Synopsis for Dissertation Report

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TITLE: Evaluation of Operational effectiveness of the grievance readressal mechanism in Care Health Insurance.

INTRODUCTION

The insurance industry in India was liberalized in the year 2000, and since then, it has seen rapid growth. Insurance plays a crucial role in offering financial security to individuals, families, and businesses. It also encourages savings and serves as a safe and reliable investment option. Insurance is recognized as a separate financial field unlike the banking or stock market sectors.A life insurance policy is a long-term agreement between the insurer and the policyholder, where both parties have specific roles and responsibilities to fulfill. Providing good customer service is essential in this industry, and effective customer relationship management helps in achieving that.

To maintain trust, every customer must have easy access to a clear and fair grievance redressal system. Online complaint systems have made the process more transparent, efficient, and accountable.

The Insurance Regulatory and Development Authority of India (IRDAI) was set up to make sure that insurance companies act in the best interests of policyholders. According to IRDAI's Grievance Redressal Guidelines, a grievance is defined as any communication that shows dissatisfaction with a service or lack of action by the insurer or its representatives and may include a request for corrective measures.

LITERATURE REVIEW

Cohen (1975) examined how federal agencies address dishonest and misleading practices under consumer protection laws. He identified three main strategies: prevention, compensation (restitution), and punishment. While he believed that prevention is the best public policy, he also noted that it is not always effective when used alone. He emphasized the importance of punishing serious offenders to deter repeated fraud and highlighted arbitration as a valuable method for resolving consumer complaints fairly. Cohen encouraged regulatory bodies to further explore arbitration as a practical solution for addressing consumer issues.

Sobti (2002) examined how patients perceive medical services and how legal regulations, particularly the Consumer Protection Act of 1986 (CPA), have influenced their experiences. After the 1995 Supreme Court ruling in the Indian Medical Association vs. V. P. Santha case, public awareness about medical negligence increased, leading to a rise in complaints against healthcare providers. Although many doctors were initially concerned that the CPA would raise treatment costs and complicate their work, Sobti found that patients felt more empowered and believed they received better justice through the CPA' s complaint system. His study illustrated how patient rights and legal regulations have progressed together.

Johary (2007) investigated how complaints are managed in the general insurance sector. He proposed the need for specific conflict resolution methods tailored for the insurance industry. His goal was to streamline the grievance process by creating systems that directly address the unique nature of insurance- related issues.

Sinha and Kulkarni (2011) in their article in The Economic Times, discussed how the Insurance Regulatory and Development Authority (IRDA) strives to protect policyholders. They noted that while the IRDA has implemented several measures to ensure consumer protection, many policyholders remain unaware of how to utilize the existing grievance redressal mechanisms. They stressed the importance of enhancing education and communication to help consumers understand their rights and foster trust in the insurance system.

OBJECTIVES

- To review how insurance companies currently handle customer complaints and grievances.
- To study and understand the various types of fraudulent claims made in insurance.

MATERIALS AND METHODS

This study is retrospective in nature, meaning it focuses on analyzing events and cases that have already taken place. It involves a detailed review of past grievances and complaints handled by a health insurance company. The data is collected from various sources, such as legal notices issued by customers, appeals filed with the Insurance Ombudsman, judgments from consumer court proceedings, and records of cases resolved through mediation. By examining these previous cases, the study aims to identify common patterns, understand the effectiveness of the grievance resolution mechanisms, and evaluate the nature and frequency of issues faced by policyholders.

DATA ANALYSIS

The data analysis involved a detailed review of selected grievance cases to understand the recurring issues, patterns, and trends raised by insurance policyholders. The purpose of this analysis was to gain deeper insights into the types of problems customers frequently encounter and to evaluate how effectively the existing grievance redressal mechanisms respond to these concerns. By examining past cases, the study aimed to highlight areas where the system is functioning well and identify gaps that may need improvement. A qualitative

approach known as thematic analysis was used to organize and interpret the information. This method helped categorize complaints into key themes, making it easier to draw meaningful conclusions about customer experiences and satisfaction levels. The insights gathered from this analysis can be valuable for improving company practices, training staff, and shaping policies that better address customer needs and expectations. Overall, the analysis provides a foundation for enhancing grievance handling in the insurance sector

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