensitisation, primarily by the Vimo Aagewan. In turn, VimoSEWA has steadily improved the training for these frontline staff. The Aagewans have a clearer understanding of what is covered, how to communicate the benefit package, and how to assist when a member has a claim. Refreshing the approach and message each year helps to increase insurance knowledge.

Table 4.7 shows the actual results, with shaded areas illustrating the period of the business plan. The count of “Child” is the number of families covering children; there are 2.7 children per family. The participation of men and children is increasing as VimoSEWA increases the emphasis to insure the whole family.

Table 4.7 Number Covered by Status, Actual Experience

	PY 2000	PY 2001	2002 Part	CY 2003	CY 2004	CY 2005
Women	22,242	72,204	71,678	85,042	72,206	84,189
Men	6,898	18,055	21,250	24,716	32,588	38,253
Child *			-	706	1,954	6,837
TOTAL	**29,140**	**90,259**	**92,928**	**110,464**	**106,748**	**129,279**
* The number of families with child coverage; CY=calendar year, PY= Policy year July 1 to June 30						

Table 4.8 shows a small decline in the FD payment method in CY 2005, as the funding requirement increased. Some members closed their accounts rather than increasing the balance.

Table 4.8 Adults Covered by Method of Payment, Actual Experience

	PY 2000	PY 2001	2002 Part	CY 2003	CY 2004	CY 2005
Fixed deposit	20,182	29,161	31,201	32,860	33,029	32,145
Yearly premium	8,958	61,098	61,727	76,898	71,765	90,297
TOTAL	**29,140**	**90,259**	**92,928**	**109,758**	**104,794**	**122,442**

The number of insured lost due to the low renewal rate in the last three campaigns was 48,000, 53,000 and 42,000 respectively, for a total of 153,000. Had an 80% renewal rate been achieved, the business plan numbers would have exceeded targets.

Since CY 2004, participants have a clearer understanding that they are insured. While this has had a negative impact on health claims, it is a positive development for the plan. Knowledgeable, engaged members will increase the renewal rate and be more willing to pay for insurance. In CY 2003, 22,500 members enrolled via SEWA's income-generating activity. As with any mass enrolment, it is believed that the insured may not have understood that they were covered and hence may not have submitted claims incurred.

The business plan developed in 2001 was aggressive (see Table 4.9); as is now known, SEWA had not developed strong enough links with other SEWA services to promote the insurance plan and retain the insured. Creating these links is the current priority of VimoSEWA, as they can increase the cost effectiveness of the distribution system.

Table 4.9 Number Covered, Business Plan

	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007
Women	85,000	106,000	141,200	169,440	203,328
Men	30,000	40,000	50,000	62,501	78,127
Child *	9,960	15,150	26,240	34,861	45,882
TOTAL	**124,960**	**161,150**	**217,440**	**266,802**	**327,337**

It is expected that participation in Scheme II and whole family coverage will increase. Each of these options increases the viability of VimoSEWA by lowering distribution transaction cost per insured adult. Reducing the plan to two schemes increases the focus of the sales

promoters; for CY 2005, Scheme II was presented as the expected coverage with Scheme I available as an option.

Table 4.10 Adults Covered by Scheme Type, Actual Experience

	PY 2000	PY 2001	2002 Part	CY 2003	CY 2004	CY 2005
Scheme I	29,140	89,996	92,665	106,804	97,239	114,561
Scheme II		209	209	2,616	7,149	7,881
Scheme III		54	54	338	406	
TOTAL	**29,140**	**90,259**	**92,928**	**109,758**	**104,794**	**122,442**

VimoSEWA has not yet offered sales bonuses for Vimo Aagewans. If implemented, it may improve the number insured; however, there may be a decrease in clear communication of what is covered and what is not covered. In prior years, Aagewans have not clearly explained benefits, which lead to dissatisfaction when the claim was not paid.

4.9 Customer Satisfaction

Renewal rates are a good indicator of client satisfaction with the product and service. As illustrated above, the renewal rates for annual pay members have been unexpectedly low. Some reasons for the low renewal rates, and VimoSEWA responses, are as follows:

- Lump sum premiums may be a problem for VimoSEWA members, even for the annual payment method. Savings and credit groups have been targeted, encouraging women to save periodically to amass the required annual premium.
- In some years, poor agricultural conditions have lowered the participation in the insurance programme. In general, migration of members seeking income has lowered renewal rates. The FD payment method has been effective in providing semi-permanent coverage. With support from the CCA, an “interest free” loan has been recently provided to members to enable them to purchase the FD.
- Poor organization in contacting members. Based on good information gathering at the campaigns, a VimoSEWA database list can now be provided to each Aagewan, indicating members that have been insured in the prior year.
- VimoSEWA has made a concerted effort to improve the speed at which claims can be reimbursed. In 2001, members could wait up to 3 months; now waiting time from event to reimbursement is 7 days to 3 weeks depending on the type of claim.
- Some members do not believe the product meets their needs. The reimbursement of hospitalization expenses may be a barrier to using the benefit. With continual efforts at educating members on the solidarity of insurance, and linking with other SEWA services, higher renewal rates are expected. Experimenting with a cashless hospitalization benefit is being researched in a few sub-districts.

Formal client satisfaction has not been measured, but the SEWA network informally gathers complaints and suggestions to see if any implementing action can be taken.

5. The Results

5.1 Management Information

A well-managed database is essential for an insurance organization to progress. Unfortunately, in 2001, VimoSEWA's database was not functional, data was difficult to get and full of errors. Consequently, VimoSEWA was unable to contact clients to renew their policies and no management reports were available to help guide the organization.

By the end of 2004, after significant effort and investment, VimoSEWA achieved a well-managed database with clean, usable data. Improved skills have also made the data timely; the January 1, 2005 client database was completed by the end of February, in contrast to the six months it took to enter the January 2004 data. The final step to be taken is occasional testing to ensure data quality is maintained.

With a well-developed database, Vimo Aagewan can produce client lists in Gujarati, permitting them to identify their policyholders. With this accurate and timely information, the sales agents should be able to be more effective in asking clients to renew their coverage.

The claims database has also been significantly improved; the data is timely, clean and ready for analysis. The information collected can be used by management to determine appropriate courses of action to achieve viability and is used to monitor delays in claims payment.

A link is being developed to cross-reference membership in SEWA Bank, SEWA Health and other SEWA services to assist in selling VimoSEWA insurance. This initiative, started in 2004 by the MIS team, is expected to be completed in 2005.

The link with SEWA Bank also includes information on the status of the FD accounts. As this programme has been operating for many years, some FD members were difficult to locate due to inadequate recordkeeping in the past. VimoSEWA now has a monthly reconciliation of the list of FD members with SEWA Bank.

Business Plans and Budgets

In general, long range and annual plans are often missing in microinsurance. This is a critical function to establish priorities, benchmarks and establish the financial resources required to execute and measure progress against the plan.

VimoSEWA developed a comprehensive business plan in October 2001, and then revised it in February 2004. It is the intention of VimoSEWA to update the 10-year business plan occasionally. Yearly budgets and work plans are prepared for the subsequent year based on the business plan and recent events. The process of developing a business plan with periodic revisions is helpful in determining areas of progress and areas requiring greater focus.

The 2001 business plan projected viability in 7 years; the revised business plan in 2004 also projected viability in 7 years! The 2001 plan was premised on the large increase in

membership from 2000 to 2001. This was a false start. VimoSEWA had not found the magic key of enrolling members; the increase was due the impact of the earthquake. Subsequently, it was determined that many who joined did not understand insurance. The latest business plan is more realistic and attainable as the management team now has a good understanding of microinsurance and the required information systems.

In addition, the goal of the 2001 business plan was to develop Scheme III for a higher-income group. The intention was to use the profits from Scheme III to subsidise insurance to the BPL population. However, this strategy was premature for VimoSEWA; it had to buckle down and focus first on its principal target market. In addition, to reach a new market, Scheme III required a different distribution channel. A key lesson learned was to stay focused and make microinsurance viable for the BPL and near-BPL population where SEWA has a brand name.

Performance Indicators

The first line of reporting is the use of several annual key indicators:

- Outreach, the total number insured for the year
- Renewal rates, the ratio of previous years members that renew coverage in the current year
- Insurance company claims ratio, measuring the results of the insurance company
- Efficiency, the total administrative cost per insured is measured annually
- Viability, insurance revenue, less cost of claims paid, premium paid to insurers and core administrative expenses
- Assets, diversification and defaults if any
- Capital and retained earnings, the quantum at the end of every year

These initial indicators provide a quick overview of the microinsurance operation and progress from previous years. If additional information is required, there can be a drill down on that particular aspect. The indicators have been chosen to quickly point out if there are major problems, e.g., if outreach goals are not being reached, there may be a problem in product design, service or distribution methods that require attention.

More frequent reporting is used to monitor detailed aspects of operations:

- Membership (Annually): Reviewed by women, men and children, by district and state, urban/rural, and by method of payment
- Productivity
    - Distribution costs per insured by Vimo Aagewan, urban/rural, by district and state (Quarterly)
    - Renewal rates by the same parameters as distribution cost (Quarterly)
    - Administration expense (other than distribution cost, Quarterly)
    - Administration expense per insured by urban, rural, and state
    - Administration cost over premium (Quarterly)
    - Claims over premium (Quarterly)
- Service: Time to reimbursement claims from date of registration to payment for life and health (Monthly)
- Training: Educationally events held (Monthly)
- Financial statements (Quarterly): Income statements, balance sheet , cash flow
- Budget and plans (Annually)

VimoSEWA uses these reports to manage the microinsurance scheme. Reports are not just generated and filed; there are follow-up actions to improve results for the next period. For example, in 2001, claims payments were very slow. A first report measured the time it took for a member to receive a payment, then discussion followed to find ways of improving speed internally and with members submitting claims. This required training and action by Vimo Aagewans to contact members periodically, help them submit claims, and monitor this action. In addition, internal processes were reviewed and revised to expedite claims decisions. With the operations manager assuming responsibility for actively monitoring service quality, there has been a steady improvement in the claims reimbursement, which should positively affect renewal rates and marketing campaigns.

5.2 Financial Results

Table 5.1 Key Results (US$)

	2004	2003	2002
Net income (net of donor contributions)	(91,042)	(15,714)	(20,616)
Total premiums (earned)	178,720	168,448	77,740
Growth in premium value	6%	116%	
Claims[12] / total premiums (%)	74%	81%	137%
Administrative costs / premiums (%)	137%	97%	150%
Commissions / Premiums (%)	0%	0%	0%
Reinsurance / Premiums (%)	N/A	N/A	N/A
Net income added for the period / Premiums (%)	114,282	147,619	96,313
Claims cost per total number adults insured	1.22	1.24	1.20
Growth in number of insured (%)	(4%)	18%	218%
Income earned from investments	96,326	108,715	123,214
Renewal rate (%)	51%	48%	N/A

The finance department regularly produces an income statement, balance sheet, cash flow report and budgets, while monitoring progress. In the course of the business plan, skills have improved in the management of the finance function. After several discussions, SEWA decided to amortize equipment on financial statements, and discussions are ongoing for the consolidation of bank accounts (to gain cash flow management efficiency). In 2005, rent charged for the use of its building will appear as investment income.

The income statement in Table 5.2 is developed along the lines of an insurance company financial report. Donor support is illustrated following net income, to provide a clear picture of operations without donor support. Premiums paid to insurance company are as charged by the insurer. However, the insurance companies are not charging enough. Their combined experience was a loss ratio of 176% in 2004 and a projected loss ratio of 154% in 2005. The only line of coverage causing difficulty is health insurance; the other lines now create a positive contribution for the insurance company.

[12] Claims cost represent the cost of premiums paid to insurers, miscellaneous claims and claims exceptions paid by VimoSEWA.

Table 5.2 Income Statement (Rupees)

	2002 Actual Audited	2003 Actual Audited	2004 Actual Un-audited
Revenue			
Earned Premium (1)	3,521,617	7,630,688	8,096,037
Earned Service fee (2)	101,600	298,874	291,010
Investment income (3)	5,581,602	4,924,803	4,363,588
A) Total Revenue	**9,204,819**	**12,854,365**	**12,750,635**
Expenses			
Claims paid (4)	528,970	300,790	57,530
Change in IBNR (5)	18,000	-	0
Cost of insurance (6)	4,294,878	5,866,406	5,732,036
Total claim cost	4,841,848	6,167,196	5,789,566
Admin expenses (7)	5,296,863	7,399,021	11,085,310
B) Total Expense	**10,138,711**	**13,566,217**	**16,874,876**
C) Net Income (A-B)	**-933,892**	**-711,852**	**-4,124,241**
D) Grants Core Administration (8)	**5,296,863**	**7,399,021**	**9,301,280**
E) Bottom line (C+D) (9)	**4,362,971**	**6,687,169**	**5,177,039**
Viability test (10)	**-6,515,494**	**-5,636,655**	**-8,487,829**

Notes to Financial statement

(1) Earned premium matches premium revenue to the time of liability. The annual campaign collects premium for the upcoming year in the current year period; this is unearned premium until the next year.
(2) Service fees are reimbursements provided by the insurance companies to cover claims administration cost. ICICI Lombard provides 7.5% of premium for VimoSEWA distribution cost and 15% of premium for claims administration cost.
(3) Investments are placed in term deposits with varying interest rates and maturities. Real estate rental income is also included.
(4) Certain claims paid are not reimbursed by the insurance company and appear directly as an expense to VimoSEWA
(5) IBNR, or Incurred But Not Reported Reserve is an estimate of the change in outstanding liabilities to VimoSEWA.
(6) Cost of insurance is the premium paid to insurance companies to cover benefits. Most of these premiums are subject to a service tax, which the 2005 Indian Government Budget proposed to reduce or remove.
(7) All expenses of running VimoSEWA are included; in 2004, amortization of equipment was included for the first time.
(8) Donors have provided support to VimoSEWA in this period.
(9) As VimoSEWA had an endowment, it has been able to produce a positive bottom line; with no further donor support future earnings will be negative for at least 5 years
(10) The viability test reflects results excluding investment income and donor support, indicating the gap to achieve viability.

For VimoSEWA, each line of the income statement is important, and the management team has been assigned responsibility for various aspects. The finance manager is responsible to optimize investment returns within the parameters of the investment policy and projected cash flow needs. The claims manager is responsible for improving service to members and maintaining good claims practices. The COO negotiates with the insurers to obtain the most favourable results. The training and distribution manager sets distribution goals and ensures training plans are followed. The MIS manager ensures quick processing of information and data integrity. Research is responsible to understand methods to reach members. By dividing responsibility and delegating tasks that can be monitored, progress on the business plan can be followed.

An important test to reach viability is to measure results without investment earnings. In VimoSEWA's case, there is very little investment income earned from insurance premium; as the cash flow for Year X comes in near the end of Year X-1, the insurance companies demand their insurance premium by December 31 of Year X-1 to cover members in Year X. Therefore, most of the investment earnings are from the GTZ and Ford Foundation endowment. Often in co-operatives and mutual insurers, the organization believes it is successful if it has a net income, even if this net income is below the rate of return on the capital and retained earnings. However, with inflation, the value of the capital has diminished capacity over time and could lead to the irrelevancy of the organization.

Table 5.3 Balance Sheet in Rupees (end of period)

	31-Dec-03 Audited	31-Dec-04 Un-audited
Assets		
Real estate (VimoSEWA bldg) (1)	3,206,110	19,269,740
Other equipments (2)	3,294,872	2,419,514
Investments	50,439,839	43,455,246
Bank Balance	14,495,841	16,645,012
Due from insurance co's (3)	1,642,762	14,752
Receivable	578,107	777,034
Refund due from insurance co's	982,950	500,000
Prepaid insurance (4)	5,517,050	8,632,743
Interest accrued but not due	2,537,398	1,783,320
Total Assets	**82,694,929**	**93,497,361**
Liabilities		
Current liabilities (5)	6,003,241	8,566,143
Grant fund (6)	41,905,569	40,940,044
Capital and retained earnings (7)	34,456,119	43,645,944
Members capital	330,000	345,230
Total Liabilities	**82,694,929**	**93,497,361**

The first Balance sheet was produced for the end of 2003. Notes to Balance Sheet:

(1) VimoSEWA constructed a building in 2004 for its own use and for rental income.
(2) Equipment was depreciated for the first time in 2004 and included in income statement.
(3) Amount owed by insurance companies for claims settlement.
(4) VimoSEWA pays the insurance companies in December to cover beneficiaries in the following year.

(5) Unearned premium reserves reflect premium collected at one year end that will be recorded in income in following year.
(6) The Grant fund includes Rs 19,000,000 from a Ford Foundation Endowment that is permanently restricted.
(7) Capital and retained earnings represents previous and current unrestricted grants provided to VimoSEWA as well as the accumulation of retained earnings.

5.3 Reserves

As all of VimoSEWA premiums are for a one-year period, and most of the risk is with insurance companies; there is only a small IBNR that is accounted for in the income statement. This reserve is measured periodically by the actuary and is immaterial in the financial statements.

5.4 Impact on Social Protection Policy

In theory, the BPL has access to public health facilities; in practice, they find these facilities difficult to access and/or with inadequate service capacities. Workers in the informal economy cannot access the formal sector pension, health and other benefits.

The informal economy does have access to a subsidized health insurance programme. However, few participate as the premium is too high for most of the BPL population; in addition, the health insurance has too many exclusions and is not communicated clearly. The government has provided funds to LIC to subsidize 50% of the cost of providing life insurance to BPL populations. Access may be difficult as a group of a least 10 people must be formed to get the benefit.

VimoSEWA has many policy initiatives. Ela Bhatt is on the insurance advisory committee and was influential in the implementation of the requirement for all companies to reach the social sector. Mirai Chatterjee is on the Consultative Group on Microinsurance and is attempting to influence IRDA to lower capital requirements for microinsurers. VimoSEWA has lobbied the Ministry of Finance (MoF) to remove the service tax on microinsurance. An exposure dialogue has been conducted with microinsurers from other countries, participants from IRDA, MoF, public and private insurers, ILO, World Bank and other interested parties.

SEWA has always felt that the government should provide a direct subsidy for social security to its members via VimoSEWA.

6. Product Development

VimoSEWA's integrated insurance scheme arose from the needs of its members, although no formal demand research was conducted. Today, the organization still relies primarily on informal market research. During the annual campaign, Vimo Aagewans get feedback on the programme; other SEWA departments also provide input. This provides the basis to make adjustments to the scheme; in most cases, the amounts of benefits are revised. The largest impediment to increasing coverage amounts or adding benefits is the members' ability to pay.

Prior to adding child health insurance, VimoSEWA received feedback, at the regular meetings that are held for SEWA activities, that members desired health insurance for their children. This started a dialogue between VimoSEWA and members. The members were queried on the amount they were willing to pay. Having obtained a ballpark premium that members could pay, VimoSEWA approached insurance companies to see what amount of coverage could be purchased. Once the premium and coverage was obtained the product was introduced for the 2003 policy year.

Similarly, when VimoSEWA wants to increase the premium, it approaches members to assess their ability to pay. Members typically are willing to increase their contribution as long as they see an increase in relevant benefits. To reach viability, the higher premium has to cover the value of the increased benefit and add to administrative margins. Therefore, VimoSEWA has to plan how to provide additional benefits to members while staying on the path to reach viability.

In modifying products, VimoSEWA has to maintain awareness of the competition. For example, the government's recent Universal Health Insurance programme offers Rs 30,000 coverage for the BPL for a premium of Rs 400 per family. Scheme II offers Rs 6,000 health benefit, plus additional insurance for a family premium of Rs 480.

In 2002, LIC introduced JBY, subsidized life insurance of Rs 20,000 for Rs 100 premium. To avoid losing insured members to the JBY programme, and ensure their members could access the same subsidized benefit, VimoSEWA increased the life insurance coverage on Scheme II to Rs 20,000 from Rs 5,000 and received the same premium from LIC.

The number of other microinsurance programmes may impact VimoSEWA in the future; however, there are few that offer an integrated package. Should the state offer a subsidized programme such as Yeshasvini in Karnataka, VimoSEWA may experience difficulty if no similar direct subsidy is obtained.

The research department has conducted surveys to understand how BPL members access health services, and it is in the process of testing methods to improve such access. Research determined that the urban poor were able to utilize the scheme successfully; however, the rural poor did not submit as many claims as better-off rural members. As a result, VimoSEWA has taken steps to improve communication with members to ensure they know how to access service.

7. Conclusions

7.1 Significant Plans

There are four important aspects that require VimoSEWA's attention to reach viability:

1. **Hiring a COO**. The previous COO recently emigrated from India. It will be important to hire someone with insurance experience and knowledge of SEWA members to guide the organization in the future. Hiring a suitable person will have a significant impact on the future of VimoSEWA.
2. **Improving renewal rates**. There are some practices currently in place in the more successful districts that have superior renewal rates, which could be implemented in other districts. Some of the important aspects seem to be links with other SEWA services, savings and credit groups' engagement to save for the premium, more frequent visits by Vimo Aagewans to ensure claims are submitted and to reinforce the insurance solidarity message.
3. **Improving medical benefits and reducing cost** by creating links with health facilities. Currently the research team is experimenting with prospective reimbursement, which may help improve service while retaining some cost control. Accrediting facilities based on appropriate treatment protocols is essential for long-term claims control and value to members. In addition, by analysing claims data, VimoSEWA can target health promotion information to members, resulting in further strengthening the value and viability of the health programme.
4. **Improving overall efficiency** to reduce administrative cost to the range of Rs 40 per insured adult. At this level, the scheme can be viable. There is still much work to do to improve processes and efficiency of operations.

Reaching viability without subsidies should be the focus of VimoSEWA. If it is successful in accessing a government subsidy for its members, VimoSEWA can use the contribution to enhance benefits. Continuing to develop expertise in microinsurance may also help VimoSEWA attain its dream of becoming a microinsurance company. Regulators will only permit an insurance company that is adequately capitalized and has experienced managers.

7.2 Key Issues Summary

Major Breakthroughs

Since the formulation of the business plan, VimoSEWA has made major strides in building an active and responsible management team. With few sources for them to learn from, they have identified problems and developed solutions.

The outreach in 2005 is over 120,000 adults insured, a large increase from the 30,000 insured in 2000. Moreover, members have a much better understanding of benefits. The insurance

scheme has enhanced benefits while increasing premiums, responding to members needs and staying within their ability to pay.

Innovative marketing skills have been developed with proper messages conveyed to the target audience. Now, insurance is marketed as a risk management tool and not a benefit scheme.

Significant improvements in the speed of reimbursing members' claims have been achieved over the last three years, while maintaining insurance standards.

The MIS is now well established, providing vital and accurate management information and developing links with other SEWA systems to improve outreach. The team running the system has improved its skills and speed of entering data. Regular reports, financial and otherwise have become valuable management tools.

Lessons Learned

Over the years, VimoSEWA has learned a number of valuable lessons from which others may also benefit.

Risk management

It is extremely dangerous for an organization to provide insurance without reinsurance, as VimoSEWA experienced with its asset benefits following the earthquake. Based on that experience, almost all of VimoSEWA coverages are provided via insurance companies.

Maintaining an accurate database is vital to an insurance operation. VimoSEWA can track claims costs by benefit and by various parameters, helping it to understand how to price each benefit in the package and negotiate with partners.

For health insurance, a well-designed cashless system should contain claims costs. Health claims have increased substantially for VimoSEWA on a reimbursement basis. Moving to a cashless system will lower claims costs while improving customer service.

Organization and management

A separate organization, even if it is a division of the existing NGO, should be given responsibility for the microinsurance operation. It has only been possible to manage VimoSEWA effectively once it had its own business plan, financial statements and performance reports.

Management needs to be focused. With the development of the VimoSEWA business plan, key benchmarks were developed and responsibilities assigned. Periodic monitoring alerts management that adjustments to procedures are required. Maintaining year-to-year focus is essential to achieving objectives.

Acquiring and training management and staff is critical for an effective and viable microinsurance operation. Constant capacity building and knowledge of the insurance industry at large should be provided to the staff. SEWA's emphasis on training is beginning to reap significant results.

Management information systems should be adequate to develop useful reports for management and other users. Insurance companies that have developed good information systems with clean relevant data have superior performance. Now that VimoSEWA has a well-maintained database, it is easier to monitor results and make appropriate modifications to achieve targets.

Quick, efficient claims service is necessary for a microinsurer. Initially VimoSEWA's claims reimbursement took months, however today claims are paid in a timely manner.

Donors have an important role to play in supporting the development and expansion of microinsurance; however, their efforts should be coordinated. The lack of a common donor reporting method imposed inefficiencies on VimoSEWA.

Product design

Product design and features should be revisited on yearly a basis to make the scheme marketable and innovative. VimoSEWA collects feedback from members and other SEWA divisions to determine if it should implement any changes.

The most viable microinsurance product is life insurance that is tied to microcredit; however, that coverage does not deal with the greater community's need for health insurance or other benefits, nor does it protect people when they are not borrowing money. VimoSEWA's integrated product is an innovative and risky means of addressing the real risk management needs of poor women (and their families). Even though viability remains a distant dream, it should be clear that VimoSEWA's multi-benefit product is both more challenging and more needed than most microinsurance products.

Integrating benefits in one product helps reduce adverse selection in a voluntary scheme.

If the microinsurer offers health coverage, staff has to have health knowledge and skills. VimoSEWA staff with health knowledge has been able to detect fraud from both health care providers and members.

Preventative measures to promote good health practices ultimately reduce claims costs.

Distribution

Insurance is sold, not bought. To sell insurance, an organization has to have the trust of the community. Hiring sales promoters with the appropriate skill set will improve results. VimoSEWA has seen an increase in renewal rates as the Vimo Aagewans have increased their skills and communication has focused on clear messages about product benefits, exclusions and claims procedures.

Obtaining a high participation of a target population is essential to achieving viability in health insurance. VimoSEWA has found that results improve when whole families are insured and when there is a large percentage of the target community insured.

Appendix 1. VimoSEWA Product in 2001-2002

Coverage and *Price* in Rs, July 1, 2001 to Dec 31, 2002		
Scheme 1 (Below poverty line)		
Coverage	Member	Spouse
Natural Death	3,000	3,000
Health	**1,200**	**1,200**
Asset & Loss	5,000	
Accidental Death	40,000	25,000
Spouse Accidental Death	15,000	
Price		
Annual Pay	*75*	*45*
Fixed Deposit	*700*	*450*
Scheme 2 (Very low income)		
Coverage	Member	Spouse
Natural Death	5,000	5,000
Health	4,500	4,500
Asset & Loss	10,000	
Accidental Death	40,000	25,000
Spouse Accidental Death	15,000	
Price		
Annual Pay	*180*	*135*
Fixed Deposit	*1,800*	*1,350*
Scheme III (Low income)		
Coverage	Member	Spouse
Natural Death	10,000	10,000
Health	9,000	9,000
Asset & Loss	20,000	
Accidental Death	40,000	25,000
Spouse Accidental Death	15,000	
Price		
Annual Pay	*360*	*300*
Fixed Deposit	*3,600*	*3,000*

Appendix 2. Insurance Coverage Evolution, 1992 to 2005

Year	Risks covered	Persons insured	Premium amount	Membership	Remarks
1992	Life +acc.death	Woman	Rs 15	50000	
1993	Life +acc.death	Woman	Rs 15	7000	
1994	Life+acc.death+ medical+assets	Woman+spouse	Rs 30	25000	Introduced life cover for spouse
1995	-same-				
1996	-same-				
1997	-same-				
1998	-same-				
1999	-same-				Introduced health insurance for spouse
2000	-same-			29 000	
2001	-same-	Woman+spouse		90 259	
2002	-same-			92 928	Health cover increased to Rs 2000. INTRODUCED 3 SCHEMES.
2003	-same-	Woman+spouse +children		112 112	Introduced child health insurance cover
2004	-same-	-same-		104 794	
2005	-same-	-same-		122 442	Increased life cover to Rs 5000 S .I. ELIMINATED SCHEME III.

Appendix 3 MoU with ICICI Lombard

ICICI Lombard
GENERAL INSURANCE

DRAFT

MEMORANDUM OF UNDERSTANDING

This Memorandum Of Understanding (MOU) is entered into by and between **ICICI Lombard General Insurance Company Limited & VIMO SEWA, Ahmedabad** on **31st December 2004.**

The basis of this MOU is the Insurance Proposal of ICICI Lombard General Insurance Company Limited enumerating the Package Scheme for Members of VIMO SEWA. (Copy Enclosed herewith).

Further to the Insurance Proposal it is agreed between both the parties as under:

1. VIMO SEWA shall provide list of Members with all relevant details. The Group Size presently shall be 115,000 Members. Members renewing the Insurance will be considered as renewed Members and Members opting for Insurance for the first time will be considered as fresh.
2. VIMO SEWA shall pay the premium in one single lump sum amount to ICICI Lombard. Any addition/alteration during the Policy period shall be made as per underwriting guidelines of ICICI Lombard.
3. ICICI Lombard shall pay Agency Commission as per IRDA guidelines for placement of business.
4. In lieu of expenses incurred by VIMO SEWA for processing Claims under Health Insurance, ICICI Lombard agrees to pay 15% of Health Insurance Premium towards service charges within 10 working days of receipt of the Premium.
5. ICICI Lombard will place a Sum equivalent to 25% of the Premium amount at the disposal of VIMO SEWA within 10 working days of receipt of Premium to enable VIMO SEWA to pay the Claim amounts under the Group Health Policy. VIMO SEWA will intimate ICICI Lombard when this Sum reaches the level of 7.5% of Premium amount and ICICI Lombard will replenish the same within 7 working days.
6. Coverage under Personal Accident and Health Insurance shall be on the lines of Group Personal Accident Insurance Policy (Death only) and Group Health Insurance Policy respectively. However Sum Insured under Group Health is exclusive of Rs. 500/- towards Maternity Benefit Extension. The coverage under Maternity Benefit Extension shall be available for first 2 children only with a waiting period of 9 months.
7. VIMO SEWA is authorised to process and pay Claims under Health Insurance as per present procedure being followed by VIMO SEWA and agreed upon by ICICI Lombard.
8. List of Claims paid with details of Insured and amount paid shall be submitted by VIMO SEWA to ICICI Lombard on a monthly basis. ICICI Lombard officials may verify the Claim Documents periodically at the time of Claim Committee Meetings.
9. ICICI Lombard will have access to all Claim Dockets and will have the right to cross check the same any time. ICICI Lombard will be carrying out Quarterly inspection of such Claim documents.
10. Proof of Accidental Death shall be on merit of the case and Police FIR and PM Report may not be mandatory.
11. ICICI Lombard shall not adhere to the under noted conditions of Group Health Insurance Policy:
    - 10/15 Beds Hospital Norm,
    - Registration of Medical establishment with Local Authority,

ICICI Lombard
GENERAL INSURANCE

- Exclusion regarding Claim during first 30 days of taking Policy will not be applicable to Members insured for the first time in the year 2005.

12. VIMO SEWA will discuss beforehand with ICICI Lombard cases pertaining to Dislocation & Sprain due to an Accident, which may not require hospitalisation. ICICI Lombard will accept such cases on their merit provided medical bills/doctors reports are in place.
13. ICICI Lombard will consider complications due to maternity leading to medical emergency for the Member on a case-to-case basis in case of 2 or more than 2 deliveries. VIMO SEWA shall bring all such cases to the notice of ICICI Lombard before sanctioning the payment.
14. All such Claim payments will be subject to overall Sum Insured limit specified against the Members under the various Policies.
15. In cases where the business is jointly conducted by the Husband & Wife although not registered in the name of the Wife (who is Member of VIMO SEWA), ICICI Lombard has agreed to attach the Goods held in trust or on commission Clause (without charging any additional Premium) to the Fire Policy to enable payment of claims in such cases.
16. ICICI Lombard will be issuing a separate Fire Stock Floater Policy apart from the existing Fire (Dwellings) Policy for 5,000 Members with Rs 2,500/- Stock per Member to cover any eventuality faced by Members who store their Stock at the Marketplace & not in their Houses.
17. VIMO SEWA will survey and process Fire and Allied Perils including Earthquake Claims. ICICI Lombard will have the right to survey any or all claims / damages and verify or participate with VIMO SEWA in processing any or all Claims. All Claims will be payable as per provisions of Fire Tariff.
18. ICICI Lombard has agreed to provide Domain / Claims Training to Employees/Aagewans of VIMO SEWA on a Quarterly basis.
19. ICICI Lombard has appointed following officer to service VIMO SEWA directly in respect of all matters including underwriting or / and claim. Her present address and contact nos. are as under :

    Ms Shveta Sharma
    Relationship Manager
    10th Floor, JMC House, Opp. Parimal Garden, Ellisbridge, Ahmedabad
    Phone No: 079 6561856 / 1095 Fax No: 079 6468091
    Mobile : 9879500549

Signed for & on behalf of :

ICICI Lombard General Insurance Company Limited,

Authorised Signatory

VIMO SEWA,

Authorised Signatory

Appendix 4 VimoSEWA Policy

સ્વાશ્રયી મહિલા સેવા સંઘ સંચાલિત

વીમો સેવા

યોજના નં - ૧

	બેન	પતિ	બાળકો	કુલ	કુટુંબ વીમો
વાર્ષિક	૧૦૦	૭૦	૧૦૦	૨૭૦	૨૫૦
ફીક્સ	૨,૧૦૦	૧,૫૦૦	-	૩,૬૦૦	
કુદરતી મરણ	૫,૦૦૦	૫,૦૦૦	-	-	
માંદગી	૨,૦૦૦ સુધી	૨,૦૦૦ સુધી	૨,૦૦૦ સુધી	-	
ઘર-ઘરવખરી	૧૦,૦૦૦સુધી	-	-	-	
અકસ્માત મરણ	૪૦,૦૦૦	૨૫,૦૦૦	-	-	
અકસ્માત મરણ (પતિ)	૧૫,૦૦૦	-	-	-	

યોજના નં - ૨

	બેન	પતિ	બાળકો	કુલ	કુટુંબ વીમો
વાર્ષિક	૨૨૫	૧૭૫	૧૦૦	૫૦૦	૪૮૦
ફીક્સ	૫,૦૦૦	૪,૦૦૦	-	૯,૦૦૦	
કુદરતી મરણ	૨૦,૦૦૦	૨૦,૦૦૦	-	-	
માંદગી	૬,૦૦૦ સુધી	૬,૦૦૦ સુધી	૨,૦૦૦ સુધી	-	
ઘર-ઘરવખરી	૨૦,૦૦૦ સુધી	-	-	-	
અકસ્માત મરણ	૬૫,૦૦૦	૫૦,૦૦૦	-	-	
અકસ્માત મરણ (પતિ)	૧૫,૦૦૦	-	-	-	

વીમા યોજનાના નિયમો

૧) નવો વીમો ૧૮ થી ૫૫ વર્ષની ઉંમરના સભ્ય બહેનનો જ લઈ શકાય. બાળકના માંદગી વીમામાં બાળકની ઉંમર ૧ જાન્યુઆરીએ ૩ મહિનાથી ૧૭ વર્ષ સુધીની હોવી જોઈએ.

૨) જો બહેનનો પોતાનો વીમો હોય તો જ તેના પતિનો અને બાળકોનો વીમો લઈ શકે.

૩) માંદગીના ક્લેમમાં હોસ્પીટલમાં ૨૪ કલાક સારવાર લીધી હોય તો જ વળતર મળી શકશે.

૪) પ્રસુતિ સહાય, કાનનું મશીન અને દાંતનું ચોકઠું માટેનું વળતર માત્ર વીમા ફીક્સ પૂરી હોય તેવા સભ્ય બહેનોને જ મળી શકે. આ જોગવાઈ વીમા ફીક્સ કરાવ્યાના એક વર્ષ પછી લાગુ પડશે.

૫) આખા કુટુંબનો વીમો એક જ રસીદમાં એક સાથે લેવાશે તો જ પ્રીમીયમમાં રૂા. ૨૦નું વળતર મળશે. આ નિયમ બન્ને યોજનામાં લાગુ પડશે.

૬) કોઈ પણ બનાવની જાણ તરત જ કરવી ક્લેમના કાગળ બને એટલા વહેલા, પણ મોડામાં મોડા ત્રણ મહિના સુધીમાં જમા કરાવવા પડે.

૭) વાર્ષિક વીમો એક વર્ષ સુધી ચાલે આથી તેની મુદ્દત પુરી થતા પહેલા બીજા વર્ષના વીમા માટેનું પ્રીમીયમ ભરી દેવું.

૮) જે સભ્ય યોજના - ૧ માંથી યોજના - ૨ જશે તેમને એક વર્ષ પુરતું એપેન્ડીક્સ, મસા, કોથળીનું ઓપરેશન હૃદયની બિમારી, મોતીયાનું ઓપરેશન વગેરેમાં પહેલી યોજના પ્રમાણે જ વળતર મળશે.

૯) વીમો સેવાની યોજનાના બાકીના નિયમો અગાઉ મુજબ જ રહેશે.

૧૦) ઘર-ઘરવખરીને નુકશાન માટેના વીમામાં પૂર, આગ, હુલ્લડ, ધરતીકંપ, વાવાઝોડું જેવી હોનારતથી નુકશાન થાય તો જ