Technical Guide on Internal Audit of Life Insurance Companies

The Institute of Chartered Accountants of India
(Set up by an Act of Parliament)
New Delhi

Technical Guide on Internal Audit of Life Insurance Companies

Internal Audit Standards Board

The Institute of Chartered Accountants of India

(Set up by an Act of Parliament)

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Foreword

The life insurance sector plays a vital role in strengthening financial security and resilience by providing protection to individuals and families, mobilising long term savings, supporting financial inclusion and contributing to capital formation and economic development. Over the years, the industry has undergone substantial transformation, driven by regulatory reforms, changing customer expectations, evolving business models and rapid technological advancements. The growing adoption of digital technologies and data-driven processes, heightened focus on customer-centricity and data security, and increasing emphasis on operational resilience have further reshaped the business and risk environment of the sector.

In this context, the Technical Guide on Internal Audit of Life Insurance Business was originally issued by the Internal Audit Standards Board of ICAI in 2011. Since then, significant developments in the life insurance sector, coupled with changes in the regulatory, technological and business environment, have necessitated a comprehensive revision of the Guide.

Recognising these developments, the Internal Audit Standards Board of ICAI has brought out the revised edition of the Technical Guide to provide members with contemporary, relevant and practical technical guidance aligned with the evolving landscape of the life insurance industry. This Guide will assist internal audit professionals in adopting a structured, risk-based approach to evaluate governance, risk management and internal controls, while supporting greater effectiveness in assurance and oversight.

I place on record my appreciation for CA. Ravi Kumar Patwa, Chairman, CA. Sridhar Muppala, Vice-Chairman and all the members of the Internal Audit Standards Board of ICAI for their leadership, vision and commitment in bringing out the revised edition of this publication.

I am confident that this Guide will serve as a valuable reference for members of the profession, internal auditors, risk and compliance professionals and other stakeholders associated with the life insurance industry, while contributing to the continued enhancement of the quality, effectiveness and value of internal audit in the life insurance sector.

September 3, 2026
New Delhi

CA. Prasanna Kumar D
President, ICAI

Preface

The life insurance industry is a specialised and dynamic segment of the services sector. Its operations involve long term policyholder obligations, complex actuarial processes, investment management, diverse distribution channels, extensive customer servicing requirements and a comprehensive regulatory framework. These distinctive features make a sound and effective internal audit function an important component of the overall governance and risk management framework of life insurance companies.

The Technical Guide on Internal Audit of Life Insurance Business was originally issued by the Institute in 2011 to provide members with guidance on the specialised areas involved in the internal audit of life insurance companies. Since then, the industry has undergone considerable transformation. The regulatory framework has evolved significantly, business and distribution models have expanded, technology has become integral to almost every aspect of insurance operations and new and emerging risks have assumed greater importance. The role and expectations of internal auditors have correspondingly evolved.

In view of these significant developments, the Internal Audit Standards Board (IASB) of the Institute of Chartered Accountants of India (ICAI) considered it appropriate to revise and update the Technical Guide. This revised edition seeks to provide contemporary and practical guidance to internal auditors by incorporating developments relevant to the life insurance industry and the changing expectations from the internal audit function.

This Technical Guide on Internal Audit of Life Insurance Companies covers various important areas of the life insurance business, including the regulatory framework, product development, actuarial processes, new business, underwriting, reinsurance, policy servicing, claims, investments, legal and compliance requirements, agency and distribution activities, management expenses and commissions, anti money laundering, outsourcing, data analytics, cybersecurity and IT controls, and financial closing processes. This Technical Guide also provides illustrative guidance to assist internal auditors in identifying key risks, evaluating controls and designing appropriate audit procedures.

This publication is intended to serve as a useful reference for internal auditors and other professionals associated with the life insurance sector. It is hoped that the revised Technical Guide will help members develop a better understanding of the specialised nature of the industry and support them in performing internal audit assignments more effectively.

We express our sincere gratitude to CA. Prasanna Kumar D, President, ICAI and CA. Mangesh Kinare, Vice President, ICAI for their leadership, guidance and continued encouragement to the initiatives of the Internal Audit Standards Board.

We also express our sincere gratitude to the Central Council Members for their valuable support and guidance. We place on record our appreciation for all the members of the Internal Audit Standards Board for their valuable contributions, insightful deliberations and continued commitment towards the revision and development of this Technical Guide.

We place on record our sincere appreciation for the significant contributions made by all the members of the Study Group, whose expertise, experience and commitment have been instrumental in the revision and development of this Technical Guide. The Board also acknowledges with gratitude the valuable inputs and suggestions received from the reviewers and subject matter experts and members through the public exposure of the draft publication, which have further enriched the quality and practical relevance of this publication.

We further acknowledge the dedicated efforts of CA. Arti Bansal, Secretary and CA. Ranjit Mahto of the Internal Audit Standards Board, for their valuable efforts in coordinating the Study Group meetings, consolidating inputs and facilitating the timely completion of this Technical Guide.

We are confident this Technical Guide will be a useful and practical resource for the profession and contribute towards strengthening the quality and effectiveness of internal audit in the life insurance sector.

CA. Ravi Kumar Patwa
Chairman
Intenral Audit Standards Board, ICAI

CA. Sridhar Muppala
Vice Chairman
Internal Audit Standards Board, ICAI

September 3, 2026
New Delhi

Foreword to the First Edition

In the current scenario, insurance market in India has witnessed dynamic changes including entry of a number of global insurers. Most of the private insurance companies are joint venturing with recognized foreign institutions across the globe. Saturation of markets in many developed economies has made the Indian market even more attractive for global insurance majors.

The Insurance Regulatory and Development Authority (IRDA) regulate and develop the insurance sector in India through calibrated policy initiatives, helps to improve disclosures. The role and importance of internal control systems in good risk management practice, with a particular emphasis on the internal audit and compliance functions within such a framework has become necessary. Introduction of mandatory quarterly internal audit for insurer is one such step taken by the Insurance Regulatory and Development Authority which would contribute towards strengthening controls and also reducing risks under volatile market conditions.

I am happy to note that the Internal Audit Standards Board is issuing this Technical Guide on Internal Audit of Life Insurance Business for guidance of the members and other readers. I congratulate CA. Rajkumar S. Adukia, Chairman, Internal Audit Standards Board and members of the Board on issuance of this Technical Guide. This Technical Guide comprehensively deals with the peculiar aspects of life insurance business, including various regulatory aspects and provides a step wise approach for internal audit.

I am sure that this Technical Guide will assist the members and others in efficiently discharging their responsibilities.

July 11, 2011
New Delhi

CA. G. Ramaswamy
President, ICAI

Preface to the First Edition

During the last two decades, the economic reforms have impacted the growth of financial sector of India significantly. As an integral part of financial sector reforms, insurance sector has emerged as regulatory development sector. Insurance Regulatory and Development Authority has issued various regulations with the objective of improving market efficiency, enhancing transparency and bringing the Indian market up to international standards. With the very same objectives, the Insurance Regulatory and Development Authority being insurance sector regulator has mandated quarterly internal audit of insurer. This would not only ensure compliance with the legal and regulatory norms but would also prove instrumental in making the system more efficient.

Internal audit is core competence area of chartered accountants. It is an important assignment being undertaken both by practising members of the Institute as well as those in industry. This demands the internal auditor to have requisite skills and high level of knowledge of the sector as well as its interrelationship with variables in its operating environment.

The Internal Audit Standards Board is issuing this Technical Guide on Internal Audit of Life Insurance Companies. This Guide would provide to the members of the Institute as well as others an in depth understanding of the activities undertaken by the insurer and the regulatory and legal framework in which they operate.

With a view to providing appropriate guidance in a manner that is easily understood by all the readers, this publication is divided into parts, dealing with the very fundamental concepts in Life Insurance Companies, sequentially as introduction, regulatory framework and internal audit of functional areas. It gives a brief overview on various aspects like, actuarial process, underwriting, reinsurance, premium collection, claims and agency licensing, etc. It also contains detailed checklist on internal audit that would help the readers in understanding the various technicalities arising during the internal audit of life insurance companies. The Guide also contains the list of abbreviations for better understanding of the readers.

I am extremely grateful to CA. Neeta Shah and her entire team *viz.,* CA. Venkatachalam Sekar, CA. Shailendra Kothavale, CA. Sangramjit

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I also wish to thank CA. G. Ramaswamy, President, ICAI and CA. Jaydeep Narendra Shah, Vice President, ICAI for their continuous support and encouragement to the initiatives of the Board. I must also thank my colleagues from the Council at the Internal Audit Standards Board, *viz*., CA. Rajendra Kumar P., CA. Amarjit Chopra, CA. Ravindra Holani, CA. Anuj Goyal, CA. Nilesh S. Vikamsey, CA. Vijay Kumar Garg, CA. Atul C. Bheda, CA. J. Venkateswarlu, CA. Shiwaji Bhikaji Zaware, CA. Abhijit Bandyopadhyay, Smt. Usha Narayanan, Smt. Usha Sankar, Shri R. P. Singh, Shri Prithvi Haldea, Shri Sidharth Birla, Dr. T.V. Somanathan for their vision and support. I also wish to place on record my gratitude for the co opted members on the Board, *viz*., CA. Madhu Sudan Goyal, CA. Rohit Choksi, CA. Ketan Vikamsey, CA. Pankaj Kumar Adukia, CA. Umakant Balkrishna Joshi as also special invitees on the Board for their invaluable guidance as also their dedication and support to the various initiatives of the Board.

I am certain that the readers, especially members of the Institute, working as internal auditors in insurance sector would find this technical guide immensely useful.

July 14, 2011
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Contents

Foreword ..... **iii**
Preface ..... **v**
Foreword and Preface to the First Edition ..... **vii**
Chapter 1: Introduction **1-22**
Insurance 1
Life Insurance 1
Evolution of the Insurance Sector 2
Life Insurance Products 7
Distribution Structures, Business Models and Revenue Streams 12
Objective and Scope of the Technical Guide 19
Intended Users of the Technical Guide 20
Chapter 2: Regulatory Framework **23-36**
Introduction 23
Legislation 23
IRDAI Regulations and Master Circulars 25
Recent Development: Adoption of Indian Accounting Standards (Ind AS) 29
Cybersecurity, Fraud and Regulatory Information Governance 30
Wider Statutory and Regulatory Overlay 32
Regulatory and Supervisory Authorities 35
Chapter 3: Product Development, File and Use **37-58**
Introduction 37
Scope of Internal Audit 37
Objective of Internal Audit 38
Standard on Internal Audit 39
Process Overview and Flowchart 40
Risk Control Matrix 41

Internal Audit Checklist-Areas and Checkpoints 47
Commonly Observed Irregularities, Violations and Deficiencies 54
Chapter 4: Actuarial Process 59-92
Introduction 59
Scope of the Audit 60
Internal Audit Objectives 62
Understanding the Actuarial Process 63
Key Risks in the Actuarial Process 66
Indicative Risk Control Matrix (RCM) 67
Indicative Audit Evidence 77
Red Flags Requiring Immediate Escalation 78
Commonly Observed Irregularities and Deficiencies 79
Internal Audit Checklists 82
Chapter 5: New Business 93-104
Introduction 93
Scope and Objective 93
Internal Audit Checklists 95
Audit Analytics/ CAATs 102
Commonly Observed Irregularities/ Violations 103
Chapter 6: Underwriting Process 105-124
Introduction 105
Scope of Internal Audit of Underwriting 105
Objectives of Internal Audit of Underwritting 109
Flowchart of Underwriting Process 110
Risk Control Matrix for Underwriting 112
Suggested Audit Analytics 114
Commonly Observed Irregularities, Violations and Deficiencies 115
Internal Audit Checklist for Field Work 118

Relevant IRDAI Circulars 124
Chapter 7: Reinsurance 125-154
Introduction 125
Regulatory Framework 125
Concept and Types of Reinsurance 125
Scope and Objectives of Internal Audit 127
Reinsurance Process Flow 128
Key Risks and Control Framework 129
Emerging Risks in Reinsurance 141
Best Practices in Reinsurance Governance 142
Commonly Observed Irregularities and Deficiencies 143
Ind AS 117 Compliance for Life Reinsurance Companies 147
Substantive Testing Sampling Guide 150
Conclusion 151
List of Internal Acts, Regulations, Circulars, Guidelines and Other References 151
Chapter 8: Policy Servicing 155-211
Introduction 155
Renewal Premium Processing 155
Free look Cancellation (FLC) 163
Policy Lapse and Revival 167
Legal Position 170
Process Flowchart of Lapsed and Revived Insurance Policies 174
Policy Surrender 177
Nomination/ Assignment 185
Change of Address, Payment Mode, Scope and Regulatory Framework 189
Fund Switch and Top Up Premium 195
Loan Against Policy 207

Chapter 9: Claims 212-226
Introduction 212
Scope and Objective 212
Claims Processing Flow 216
Illustrative Internal Audit Checklist 216
Audit Analytics/ CAATs 225
Commonly Observed Irregularities/ Violations 225
Chapter 10: Investments 227-260
Introduction 227
Scope and Objective 228
Investment Operating Model 229
Types of Investment Instruments 233
Illustrative Internal Audit Checklist 239
Audit Analytics/ CAATs 251
Red Flags 258
Commonly Observed Irregularities/ Violations 259
Chapter 11: Legal Framework and Compliances 261-295
Scope and Objective 261
The Compliance and Governance Operating Model 261
Auditing the Corporate Governance Compliance Framework 264
Building the Compliance Universe: the Risk Ranked Obligations Register 268
Regulatory Change Management 271
The Regulatory Returns and Filings Universe 273
Registration, Capital and Ongoing License Conditions 278
Rural and Social Sector Obligations 281
Tax Compliance 283
Other Compliances 287

Regulatory, Inspection, Enforcement and Remediation 290
Red Flags and Illustrative Deficiencies Observed in Practice 292
Chapter 12: Relationship and Complaint Handling 296-305
Introduction 296
Scope and Objective 296
Chapter 13: Agency Licensing Function 306-353
Introduction 306
Regulatory Framework 311
Agency Recruitment and Licensing Audit 316
Digital Licensing and Technology Risks 323
Agency Operations Audit 326
Mis Selling and Conduct Risk 329
AML, Compliance and KYC Audit 333
Risk Based Internal Audit Approach 335
Emerging Challenges and Current Scenario 338
Conclusion 341
Glossary of Key Terms 342
Internal Audit Checkpoints 344
Chapter 14: Commission 354-369
Introduction 354
Scope and Objective 354
Regulatory Framework 356
Illustrative Internal Audit Checklist 358
Red Flags .....
Common Audit Observations .....
Chapter 15: Rewards and Recognition 370-409
Introduction 370
Regulatory and Governance Framework 373

Rewards Policy and Approval Audit 376
Sales Incentive Audit 378
Digital Reward Systems and Technology Risks 380
Fraud Risks in Reward and Recognition Function 383
Conduct Risk and Mis-Selling Linkages 386
Rewards Expense and Financial Controls Audit 387
Vendor and Third-Party Risk Audit 389
Vendor Onboarding and Conflict of Interest Controls 390
Data Analytics and Continuous Monitoring 391
Internal Financial Controls (IFC) and IT Controls 393
Risk Based Internal Audit Approach 395
Emerging Challenges and Current Scenario 396
Future of Internal Audit in Rewards and Recognition 398
Illustrative Internal Audit Checklist 400
Chapter 16: Advertisements 410-420
Introduction 410
Scope and Objective 410
Illustrative Internal Audit Checklist 412
Audit Analytics/CAATs 416
Commonly Observed Irregularities 416
Chapter 17: Management Expenses 421-462
Introduction 421
Regulatory Framework 424
Expense Governance and Policy Audit 426
Budgetary Control and Expense Monitoring Audit 429
Employee and Administrative Expenses Audit 432
Procurement and Vendor Expenses Audit 435
Digital Transformation and Technology Expenses Audit 438

Marketing, Distribution and Advertisement Expenses Audit 440
IT Systems and Internal Financial Controls (IFC) 442
Data Analytics and Continuous Auditing 443
Risk Based Internal Audit Approach 446
Audit Reporting and Governance 448
Emerging Challenges and Current Scenario 450
Internal Audit Checkpoint 451
Key Analytics Use Cases 458
Conclusion 461
Chapter 18: Anti Money Laundering 463-474
Introduction 463
Scope and Objective 463
Illustrative Internal Audit Checklist 465
Audit Analytics/CAATs 472
Commonly Observed Irregularities 473
AML Red Flags 473
Chapter 19: Outsourcing Functions 475-483
Introduction 475
Scope and Objectives 475
Regulatory Framework 476
Risk Control Matrix 477
Illustration Internal Audit Checklist 480
Red Flags 482
Commonly Observed Irregularities 482
Key Regulatory References 483
Chapter 20: Use of Data Analytics in Internal Audit 484-468
Introduction 484
What Data Analytics Delivers and What Stands in its Way 484

Understanding the Life Insurer's Data Landscape 486
Getting the Data Right 489
A Working Toolkit of Analytics Techniques 491
Using Artificial Intelligence and Machine Learning in Analytics 494
Chapter 21: Cybersecurity and IT Controls 499-523
Introduction 499
Regulatory Framework 499
Cyber Governance 500
Audit Objectives 501
Scope of Internal Audit 502
Cybersecurity Internal Audit Process Flow 503
Risk Control Matrix (RCM) 504
Comprehensive Internal Audit Programme 510
Red Flags 517
Commonly Observed Deficiencies 519
Emerging Risks for Internal Audit 521
Chapter 22: Financial Closing Process 524-537
Introduction 524
Scope and Objectives 524
Mandatory IRDAI Forms 525
Purpose 527
Structure and Key Components 527
Format (Simplified) 528
Regulatory References 529
Key Features Unique to Insurers 530
Legal Reference 532

ANNEXURES

Annexure 1: Eligibility Certificate and Appointment Formality of Internal Auditors 541-541

Annexure 2: Illustrative (Sample) Internal Audit Report 545-551

Annexure 3: Sample Audit Programs 552-569

Annexure 4: Audit Committee Reporting Deck 570-573

Annexure 5: Data Analytics Use Case Library 574-665

Part A: How to Use this Library 574

Part B: The Use Case Library 575

Annexure 6: Regulations and Circulars 666-677

Chapter 1
Introduction

Insurance

1.1 Insurance is a form of risk management primarily used to protect against the risk of a contingent or uncertain loss. It involves the equitable transfer of the risk of potential loss from one entity to another in exchange for the payment of a premium. Insurance operates on the principle of indemnity, whereby the insured is compensated for actual losses suffered, subject to the terms and conditions of the policy. It is also regarded as a contract of utmost good faith, requiring both parties to disclose all material facts honestly and transparently.

Life Insurance

1.2 Life Insurance is a contractual agreement whereby the insurer guarantees payment of a specified sum of money either upon the death of the insured person or upon the expiry of a specified term, in consideration of the payment of premiums. Life insurance provides financial security against uncertainties arising from death or loss of earning capacity due to physical disability. In addition to offering protection against untimely death, life insurance serves as an effective financial planning and savings instrument by enabling individuals to systematically accumulate wealth for future needs and commitments such as children's education, marriage, retirement planning and other long term financial goals. In the Indian context, life insurance also serves as an important avenue for tax savings under the applicable provisions of the Income Tax Act.

1.3 Life insurance contracts can broadly be classified into two major categories:

(i) Protection Policies: These policies are primarily designed to provide financial protection in the event of a specified contingency, such as death, illness, or disability, generally through lump sum payment. The most common forms of protection oriented policies include Term Insurance policies.

Term Insurance Policies

Term Insurance is a pure protection oriented life insurance policy that provides financial coverage for a specified period or "term." In the event of the death of the life insured during the policy term, the insurer pays the sum assured to the

nominee or beneficiary. If the insured survives the policy term, no maturity benefit is generally payable unless specifically provided under the policy. These policies are designed primarily to provide financial security to dependents at comparatively low premium costs.

(ii) Savings/ Investment Policies: These policies are primarily intended to facilitate long term savings and wealth creation through regular or single premium contributions. In addition to providing life cover, such policies enable the accumulation and growth of capital over time. Common examples include:

- **Unit Linked Insurance Plans (ULIPs)** are life insurance products that combine insurance coverage with investment benefits. A portion of the premium is allocated towards life insurance cover, while the remaining portion is invested in market linked instruments such as equity, debt, or balanced funds, based on the policyholder's choice and risk appetite. The returns under ULIPs depend upon the performance of the underlying investment funds.
- **Whole Life Insurance Policies** provide life coverage for the entire lifetime of the insured person, subject to payment of premiums as prescribed under the policy terms. The policy generally pays the sum assured along with accrued bonuses, if any, upon the death of the insured. Some whole life policies may also acquire surrender or loan value over time, thereby serving both protection and long-term savings objectives.
- **Universal Life Insurance Policies** are flexible life insurance products that combine life cover with savings or investment features. These policies allow flexibility in premium payments, policy benefits and investment allocation, subject to specified limits and conditions. The policyholder may increase or decrease premiums and death benefits during the policy term and the policy accumulates a cash value based on declared or market linked returns.

Evolution of the Insurance Sector

1.4 The following milestones highlight the key stages in the evaluation of the Indian Insurance sector:

The Initial Establishment

India observed the advent of life insurance business in 1818 with the establishment of British Company, the Oriental Life Insurance Company in

Calcutta. This marked a key step in the evolution of life insurance in India. The company was started by Europeans, exclusively to serve their community and ultimately failed in 1834.

The Rise of the Indian Insurance Company

Indians step into the insurance business due to pioneering efforts of social workers and reformers, including Raja Rammohan Ray, Ramtanu Lahiri, Dwarakanath Tagore, Rustomji Cowasji among others. The efforts lead to the founding of the first Indian insurance company under the name 'Bombay Life Insurance Society' that started operating in 1870 and offered Life Insurance Plans to Indians at standard rates.

The Landmark Decision

The life insurance business in India was first regulated in 1912 which observed the Indian Life Assurance Companies Act. The first regulation regarding life insurance in India came in 1914 when the government of India started publishing returns of Life Insurance Companies in India. In 1928, the Indian Insurance Companies Act was enacted to enable the Government to collect statistical information about both life and non-life insurance business transacted in India by Indian and foreign insurers including provident insurance societies. In 1938, with a view to protect the interest of the public who are insured, the earlier legislation was consolidated and amended by the Insurance Act, 1938 with comprehensive provisions for effective control over the activities of insurers.

The Insurance Amendment Act of 1950 abolished Principal Agencies. However, there were a large number of insurance companies and the level of competition was high. There were also allegations of unfair trade practices. The Government of India, therefore, decided to nationalize insurance business.

An ordinance was issued on 19th January, 1956 nationalising the Life Insurance sector and Life Insurance Corporation came into existence in the same year. The LIC absorbed 154 Indian, 16 non-Indian insurers as also 75 provident societies 245 Indian and foreign insurers in all. The LIC had monopoly till the late 90s when the Insurance sector was reopened to the private sector.

In January 1956, the Government of India nationalized the life insurance industry with establishing Life Insurance Corporation of India (LIC) that absorbed 245 life insurance companies and became the sole provider.

The Industrial Policy – The New Ray of Hope

In 1991, the Indian Government implemented the New Industrial Policy, under which the Indian economy was opened up for foreign investment. It leads to the reformation of sectors, like banking and finance. The life insurance industry in India was liberalized in 2000 with the prime objective of increasing competition in the industry and to ignite the immense potential that this rapidly growing market has to offer. With this landmark incident, LIC's monopoly over life insurance in India came to an end.

Constitution of IRDA

In 1999, Insurance Regulatory and Development Authority Act was enacted by Parliament. The insurance sector in India was opened to private participation following the recommendations of the Malhotra Committee. Based on these recommendations, the IRDA was constituted as an autonomous statutory body in 1999. Following the enactment of the Finance Act, 2015, the IRDA Act was repealed and the Authority now functions under the provisions of the Insurance Act, 1938. The regulator is now officially known as Insurance Regulatory and Development Authority of India.

Post Liberalization Transformation

During the year 2000 to 2010 the economic policies of India have witnessed a significant transformation. A consensus has been built up to conceive greater role for the private sector in the interplay of market dynamics with the objective of increasing the overall efficiency of the economy and enhancing the flow of investments and technology.

Post liberalisation, life insurance market in India witnessed dynamic changes including the entry of a number of global life insurers that led to increased competition in the Indian Life Insurance Market. The industry has grown from single player industry to 23 players industry in the last one decade. The Indian Life Insurance Industry is now considered fifth largest life insurance market in the world. According to the Life Insurance Council, it is USD 56 billion industry (on total premium basis) and grown at a CAGR of 25% in last 10 years.

Insurance law in India post 2010 has shifted from strict protectionism to dynamic liberalization and consumer empowerment. Key milestones include the FDI limit enhancements, the codification of health insurance, the establishment of dedicated policyholder funds and expanded regulatory modernization.

Key Legal Developments and Amendments

1.5 The Insurance Laws (Amendment) Act, 2015 increased the Foreign Direct Investment (FDI) limit in the insurance sector from 26% to 49%, introduced provisions facilitating the operation of foreign reinsurers in India, strengthened policyholder protection measures and enhanced the regulatory and enforcement powers of the Insurance Regulatory and Development Authority of India (IRDAI). Subsequently, the Insurance (Amendment) Act, 2021 further increased the FDI limit from 49% to 74%, permitting foreign ownership and control subject to prescribed safeguards.

More recently, The Insurance Act, 1938 was amended through the Sabka Bima Sabki Raksha (Amendment of Insurance Laws) Act, 2025 to modernise and strengthen India's insurance regulatory framework. The major amendments include:

(a) **Increase in Foreign Direct Investment (FDI) Limit:** The permissible FDI limit in Indian insurance companies was increased to 100%, subject to prescribed safeguards and conditions.

(b) **Strengthening Powers of IRDAI:** The powers of the Insurance Regulatory and Development Authority of India (IRDAI) were enhanced to improve regulatory oversight, enforcement, inspections, investigations and protection of policyholders' interests.

(c) **Modernisation of Definitions and Provisions:** Several provisions and terminologies under the Insurance Act, 1938 were updated and streamlined to align with current industry practices and technological developments.

(d) **Operational Flexibility for Insurers and Intermediaries:** The amendment introduced simplified compliance norms, perpetual registration validity for intermediaries and greater operational flexibility for insurance entities.

(e) **Data Protection and Digital Record Requirements:** New provisions relating to maintenance of electronic records, data confidentiality and digital governance were introduced to improve transparency and efficiency.

(f) **Policyholder Protection Measures:** The amendment strengthened provisions relating to policyholder education, grievance protection and prevention of unfair practices by insurers.

(g) **Changes Relating to Reinsurance and IFSC Operations:** The amendment reduced net owned fund requirements for foreign reinsurers and extended certain regulatory relaxations to entities operating in International Financial Services Centres (IFSCs).

(h) **Technical and Drafting Amendments:** Certain obsolete provisions were omitted and statutory terminology was revised for clarity and consistency.

Regulatory & Consumer Reforms by IRDAI Driven by the goal of "Insurance for All", the IRDAI has vastly overhauled its regulatory framework to protect policyholders and improve the ease of doing business.

Capital and Investment Flexibility: The 2025 Act removed archaic restrictions, allowing insurance companies to invest directly in technology and ancillary (e.g., Insurtech) companies.

Health Insurance Focus: The 2025 amendments codify inclusive health plans, addressing pre existing diseases, mental healthcare mandates and specific provisions for senior citizens.

Simplified Compliance: Increased the threshold for prior regulatory approval for share transfers from 1% to 5% to streamline M&A and corporate actions.

Landmark Judicial & Quasi Judicial Interventions

1.6 The Consumer Protection Act, 2019 replaced the Consumer Protection Act, 1986 and significantly strengthened the rights of insurance policyholders. Since insurance is considered a "service" under consumer law, policyholders can seek redressal against insurers for deficiencies in service, unfair trade practices, delayed claim settlement, wrongful claim repudiation and mis selling of insurance products. The Act has enhanced consumer protection by making insurance grievance redressal more accessible, efficient and policyholder friendly.

Strict Interpretation of Exclusions: Indian courts, particularly the Supreme Court of India, have consistently held that exclusion clauses in insurance contracts must be interpreted strictly and narrowly. This approach is based on the doctrine of Contra Proferentem, which means that any ambiguity in a contract is construed against the party that drafted it and interpreted in favour of the insured.

Overall Significance of Judicial and Quasi Judicial Development

These judicial and quasi judicial developments have strengthened policyholder rights in India by:

- Improving access to justice through consumer forums.
- Promoting fair treatment of insured persons.
- Ensuring greater transparency in insurance contracts.
- Discouraging arbitrary claim repudiations.
- Enhancing trust and confidence in the insurance sector.

Together, these interventions have contributed significantly to a more consumer centric insurance regulatory and dispute resolution framework in India.

Life Insurance Products

1.7 Life insurance industry in India has witnessed varied product designs during the last 5 decades. The primary products can be traced as term or protection products which gradually moved towards the savings products, such as, endowment and pure endowment. Term and endowment products, generally referred as traditional or conventional products, ruled the life insurance market till Unit Linked Insurance Plan (ULIP), which came into existence in early years of 21st Century. In fact until privatization in year 2000, the insurance market was primarily a market with a few product categories primarily in the term and endowment space. Privatization led to a spate of new product development and thereafter ULIP products dominated the life insurance market.

The Indian insurance industry is regulated by Insurance Regulatory and Development Authority of India and is undergoing major transformation driven

by digitalisation, regulatory reforms, embedded insurance and the government's "Insurance for All by 2047" vision.

Types of Life Insurance Products in India

Insurance products in India are broadly classified into:

(i) Protection Products: Protection products are pure risk cover policies designed to provide financial security to the family or dependents in case of death, disability, illness, or loan liability. These plans generally do not provide maturity benefits or savings components.

- **Term Insurance Plans:** A Term Insurance Plan is the purest form of life insurance where the insurer agrees to pay a specified Sum Assured if the insured dies during the policy term. The key features are that the Term Insurance policies are Pure protection plan, has low premium with high coverage, it has no maturity benefit (except Return of Premium variants), it is a Fixed policy tenure and gives Financial protection to the family.
- **Mortgage Protection Plans:** Mortgage Protection Insurance is designed to repay outstanding home loans if the borrower dies during the loan tenure. The key features are that the plans are linked with the home loans, the sum assured reduces with loan balance, it protects the family from loan burden and usually assigned to the lender/bank.
- **Credit Life Insurance:** This type of insurance that protects lenders against the risk of borrower default arising due to death or disability of the borrower. Under this policy, the outstanding loan amount is paid to the lender in case of such unforeseen events. Credit Life Insurance helps reduce credit risk for lenders while providing financial protection to borrowers and their families. The key features include the loan is available on single premium or regular premium basis, the loan is linked to insurance policy and the coverage is generally equal to the outstanding loan amount. The insurance policy covers Personal loans, Vehicle loans, Education loans, MSME loans, Consumer durable financing.
- **Group Term Insurance:** Group Term Insurance provides life cover to a group of individuals under one master policy. This is frequently used as employee benefit under HR policies in corporates or institutions The common groups covered are employees, association members, bank account holders, SHG members and similar other groups. In this type of policy, the employer/master policyholder manages the policy and premium

is lower due to the group coverage and premium is usually renewable annually.

(ii) Savings & Investment Products: Savings & Investment Products are life insurance plans that combine insurance protection with savings and investment benefits. These products help policyholders to build a financial corpus over time while also providing life cover to protect their families against unforeseen events. The major types of Savings & Investment Products.

- **Endowment Policies:** Endowment Policies are traditional life insurance products that combine life insurance protection with long term savings. Under these plans, the insurer pays the Sum Assured along with applicable bonuses upon the maturity of the policy if the policyholder survives the policy term. In the event of the policyholder's death during the policy term, the nominee receives the death benefit as per the policy conditions.
- **Money Back Policies:** Money Back Policies are traditional life insurance plans that provide life insurance protection along with periodic survival benefits during the policy term. Unlike Endowment Plans, a portion of the Sum Assured is paid to the policyholder at regular intervals, while the remaining amount along with bonuses (if applicable) is paid at maturity.
- **Whole Life Policies:** Whole Life Policies are life insurance plans that provide coverage for the entire lifetime of the insured, typically up to the age of 99 or 100 years. Unlike term or endowment policies, these plans do not have a fixed maturity period and are primarily designed to provide long term financial protection and wealth transfer to beneficiaries.
- **Guaranteed Return Plans:** This life insurance products that provide life cover along with assured returns, irrespective of market fluctuations. These plans offer guaranteed benefits at maturity or regular guaranteed income during the policy term, making them suitable for individuals seeking financial security and predictable returns.
- **Child Plans:** This life insurance products specifically designed to help parents or guardians build a financial corpus for a child's future needs, such as higher education, professional studies, marriage, or other important life milestones. These plans combine insurance protection with long term savings and investment benefits.

(iii) Market Linked Products: This life insurance plans that combine insurance protection with investment opportunities in capital markets. A portion of the premium is used to provide life insurance coverage, while the remaining amount is invested in market linked funds such as equity, debt, or balanced funds. The returns generated under these products depend on the performance of the underlying investments and are not guaranteed. Investment linked to capital markets.

- **Unit Linked Insurance Plans (ULIPs):** This life insurance products that combine insurance protection with market linked investment opportunities. A portion of the premium is used to provide life insurance coverage, while the remaining portion is invested in funds chosen by the policyholder. The returns under a ULIP depend on the performance of the underlying investment funds and are therefore not guaranteed.

  The key features include dual benefit of life insurance and investment, premium is allocated between insurance cover and investment funds, investments are linked to capital market performance, choice of investment funds based on risk appetite, facility to switch between funds during the policy term, transparency through daily declaration of Net Asset Value (NAV) and mandatory lock in period of 5 years as per regulatory requirements.

  The three types of funds available are:

  - **Equity Funds:** Invest primarily in shares and offer high growth potential with higher risk.
  - **Debt Funds:** Invest in fixed income securities and offer relatively stable returns with lower risk.
  - **Balanced/Hybrid Funds:** Invest in a mix of equity and debt to balance risk and return.

(iv) Pension & Retirement Products: This life insurance products designed to help individuals build a retirement corpus during their earning years and provide a regular stream of income after retirement. These products ensure financial security and independence in old age by converting accumulated savings into periodic pension or annuity payments.

Major Types of Pension & Retirement Products

(a) Deferred Annuity Plans

Under these plans, the policyholder contributes premiums during the accumulation phase. The accumulated corpus is converted into an annuity at retirement, providing regular pension payments thereafter. The investor can avail tax benefits and guaranteed income useful for financial independence after retirement.

(b) Immediate Annuity Plans

These plans provide pension payments immediately after the payment of a lump sum purchase price. They are generally purchased by individuals who have already accumulated a retirement corpus. The investor has to pay one time premium and can avail immediate regular income along with a Lifelong pension option.

(c) Pension ULIPs

These are market linked retirement products that combine retirement savings with investment in equity, debt, or balanced funds. The retirement corpus depends on the performance of the selected funds. It creates a dedicated retirement fund, provides a regular income stream after retirement, helps maintain financial stability during old age and offers flexibility in choosing annuity option.

(v) Group Insurance Products: Group insurance products are designed for organisations, employers, associations and institutions for employee retirement benefits management. The types of Group Insurance Products are:

- **Group Gratuity Schemes:** These schemes help employers fund gratuity liabilities under the Payment of Gratuity Act. The advantages are the funds are managed professionally by professional fund manager and also provides tax benefit to the employer. These are usually managed through insurance company trust, Employer contributions are invested and contribution is done on the basis of Actuarial valuation of the Fund.
- **Group Superannuation Schemes:** This is employer sponsored retirement benefit schemes providing pension to employees. It acts an Employee retention tool which provides Retirement security to the employees. There are two types Defined Benefit Scheme and Defined Contribution Scheme. In this scheme Employer's contributes to the superannuation fund and Corpus is used for annuity purchase upon retirement.

- **Group Credit Life Insurance:** Provides insurance cover against loans extended to a group. The common Users are Banks, MFIs, NBFCs, Cooperative societies. It gives Financial protection to the borrowers and Portfolio risk reduction for lenders.

Distribution Structures, Business Models and Revenue Streams

1.8 The Insurance distribution landscape in India has evolved considerably with the emergence of multiple business models and channels for reading customers. The key aspects of this evolving distribution ecosystem are discussed below:

Current Distribution Structure in India

Insurance distribution refers to channels through which insurance products are sold. Until the year 2000, the insurance sector, was dominated by the agency force i.e. sale through individual agents.

India currently follows a multi channel distribution system. The distribution mix in Indian life insurance industry has evolved significantly over the past decade and is now moving in line with mature markets, where alternate channels (non-agency) contribute significant proportion of new business. The Indian insurance sector is shifting from a traditional agent driven model to a technology enabled, multi channel ecosystem. While agency and bancassurance remain dominant, digital platforms, embedded insurance, brokers and unified marketplaces like Bima Sugam are reshaping the future of insurance distribution in India. Regulatory reforms by Insurance Regulatory and Development Authority of India are focused on affordability, transparency, wider reach and operational efficiency.

Major Distribution Channels in Indian Life Insurance Industry

A. Individual Agency Channel

The Individual Agency Channel is the traditional and is still the largest distribution channel in the life insurance industry. Under this model, insurance agents are tied to a single insurer and solicit insurance business on behalf of that company. This channel remains a major contributor to retail life insurance sales due to the personal relationship and trust built by agents with customers.

It also has strong penetration in rural and semi urban areas, helping insurers reach a wider customer base.

B. Bancassurance

Bancassurance is a distribution channel where banks distribute insurance products through their branch network and digital platforms. It enables insurers to leverage the bank's large customer base, reach and trust factor for selling insurance products. Bancassurance is a dominant channel for many private life insurers due to its wide accessibility and cross selling opportunities. Banks and corporate agents are permitted to have multiple insurer tie ups subject to the norms prescribed by the Insurance Regulatory and Development Authority of India (IRDAI).

The following models are generally followed under Bancassurance:

- Exclusive Partnership Model – A bank partners exclusively with one insurer for distribution of insurance products.
- Open Architecture Model – A bank is allowed to distribute products of multiple insurers.

C. Insurance Brokers

Insurance Brokers are independent intermediaries who represent the interests of customers rather than insurance companies. They assist clients in selecting suitable insurance products, negotiating terms and ensuring proper risk coverage based on the customer's requirements. Insurance brokers also provide advisory and claims assistance services.

The different types of Insurance Brokers are:

Direct Brokers: Deal directly with clients for life, general, or health insurance business and place insurance policies with insurers.

Reinsurance Brokers: Arrange reinsurance business between insurance companies and reinsurers to help insurers manage and spread risks.

Composite Brokers: Carry out the functions of both Direct Brokers and Reinsurance Brokers.

D. Corporate Agents

Corporate Agents are entities that distribute insurance products of insurers through corporate arrangements. These entities act as intermediaries between insurers and customers and help in expanding the reach of insurance products

through their established customer networks and distribution channels. Corporate agents play an important role in increasing insurance penetration by leveraging their customer base, branch network and digital platforms for insurance distribution.

Entities acting as Corporate Agents include:

- NBFCs (Non Banking Financial Companies)
- Banks
- Corporate houses
- Fintech companies

E. Insurance Marketing Firms (IMFs)

Insurance Marketing Firms (IMFs) are hybrid intermediaries permitted to distribute a variety of financial products and services. They play an important role in improving financial inclusion and insurance penetration, especially in smaller towns and rural areas of India. These firms act as a one stop platform for customers seeking multiple financial services and contribute significantly towards expanding the reach of the insurance sector in underserved regions.

- IMFs are allowed to distribute:
- Insurance products
- Mutual fund products
- Pension products
- Banking products

F. Web Aggregators

Web Aggregators are digital insurance comparison platforms regulated by the Insurance Regulatory and Development Authority of India (IRDAI). They enable customers to compare insurance products offered by different insurers and make informed purchase decisions online. Web aggregators have significantly contributed to the growth of digital insurance distribution by improving transparency, convenience and accessibility for customers.

Examples of Web Aggregators include:

- Policybazaar Insurance Brokers
- Coverfox Insurance Broking Private Limited

G. Digital & Embedded Insurance

Digital and Embedded Insurance is one of the fastest growing segments in the insurance industry. Under this model, insurance products are seamlessly integrated into digital platforms and customer transactions, making insurance purchase simple, convenient and instant. Embedded insurance and API based insurance marketplaces have witnessed rapid growth following digital reforms and increasing adoption of digital financial services.

Examples include:

- Mobile insurance offered along with smartphone purchases
- Travel insurance provided with airline ticket bookings
- Credit protection insurance bundled with loans

H. Direct to Customer (D2C)

Direct to Customer (D2C) is a distribution model where insurers sell insurance products directly to customers without involving intermediaries. This channel primarily operates through digital and direct communication platforms, enabling customers to purchase policies conveniently and quickly. The D2C model helps insurers reduce intermediary and distribution costs while offering customers a faster and more transparent buying experience. It also supports greater digital adoption in the insurance sector.

The Insurers sell directly through:

- Websites
- Mobile applications
- Call centres

Key Challenges in Insurance Distribution

The insurance distribution sector in India faces several challenges despite significant growth, technological advancements and regulatory reforms. These challenges affect the accessibility, affordability, efficiency and credibility of insurance products. Although the Indian insurance industry has expanded substantially, insurance penetration and density remain relatively low compared to many developed economies.

1. Low Insurance Penetration

Insurance penetration refers to the ratio of insurance premiums to a country's Gross Domestic Product (GDP). Despite increasing awareness and product innovation, a large segment of India's population remains uninsured or underinsured.

Reasons

- Limited awareness of insurance benefits.
- Low disposable income in certain segments.
- Preference for traditional savings instruments.
- Lack of adequate financial planning.

Impact

- Increased financial vulnerability of individuals and families.
- Untapped market potential for insurers.
- Reduced contribution of insurance to economic resilience.

2. Mis-selling of Insurance Products

Mis selling occurs when insurance products are sold without adequately assessing customer needs or when product features, benefits, risks, or costs are inaccurately represented.

Common Forms

- Selling investment oriented policies as guaranteed savings products.
- Inadequate disclosure of policy exclusions and charges.
- Selling unsuitable products to customers.

Impact

- Customer dissatisfaction and complaints.
- Policy lapses and early surrenders.
- Reputational damage to insurers and intermediaries.
- Increased regulatory scrutiny.

3. High Commission and Distribution Costs

Insurance distribution often involves significant expenses related to agent commissions, broker remuneration, marketing, training and customer acquisition.

Reasons

- Large dependence on intermediary driven sales.
- Extensive agent recruitment and training costs.
- High customer acquisition expenses.

Impact

- Increased operating expenses for insurers.
- Higher product pricing.
- Pressure on profitability and efficiency.

4. Accessibility Gap in Rural and Remote Areas

A substantial portion of India's population resides in rural and semi urban regions where insurance distribution infrastructure remains limited.

Challenges

- Inadequate distribution networks.
- Limited availability of trained insurance professionals.
- Poor digital connectivity in certain regions.
- Geographical and logistical constraints.

Impact

- Lower insurance awareness and adoption.
- Uneven market development.
- Exclusion of vulnerable populations from financial protection.

5. Low Financial Literacy

Many consumers have limited understanding of insurance concepts, policy terms, coverage benefits, exclusions and long term financial planning.

Consequences

- Difficulty in selecting appropriate products.
- Increased susceptibility to mis selling.
- Underinsurance or inadequate coverage.
- Low participation in long term financial protection plans.

Need

- Enhanced financial education initiatives.
- Simplified insurance products and disclosures.
- Consumer awareness campaigns.

6. Trust Issues Relating to Claims Settlement

Customer confidence in insurance largely depends on fair and timely claim settlement. Delays, disputes, or claim repudiations often create trust deficits.

Causes

- Lack of understanding of policy terms and exclusions.
- Incomplete disclosure at the proposal stage.
- Delays in documentation and claim processing.
- Perceived lack of transparency.

Impact

- Reduced consumer confidence.
- Negative perception of insurance products.
- Lower policy renewals and customer retention.

Conclusion

Addressing these challenges is critical for achieving broader insurance coverage and enhancing consumer confidence in the insurance sector. Greater financial literacy, technological innovation, transparent sales practices, efficient claims management and expanded rural outreach can significantly improve the effectiveness of insurance distribution in India. Strengthening these areas will support the long term objective of increasing

insurance penetration and achieving inclusive financial protection for all sections of society.

Emerging Trends in Indian Insurance Distribution

The Indian insurance distribution landscape is evolving rapidly due to technological advancements, digital transformation and changing customer preferences. Insurers are increasingly adopting innovative distribution models to improve reach, efficiency and customer experience. These trends are transforming the insurance distribution ecosystem and are expected to drive higher insurance penetration in India.

Key emerging trends in Indian insurance distribution include:

- Growth of digital and embedded insurance platforms
- Increasing use of Artificial Intelligence (AI) and data analytics
- Expansion of InsurTech and API based marketplaces
- Rise in online policy purchases through websites and mobile applications
- Greater adoption of Bancassurance and partnership models
- Increased focus on rural and financial inclusion initiatives
- Use of UPI and digital payment ecosystems for insurance distribution
- Personalized and customer centric insurance offerings

Objective and Scope of the Technical Guide

1.9 This Technical Guide is intended to assist internal auditors in carrying out internal audit of entities operating in the insurance business. The Technical Guide deals with operational areas of entities operating in this industry with emphasis on compliance mandated as per various regulations applicable to the specific industry.

This Technical Guide covers the following aspects:

(i) Abbreviations peculiar to insurance industry.

(ii) Scenario in the insurance industry, special features and challenges faced by entities operating in this industry.

(iii) Discussion on Internal Audit and compliance related issues.

(iv) Legal Framework for entities operating in the Indian insurance industry.

(v) Major areas of internal audit significance and risks faced by an entity operating in this industry, procedures that an internal auditor can perform.

Intended Users of the Technical Guide

1.10 The Technical Guide on Internal Audit of Life Insurance Companies issued by the Institute of Chartered Accountants of India is primarily intended for professionals and stakeholders involved in accounting, auditing, financial reporting, compliance and operations within the life insurance sector. The life insurance industry has highly specialised accounting and reporting requirements due to Long term policy liabilities, Actuarial assumptions, Complex investment structures, IRDAI prescribed reporting formats, Policyholder versus shareholder fund accounting. Therefore, the guide acts as an industry specific interpretational and implementation support document for professionals working in or auditing the sector.

The Intended Users of the Technical Guide are:

1. Chartered Accountants

The primary target audience used by:

- Statutory Auditors
- Internal Auditors
- Concurrent Auditors
- Tax Auditors
- Consultants and Advisors

Purpose

- Understanding life insurance accounting
- Audit procedures
- Regulatory compliance
- Financial statement presentation
- Revenue recognition and actuarial considerations

2. Finance & Accounts Teams of Life Insurance Companies

Includes: CFO teams, Financial Controllers, Accounting Managers, MIS teams

Purpose

- Preparation of financial statements
- Compliance with:
  - Insurance Act, 1938
  - IRDAI Regulations
  - Companies Act, 2013
  - Accounting Standards/ Ind AS
- Policy liability accounting
- Solvency reporting

3. Internal Audit & Risk Management Professionals

Purpose

- Internal control evaluation
- Risk assessment
- Process reviews
- Governance framework assessment

Particularly relevant for

- Premium accounting
- Claims processing
- Investment accounting
- Commission payouts
- Reinsurance accounting

4. Actuarial Professionals

Although actuarial standards are separately governed, the guide is useful for

- Coordination between actuarial valuation and financial reporting
- Understanding liability measurement
- Embedded value considerations
- Product profitability analysis

5. Insurance Company Management

Includes

- Senior management
- Compliance heads
- Operations heads
- Board and Audit Committee members

Purpose

- Understanding accounting implications
- Regulatory expectations
- Governance requirements
- Financial disclosures

6. Students & Academicians

Useful for

- CA Final students
- Insurance and finance students
- Researchers in insurance accounting

Helps in understanding

- Industry specific accounting
- Insurance operations
- Regulatory environment

7. Regulators & Compliance Professionals

Relevant for

- Compliance officers
- Regulatory reporting teams
- Professionals dealing with IRDAI inspections

Chapter 2
Regulatory Framework

Introduction

2.1 This chapter sets out the legal and regulatory framework within which a life insurance company in India operates. The framework stated is as updated up to **30 April, 2026**. It is organised as:

(i) The governing legislation

(ii) Consolidated IRDAI regulations and the master circulars that operationalise them

(iii) Cybersecurity, fraud and regulatory information governance

(iv) Wider statutory overlay applicable to a life insurer

(v) Regulatory and supervisory authorities and

(vi) Mapping of key powers under the principal Acts.

Auditor's note on method

Following IRDAI's 2024 consolidation and the principle based regime that replaced it, the substantive obligations no longer sit only in the regulations. For most areas the regulation is a thin enabling instrument and the testable detail resides in the associated master circular, which is amended more frequently. Each regulation below is, therefore, paired with its operative circular where one exists.

As this framework is principle based and frequently amended, every instrument should be reconciled to IRDAI's live register and the bere amended Acts as on the testing date. The latest version of the Acts, Rules, Regulations, Notifications, Circulars, Guidelines, Orders and Notices can bere found at https://irdai.gov.in/legal.

Legislation

2.2 The principal insurance statutes are the Insurance Act, 1938, the Insurance Regulatory and Development Authority Act, 1999 and where the auditee is the Life Insurance Corporation, the Life Insurance Corporation Act, 1956. These were amended by the Sabka Bima Sabki Raksha (Amendment of

Insurance Laws) Act, 2025, which received Presidential assent on 20 December 2025 (Act No. 40 of 2025). The Central Government appointed 5 February, 2026 as the commencement date for the provisions of the Act, except Section 25, which has been kept out of the first phase of implementation and is to be notified separately.

Insurance Act, 1938 (as amended)

- The principal statute governing the carrying on of insurance business in India defines "insurance business" (term substituted by the 2025 Act) and the conditions for registration, operation and winding up of insurers.
- Section 64VB no risk to be assumed unless premium is received in advance a foundational compliance control for any life insurer (unchanged by the 2025 Act).
- Sections 64V and 64VA Valuation of assets and liabilities and maintenance of the required solvency margin (control level of solvency 150%).
- Sections 27 to 27E and Section 28 investment of assets, prohibitions and the pattern of investment of the controlled fund.
- Section 49 distribution of surplus to policyholders and shareholders in participating business, with the shareholders' share capped at one tenth of the surplus this cap is unchanged by the move to Ind AS.
- Sections 102 to 105C penalties for contravention the 2025 amendment added a disgorgement power enabling recovery of wrongful gains from insurers and intermediaries.
- Section 114A power to make regulations.
- 2025 amendments of note: a new Section 3AA permitting foreign investment up to 100% of paid up equity a requirement that at least one of the Chairperson, Managing Director or Chief Executive Officer be a resident Indian citizen amalgamation of non-insurance and insurance companies reduction of the net owned fund requirement for foreign reinsurers from Rs. 5,000 crore to Rs. 1,000 crore and the threshold for prior approval of share transfers raised from 1% to 5% of paid up equity.

Insurance Regulatory and Development Authority Act, 1999 (IRDA Act, as amended)

- Establishes IRDAI as the apex regulator and confers its powers, duties and functions under Section 14.
- Provides, with Section 114A of the Insurance Act, the power under which most IRDAI regulations are framed.
- Constitutes the Insurance Advisory Committee and provides for the levy of fees.
- Amended in 2025 to strengthen IRDAI's governance, including disgorgement powers and a codified, consultative regulation making procedure.

Life Insurance Corporation Act, 1956 (LIC Act, as amended)

- Constitutes the Life Insurance Corporation of India and governs its capital, management and the transfer of the controlled business of the erstwhile insurers.
- Relevant only where the auditee is LIC LIC remains subject to a separate statutory framework and, post 2025, a foreign investment ceiling of 20% as against 100% for other insurers.
- Amended in 2025 in consequence of the wider insurance law reforms.

IRDAI Regulations and Master Circulars

2.3 In 2024, IRDAI undertook a comprehensive consolidation, replacing 37 earlier regulations with a smaller set of principle based regulations and two new ones, each supplemented by a master circular. The instruments below are those applicable to a life insurer, stated as updated to 30 April, 2026.

IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations, 2024

- Consolidates the norms on appointment, powers and duties of the Appointed Actuary valuation of assets and liabilities maintenance of solvency margin and the investment regime.
- Operative guidance: Master Circular on Actuarial, Finance and Investment Functions of Insurers, 17 May, 2024.

- Amended by the IRDAI (Actuarial, Finance and Investment Functions of Insurers) (Amendment) Regulations, 2026 (F. No. IRDAI/Reg/2/216/2026, approved at the Authority's 135th meeting on 30 March 2026), inserting Schedule IIA mandating preparation of financial statements under Indian Accounting Standards (Ind AS) from 1 April 2026.
- Note for the auditor: valuation of assets and liabilities for solvency purposes and maintenance of the solvency margin, continue to be governed by Sections 64V and 64VA of the Insurance Act and Schedule I the Ind AS basis does not displace the solvency basis.
- IRDAI Guidelines on Stewardship Code for Insurers binding on the insurer as an institutional investor testable elements include the board approved stewardship policy, compulsory voting disclosures, monitoring of investee companies and the management of conflicts of interest in respect of investee companies.

IRDAI (Insurance Products) Regulations, 2024

- Governs the design and development of insurance products on a principles basis for life insurers it repealed and absorbed the Unit Linked Insurance Products Regulations 2019, the Non Linked Insurance Products Regulations 2019, the Micro Insurance Regulations 2015, the Minimum Limits for Annuities Regulations 2015 and the Acquisition of Surrender and Paid up Values Regulations 2015.
- Operative guidance: Master Circular on Life Insurance Products, 12 June 2024 prescribing minimum sum assured by age, revised surrender value computation, conditions for premium reduction, a mandatory policy loan facility for savings products and a free look period extended to 30 days.
- Recognises index linked life insurance products as a distinct category.

IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024

- Consolidates the norms on policyholders' interests, advertisements, outsourcing, manner of receipt of premium, places of business and the procedure for nomination and assignment.

- Operative guidance: Master Circular on Protection of Policyholders' Interests, 5 September 2024 and the Master Circular on Operations and Allied Matters of Insurers, 19 June 2024.
- Prescribes turnaround times for policy servicing and claims, grievance redress obligations and the conduct of distribution.

IRDAI (Expenses of Management, including Commission, of Insurers) Regulations, 2024

- Merges the erstwhile Expenses of Management and commission cap regimes into a single, board governed framework with self determined limits within prescribed ceilings.
- Operative guidance: Master Circular on Expenses of Management, including Commission, of Insurers, 15 May 2024.
- A high-risk audit area: the shift from hard caps to a board approved policy places the burden of compliance demonstration on the insurer's own governance.

IRDAI (Corporate Governance for Insurers) Regulations, 2024

- Prescribes board composition, appointment of key management persons, selection of statutory auditors, conflict of interest norms and the constitution and responsibilities of board committees (Audit, Risk Management, Policyholder Protection, Investment, Nomination and Remuneration).
- Operative guidance: Master Circular on Corporate Governance for Insurers, 22 May 2024.

IRDAI (Registration, Capital Structure, Transfer of Shares and Amalgamation of Insurers) Regulations, 2024

- Governs registration of insurers, capital structure, transfer of shares and amalgamation the threshold for prior IRDAI approval of share transfers was raised to 5% of paid up equity (from 1%) by the 2025 reforms.

- Read with the Indian Insurance Companies (Foreign Investment) Rules and the FEMA Non Debt Instrument Rules for foreign investment compliance.

Reinsurance Framework

- IRDAI (Consolidated Re-insurance) Regulations, 2024 the consolidated reinsurance regime applicable to insurers, foreign reinsurance branches and Lloyd's India.
- Operative guidance: Master Circular on Reinsurance, 31 May 2024.
- Annual obligatory cession notifications, including the cession notification for FY 2026 27 issued on 17 April 2026, relevant to a life insurer's reinsurance programme, retention and cession testing.

Distribution Channel Framework

- IRDAI (Appointment of Insurance Agents) Regulations, 2016 governing individual agency.
- Registration of Corporate Agents Regulations, 2015 Insurance Brokers Regulations, 2018 Insurance Web Aggregators Regulations, 2017 Registration of Insurance Marketing Firms Regulations, 2015.
- Point of Sales Person (POSP), specified person, tele sales and digital sales norms, where applicable to the channel mix.
- Bima Vahak Guidelines, 2023 relevant where the insurer uses or plans rural and women centric distribution.

Digital issuance, Repositories and Premium Blocking

- Revised Guidelines on Insurance Repositories and Electronic Issuance of Insurance Policies, including the amendment of 29 July 2025 relevant to dematerialised policy issuance and e insurance accounts.
- Bima ASBA a one time UPI mandate for blocking the premium amount for issuance of life and health insurance policies (listed by IRDAI on 18 February 2025), relevant to premium receipt, Section 64VB compliance, refund controls, customer consent and reconciliation.

- Insurance Self Network Platform (ISNP) and the insurance e commerce framework where the life insurer operates an ISNP for online sale and service, the audit must cover the mandatory periodic Information Systems (IS) audit of the platform and the independent operational controls over its functioning (sale, payment, issuance and grievance handling).

Anti Money Laundering and Other Applicable IRDAI Instruments

- Master Guidelines on Anti Money Laundering/ Counter Financing of Terrorism, 2022 (effective 1 November 2022, amended March 2023 and October 2023), issued under the PMLA covering customer due diligence, beneficial ownership identification, STR/CTR reporting to FIU IND, appointment of a Principal Officer and an annual compliance certificate to IRDAI within 45 days of the financial year end.
- IRDAI (Bima Sugam Insurance Electronic Marketplace) Regulations, 2024 IRDAI (Rural, Social Sector and Motor Third Party Obligations) Regulations, 2024 (rural and social sector limb applicable to life insurers).

Recent Development: Adoption of Indian Accounting Standards (Ind AS)

2.4 Ind AS has been introduced as an amendment to the IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations, 2024, through the insertion of Schedule IIA, operationalised by circular IRDAI/IFRS/CIR/MISC/45/4/2026 (issued under Section 34 of the Insurance Act and Section 14 of the IRDA Act read with Regulations 7 and 8 of the 2024 Regulations).

- **Applicability and date:** All insurers life, general, standalone health and reinsurers prepare and present financial statements under Ind AS from 1 April 2026, with Ind AS 117 (Insurance Contracts, India's equivalent of IFRS 17) and Ind AS 109 (Financial Instruments) at its core.
- **Parallel reporting:** For the first two years, insurers furnish Ind AS financial statements (Schedule IIA, filed with IRDAI and audited) alongside the existing IGAAP based financial information (Schedule II, limited reviewed), to permit impact assessment.

- **Forbearance:** A one year forbearance from full Ind AS statutory statements was available on application the application window closed 30 April 2026. Even under forbearance, quarterly Schedule IIA financial information must be submitted and monthly progress reports on implementation readiness are required.
- Retrospective cohort construction (participating business): graduated application 10 years for FY 2026 27, 15 years for FY 2027 28, 20 years for FY 2028-29 creating a material data lineage and historical data integrity audit exposure.
- **Cross dependencies the auditor must track:** (i) The Ind AS 117 discount rate is aligned with the methodology of the proposed Risk Based Capital (RBC) framework, so the two move together (ii) Accounting profit under Ind AS 117 does not equal distributable surplus Section 49 of the Insurance Act continues to govern surplus distribution and insurers must reconcile actuarial surplus to Ind AS profit (iii) The taxation basis must be reconciled to Ind AS profit (iv) listed insurers face SEBI LODR quarterly review timelines on the new basis.

Cybersecurity, Fraud and Regulatory Information Governance

2.5 These instruments are central to an internal audit guide: they map directly to information technology general controls, fraud risk procedures, audit trails, record retention and regulatory return testing.

IRDAI Information and Cyber Security Guidelines, 2026
• Issued by circular IRDAI/GA&HR/CIR/MISC/51/4/2026 dated 6 April 2026 (Version 2.0), replacing the 2023 guidelines. • Apply broadly to insurers, foreign reinsurance branches, intermediaries (brokers, corporate agents, web aggregators), TPAs, insurance repositories and the Insurance Information Bureau of India compliance required from the current financial year. • Relevant to ITGC, cyber governance (Board level cybersecurity oversight and the CISO role), incident response and CERT In reporting, access controls, data leakage prevention, ransomware resilience, encryption and third party/ outsourced technology risk.

- Prescribes a NIST structured auditor's report (Annexure III) filed within prescribed timelines after the financial year end auditor eligibility is specified separately.

IRDAI (Insurance Fraud Monitoring Framework) Guidelines, 2025

- Issued 9 October 2025, effective 1 April 2026, repealing the 2013 Fraud Monitoring Framework circular.
- Apply to all insurers and distribution channels require a board approved anti fraud policy reviewed annually, a dedicated and independent Fraud Monitoring Committee (FMC) and Fraud Monitoring Unit (FMU).
- Prescribe compressed, binding reporting timelines to law enforcement, IRDAI and the IIB and explicitly address cyber fraud and vendor/ channel oversight.
- For internal audit: map to fraud risk procedures across sourcing, underwriting, claims, policy servicing, surrenders, free look cancellations, channel payouts and employee/ vendor fraud.

IRDAI (Maintenance of Information by the Regulated Entities and Sharing of Information by the Authority) Regulations, 2025

- Listed by IRDAI as dated 10 January 2025 governs maintenance of records, system generated records and the sharing of information by the Authority.
- Relevant to audit trails, record retention, regulatory inspection readiness, management information and data governance testing.

Master Circular on Submission of Returns, 2024

- Issued 14 June 2024 provides a one stop reference for the submission of regulatory returns.
- Defines the regulatory return framework an internal auditor must test as an audit population: solvency, investment, actuarial, expenses/

commission, policyholder protection, grievance, rural/ social obligation, fraud and AML returns and public disclosures.

Wider Statutory and Regulatory Overlay

2.6 A life insurer is also a company and a financial sector entity and is bound by laws administered outside IRDAI. The principal overlay instruments are set out below.

Anti Money Laundering and Corporate Law

- Prevention of Money Laundering Act, 2002 (PMLA) makes the insurer a "reporting entity" with customer due diligence, record maintenance, beneficial ownership identification and STR/CTR reporting to FIU IND operationalised through the IRDAI AML/CFT Master Guidelines 2022 (as amended) and the PML (Maintenance of Records) Rules 2005 (as amended).
- Companies Act, 2013 governs the insurer as a body corporate (incorporation, board and committee constitution, statutory audit, related party transactions and CSR), operating in parallel with the IRDAI Corporate Governance Regulations annual financial statements are audited under both the Insurance Act and the Companies Act.
- Prevention of Corruption Act, 1988 anti-bribery and corrupt practices (ABAC) exposure, particularly for government/ group policies, institutional sales and distribution channel remuneration structures.

Data Protection, Privacy and Information Technology

- Digital Personal Data Protection Act, 2023 (DPDP Act) and its rules/ commencement status governing processing of policyholder and prospect personal data: consent, notice, retention, data minimisation, data principal rights and breach handling.
- Information Technology Act, 2000 and the SPDI Rules (to the extent still relevant during transition) and CERT In cyber incident reporting directions.

- Outsourcing and vendor processing of policyholder medical, financial and nominee data, aligned with IRDAI cybersecurity and outsourcing requirements.

Consumer Protection and Grievance Ecosystem

- Insurance Ombudsman Rules, 2017 alternate grievance redress for policyholders.
- Bima Bharosa IRDAI's integrated grievance management portal grievance turnaround times under the policyholder protection framework.
- Consumer Protection Act, 2019 consumer disputes beyond the Ombudsman framework relevant to mis selling, unfair business practice, repudiation disputes and claim delay exposures.

Domestic Systemically Important Insurers (D SII): Conditional Module

- Applies only where the auditee carries a D SII designation. IRDAI identifies D SIIs annually on the basis of size, market importance and interconnectedness for FY 2025 26 the designated insurers are LIC, GIC Re and New India Assurance of which, among life insurers, only LIC is in scope.
- Where applicable, the internal audit must independently verify the enhanced corporate governance standards, the identification of all relevant risks and the soundness of the risk management framework, the systemic risk mitigation/ recovery arrangements and adherence to the specific disclosure mandates stipulated by IRDAI for D SIIs.

Actuarial and Professional Framework

- Actuaries Act, 2006 and the standards and guidance notes of the Institute of Actuaries of India.
- Professional responsibilities of the Appointed Actuary, cross linked to the Actuarial, Finance and Investment Regulations.

- Relationship between the actuarial investigation, surplus distribution (Section 49), solvency (Sections 64V/64VA) and Ind AS 117 financial reporting.

Contract and Fiscal Law

- Indian Contract Act, 1872 and the stamp laws relevant to policy contracts, assignments, nominations, releases, settlements and powers of attorney.
- Income tax law the Income tax Act, 1961 taxation of life insurance business under Section 44 and the First Schedule TDS under Sections 194D and 194DA (For FY 2026 27 onwards, the Income tax Act, 2025 taxation of life insurance business under Section 55 and Schedule XIV TDS under Section 393(1), Table Sl. No. 1(i) for insurance commission and Section 393(1), Table Sl. No. 8(i) for payments under life insurance policies) and the Central Goods and Services Tax Act, 2017 and allied GST law on premium and input credit.
- FATCA/ CRS Section 285BA of the Income tax Act, 1961 read with Rules 114F to 114H of the Income tax Rules, 1962 (For FY 2026 27 onwards, Section 508 of the Income tax Act, 2025 read with Rules 238 to 240 of the Income tax Rules, 2026). A life insurer issuing cash value insurance or annuity contracts is a Reporting Financial Institution (RFI). The audit framework must cover determination of RFI status, the Rule 114H due diligence procedures for identifying reportable accounts (Rule 240 of Income tax rules, 2026), procurement of valid self-certifications and the annual filing of Form 61B with the CBDT (From FY 2026 27 onwards, Form 166 under Income tax act, 2025).
- Unclaimed amounts of policyholders and the policyholder education/ protection framework a recurring regulatory and audit exposure specific to life insurers (lapsed policies, untraced policyholders, transfer to the prescribed fund).

Foreign Investment, Listing and Employment

- The 2025 amendments liberalise foreign investment in Indian insurance companies up to 100%, subject to prescribed conditions. For audit

purposes, FEMA/ NDI operationalisation, automatic route eligibility, IRDAI approval/ verification, resident Indian citizen requirements and LIC's separate 20% cap should be checked against the FEMA/ FDI framework applicable on the testing date.

- SEBI (Listing Obligations and Disclosure Requirements) Regulations, 2015 applicable to listed insurers.
- Employment and workplace overlay: the New Labour Codes (comprising provisions relating to POSH, Gratuity, Bonus, EPF, ESI, etc.), Shops and Establishments laws, as applicable to insurer operations.

Regulatory and Supervisory Authorities

2.7 The following authorities supervise, or share supervision of, the activities of a life insurance company:

Insurance Regulatory and Development Authority of India (IRDAI)

- The apex regulator for the insurance sector registers, regulates, supervises and takes enforcement action against insurers and intermediaries.
- Frames regulations and issues master circulars, guidelines and directions conducts-on-site inspection and off-site surveillance and, post 2025, may disgorge wrongful gains.

Financial Intelligence Unit – India (FIU IND)

- Receives, processes and analyses suspicious transaction and cash transaction reports filed by insurers under the PMLA and coordinates national anti-money laundering efforts.

Insurance Information Bureau of India (IIB)

- Repository for industry data, including fraud monitoring data reported under the Fraud Monitoring Framework Guidelines, 2025.

Indian Computer Emergency Response Team (CERT In)

- National agency for cyber incident response recipient of incident reporting under the IT Act and aligned with the IRDAI cybersecurity guidelines.

Ministry of Corporate Affairs (MCA) and Registrar of Companies

- Administers the Companies Act, 2013 statutory filings, corporate governance and audit requirements applicable to the insurer as a company.

Securities and Exchange Board of India (SEBI)

- Regulates a listed insurer's securities market disclosures and conduct under the SEBI Act and LODR.

Reserve Bank of India (RBI)

- Regulates monetary policy, foreign exchange transactions and, through banks acting as corporate agents, the bancassurance channel relevant to FEMA compliance and debt instrument investments.

Other Bodies

- Insurance Ombudsman grievance redress under the Insurance Ombudsman Rules, 2017.
- Securities Appellate Tribunal (SAT) hears appeals against certain orders of IRDAI.
- GST authorities and the Income tax Department administration of indirect and direct tax respectively.

Note: This framework is principle based and amended frequently the master circulars carry the operative detail and change more often than the parent regulations. The audit framework built on this chapter should be maintained as a change management register instrument, parent authority, governing master circular, last amended date and cross dependencies and reconciled to IRDAI's live "Acts and Regulations" register and the bare amended Acts at each audit planning cycle.

Chapter 3
Product Development, File and Use

Introduction

3.1 Product development in a life insurance company is not merely a product-design or actuarial activity. It is a controlled governance process that should evidence customer need, insurable risk, fair pricing, policyholder protection, capital and solvency implications, system readiness, distribution readiness and post launch monitoring. Internal audit should therefore test both the design controls and the implementation controls that allow a product to be launched and sold in the market.

The current Indian framework requires life insurers to comply with the IRDAI (Insurance Products) Regulations, 2024 and the IRDAI Master Circular on Life Insurance Products dated 12 June 2024. The product approval process permits two routes:

Use & File (U&F) and

File & Use (F&U).

Under F&U, products are marketed only after prior filing with the Authority and allotment/assignment of UIN under U&F, the insurer can launch after UIN assignment without prior filing, subject to the prescribed categories and internal governance requirements.

Scope of Internal Audit

3.2 The internal audit scope should include:

- Board approved (i) Product Management and Pricing Policy, (ii) Underwriting Policy and (iii) Advertisement Policy, including alignment with current IRDAI requirements.
- Product ideation, market/customer need assessment, target market definition, product classification and approval route determination.
- Pricing basis, profit testing, sensitivity testing, surrender value basis, guarantees/options, reinsurance cost, commission/expense assumptions and capital/solvency impact.

- Review and approval by Appointed Actuary, Compliance, Legal, Underwriting, Reinsurance, Investment, Finance, Operations, Technology, Risk Management and PMC.
- Completeness, accuracy, consistency and version control of product filing documents, certifications, policy documents, CIS, benefit illustrations, proposal forms, sales literature, online journeys and website disclosures.
- UIN allotment, UIN version control, withdrawn product controls, product modification controls and reporting to IRDAI.
- System configuration and UAT across policy administration, illustration system, premium calculator, underwriting engine, claims, accounting, commission, GST, reserving, solvency and MIS.
- Distributor training, sales conduct controls, advertisement approval, channel level restrictions and monitoring of mis selling indicators.
- Post launch review of product performance, including sales trends, free look cancellations, policy cancellations, grievances, claims, persistency, profitability, adverse selection, reinsurance recoveries and complaints from distribution channels.

Objectives of Internal Audit

3.3 The assignment is directed at obtaining reasonable assurance on the following:

- That product development and approval are governed by current Board approved policies and an effective PMC framework that decisions are evidenced rather than merely minuted.
- That product design and pricing protect policyholders are consistent with the insurer's risk appetite, actuarial basis, underwriting policy, reinsurance strategy, capital position and solvency requirements.
- That the correct U&F or F&U route was determined on a documented basis and that the related forms, certifications, checklists, pricing documentation and approvals are complete and accurate.
- That every customer facing and market conduct document is internally consistent and faithful to the design approved by the PMC and, where applicable, filed with the IRDAI.

- That system build, UAT, operational readiness and distribution readiness were genuinely completed before the product was offered for sale.
- That post launch monitoring detects mis selling, profitability deterioration, policyholder harm, weak persistency, grievances and claims stress on a timely basis.
- That identified deficiencies translate into timely modification, withdrawal, disclosure correction, distributor remediation, system correction or regulatory reporting, as the case requires.

Standards on Internal Audit

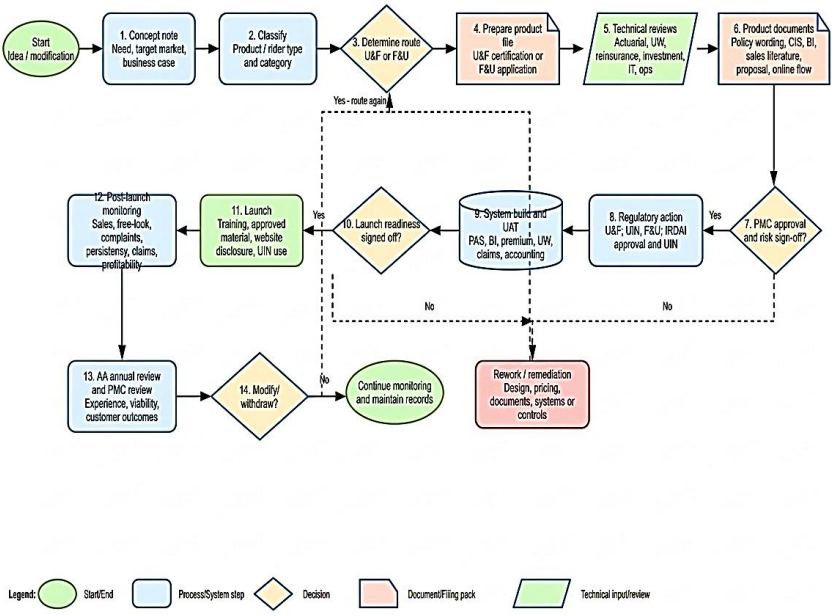
3.4 The following SIAs particularly relevant for internal audit of product development and F&U activities with their applications are as follows:

Relevant SIA	**Application to Product Development and F&U Audit**
SIA 140, Internal Controls	Evaluate design and operating effectiveness of product governance, approval, document control, system and monitoring controls.
SIA 150, Risk Management	Assess how product, pricing, policyholder, market conduct, capital, operational and regulatory risks are identified and mitigated.
SIA 160, Compliance with Laws and Regulations	Test compliance with IRDAI product regulations, master circulars, filing requirements, UIN requirements, policyholder disclosures and reporting obligations.
SIA 220, Internal Audit Planning	Include product development as a high-risk area based on regulatory change, volume of launches, channel risk and complaint indicators.

SIA 270, Expert and Third Party Engagement	Use actuarial or technology specialists where pricing/profit testing, actuarial models, UAT or system configuration require technical expertise.
SIA 230, Internal Audit Evidence	Obtain sufficient appropriate evidence such as PMC minutes, signed certifications, UAT evidence, filing packs, UIN records and post launch MIS.
SIA 250, Internal Audit Documentation	Document test of controls, sample basis, exceptions, root causes, management responses and cross references to supporting evidence.
SIA 290, Communication with Management and those charged with Governance	Communicate material gaps to management and those charged with governance report regulatory, policyholder and control impact implications clearly.

Process Overview and Flowchart

3.5 Process overview and flowchart for product development and F&U process is as follows:



Risk Control Matrix

3.6 The matrix below decomposes the product life-cycle into thirteen sub-processes. For each, it states the principal risk, the control the auditor expects to find, the procedure to test that control and the evidence that substantiates the test. The matrix is the spine of the audit.

S. No.	Sub Process	Key Risk	Expected Control	Audit Procedure	Evidence
1.	Ideation and Business Case	Product built for channel push or margin rather than a real customer	Concept note documents the need, target market, value proposition, expected	Review sampled concept notes test that the rationale rests on customer	Concept note, market research, competitor analysis, product calendar,

		need unsuitable target market.	volumes, competitor benchmarking and a policyholder impact assessment approved by Product/ Strategy/ Risk department.	benefit and not sales alone confirm the approval trail.	approval note.
2.	Classification and Route	Product or rider misclassified U&F used where F&U was required a modification wrongly treated as minor or as needing no UIN change.	A documented route decision checklist mapped to the master circular Compliance and Appointed Actuary sign off before PMC approval UIN version control.	For each sampled product or change, re perform the route determination and test the basis for U&F versus F&U and for any UIN versioning.	Route checklist, compliance/ legal note, AA sign off, UIN register, table of changes.
3.	Design and Benefit Structure	Opaque or over complex product benefits, charges, options or exclusions	Design principles embedded in the BAPMPP independent Legal/ Compliance/ Actuarial	Compare features against the regulatory design principles test that charges, options,	BAPMPP, policy wording, CIS, product specification, customer literature.

		unclear potential for policyholder harm or unfair discriminatio n.	review plain language review of wording, CIS and literature.	surrender values and exclusions are clear and consistent across documents.	
4.	Pricing and Actuarial Basis	Premium inadequate, excessive or unfairly discriminato ry assumptions unsupported guarantees mispriced capital strain not understood.	A pricing note with assumptions, experience basis, sensitivity and scenario tests, profit testing, surrender value basis, EOM/ commission consistency, capital impact and AA sign off.	Review the pricing pack test assumption sources and approval inspect sensitivity testing verify treatment of expenses, commission, mortality/ morbidity, persistency, investment return and tax.	Pricing memo, profit test output, model change log, AA certificate, peer review, EOM analysis.
5.	Underwritin g and Reinsuranc e	Pricing assumptions inconsistent with underwriting rules or reinsurance terms adverse selection unapproved	Underwriting grid and financial/ medical limits mapped to the BAUP and approved reinsurance terms and retention agreed before launch.	Compare pricing assumptions with underwriting rules verify the reinsurance quote or treaty addendum test approval	BAUP, underwriting manual, product underwriting matrix, reinsurance confirmation, retention approval.

		concessions.		of non-standard features.	
6.	Investment and ALM Feasibility	Guarantees, linked funds, index features or annuity benefits not supported by investment capability asset liability mismatch.	Investment/ CIO sign off on strategy, fund availability, guarantee support, liquidity, index methodology and ALM implications.	Inspect the investment sign off test that product cashflows and guarantees were considered verify new fund approval and NAV/ accounting readiness for linked products.	CIO memo, ALM note, investment committee extracts, fund setup evidence, NAV control note.
7.	Documents and Market Conduct Material	Policy document, CIS, illustration, literature, proposal form and online flow inconsistent with the approved design misleading material.	A single controlled product file maker checker review PMC/ Advertisement Committee approval of conduct material a document consistency checklist.	Trace key benefits, charges, exclusions, surrender values and UIN from the approved filing through to every customer facing document inspect version control.	Document checklist, policy bond, CIS, illustration, prospectus, literature, proposal form, online screenshots.
8.	PMC Governance	PMC lacks quorum,	PMC terms of reference	Review the PMC	PMC charter, attendance,

	and Approval	members or technical due diligence minutes record approval without evidencing review certifications unsupported.	mandatory members and quorum a structured agenda covering each product risk documented sign offs on pricing, capital, underwriting, reinsurance, technology, compliance and conduct.	constitution, attendance and minutes verify Appointed Actuary participation test that conditions or dissent were recorded and closed before launch.	minutes, action tracker, risk sign off matrix, certifications.
9.	Filing, UIN and Regulatory Communication	Incomplete or inconsistent filing delayed response to the IRDAI sale before UIN or approval wrong UIN in documents.	A filing checklist with a compliance owner digital signing controls a UIN register a correspondence tracker a pre launch gate requiring UIN and approval status.	Review the application and IRDAI correspondence verify the UIN assignment date against the launch date test the UIN across documents, website and returns.	Filing pack, IRDAI submissions, UIN allotment, launch approval, regulatory tracker.
10.	System Configuration and UAT	Product sold or serviced incorrectly through a wrong premium calculator,	A product implementation requirements document UAT scripts approved by	Test sampled UAT cases across age, term, premium, mode, rider, surrender and	BRD/ FRD, configuration tables, UAT scripts, defect tracker, deployment

		illustration, admin setup, charge, commission, accounting, claims or reserving logic.	business/ actuarial/ IT/ operations defect log closure a production deployment approval.	claim verify critical defect closure reconcile calculator and admin output to the approved tables.	approval, sample outputs.
11.	Launch Readiness and Training	Premature launch unapproved material in the field distributors untrained on suitability, exclusions, surrender or target market.	A launch readiness checklist covering UIN, documents, systems, training, website disclosure, call centre scripts, the complaints process and approved material.	Inspect the launch readiness sign off verify training records for key channels test withdrawal of obsolete documents review distributor communicatio n.	Launch checklist, training deck, attendance logs, distributor circulars, website screenshots, obsolete document withdrawal evidence.
12.	Post Launch Monitoring	Early warning indicators ignored mis selling, high free look, weak persistency, adverse claims, product loss or customer	Post launch management information to the PMC covering sales, channel mix, complaints, free look and cancellations, persistency, claims, profitability	Review the product MIS for sampled products verify escalations and corrective action test that U&F quarterly performance reports and	Product dashboards, complaint analytics, free look/ cancellation reports, quarterly reports, AA annual report extracts, action tracker.

		harm not escalated.	and exceptions, with periodic regulatory submissions.	AA annual report inputs were prepared and filed.	
13.	Modification or Withdrawal	Product modified without the right route or UIN existing policyholders not informed withdrawn product documents altered old product still being sold.	A modification/ withdrawal SOP route assessment a table of changes, track changed documents, withdrawal communication, a system lock preventing new sales under the old UIN.	Test modifications for route, UIN change and approval verify the withdrawal date, the communication to IRDAI, the website and document changes and the stop sale control.	Modification file, table of changes, track changed documents, withdrawal intimation, stop sale evidence, customer/ distributor communication.

Internal Audit Checklist-Areas and Checkpoints

3.7 The checklist translates the Risk Control Matrix into specific checkpoints the auditor can work through during fieldwork. It is grouped by area each checkpoint is paired with the evidence that should support a positive conclusion. The auditor should treat an inability to produce the listed evidence as a finding in itself, since SIA 230 requires sufficient and appropriate evidence and absence of records is a control weakness.

S. No.	Area	Checkpoint	Illustrative Evidence
1.	Governance and Policies	Whether the Basic Annualised Premium/ Minimum Premium	Board minutes, policy

		Payable (BAPMPP), Basic Annualised Unit Premium (BAUP) and Basic Annualised Premium (BAAP) are Board approved, current and mapped to the IRDAI 2024 product framework.	documents, change history.
2.	Governance and Policies	Whether the BAPMPP defines ideation, pricing governance, the U&F/ F&U route decision, modification, withdrawal, post launch monitoring and escalation.	BAPMPP, SOPs, process maps.
3.	Governance and Policies	Whether the Product Management Committee (PMC) is constituted with the required members and quorum, including the Appointed Actuary, Chief Investment Officer (CIO), Distribution, Chief Technology Officer (CTO) and Compliance.	PMC constitution, attendance, minutes.
4.	Governance and Policies	Whether CEO/ Principal Officer and Appointed Actuary certifications rest on underlying evidence rather than being signed as a formality.	Certifications, supporting pack, sign off matrix.
5.	Idea and Target Market	Whether customer need, target segment, affordability, channel suitability and product	Concept note, customer research, committee note.

		complexity are documented.	
6.	Idea and Target Market	Whether the product covers an insurable risk with genuine risk transfer, rather than an investment wrapper with token cover.	Product specification, actuarial note, legal review.
7.	Classification	Whether the product is correctly classified across the linked/ non-linked, par/ non-par, individual/ group, base/ rider and pension/ annuity/ health dimensions.	Classification checklist, filing form, specification.
8.	Approval Route	Whether the U&F/ F&U determination is documented and approved by Compliance and the Appointed Actuary before filing or launch.	Route note, master circular mapping, approvals.
9.	Approval Route	For modifications, whether a change in benefit structure is treated as a new product where required and UIN versioning is handled correctly.	Table of changes, track changed documents, UIN register.
10.	Pricing	Whether pricing assumptions are reasonable, supported by experience or a credible external basis and	Pricing memo, experience studies, peer review.

		approved by the Appointed Actuary.	
11.	Pricing	Whether profitability, expense loading, commission, Expenses of Management (EOM impact and sensitivity testing are documented.	Profit test model, EOM analysis, commission schedule.
12.	Pricing	Whether premium rates, charges and benefits are fair, objectively defined and not unfairly discriminatory among similar risks.	Pricing basis, rate tables, discount/ loading rules.
13.	Pricing	Whether surrender values are fair and reasonable and the asset share or notional asset share basis is documented where applicable.	Surrender value note, actuarial basis, AA sign off.
14.	Capital and Solvency	Whether the capital and solvency impact of guarantees, options, annuity benefits or linked guarantees is assessed.	Capital/ solvency note, actuarial memo, risk committee papers.
15.	Underwriting	Whether product underwriting rules align with the BAUP and the pricing assumptions and limits are approved and configured.	Underwriting matrix, product guide, system rules, approval trail.
16.	Reinsurance	Whether reinsurance support, rates, exclusions	Treaty addendum,

		and claims sharing are in place before launch.	reinsurer quote, sign off.
17.	Investment/ ALM	Whether the investment strategy supports guarantees, annuity payments, linked funds, index features and liquidity needs.	Investment sign off, ALM note, fund setup papers.
18.	Legal and Wording	Whether terms, exclusions, definitions, benefits, options, nomination, free look, grace, revival, surrender and claims clauses are complete and clear.	Policy document, legal review, compliance checklist.
19.	CIS and Disclosure	Whether the Customer Information Sheet (CIS) is in the prescribed format and contains key benefits, exclusions, the claim process, servicing, grievance details and policyholder rights.	CIS, disclosure checklist, sample policy pack.
20.	Benefit Illustration	Whether illustration calculations reconcile to the approved rates and terms, with signatures and consents embedded where required.	Illustration output, UAT, sample proposals.
21.	Literature/ Advertisements	Whether literature and advertisements are approved by the Advertisement Committee and	Ad committee minutes, approved creatives, sales decks.

		consistent with the PMC approved design.	
22.	Online Journey	Whether the online flow accurately captures proposal data, disclosures, consent, illustration, CIS and suitability warnings.	Screenshots, UAT scripts, journey approval.
23.	Filing Pack	Whether the applicable IRDAI form is used without deleting or altering prescribed sections and every item is completed.	Applicable IRDAI Life form (non-linked/ linked/ rider/ health).
24.	Filing Pack	Whether all documents under the document management requirements are complete, correct, digitally signed and centrally maintained.	Document register, product repository, signed PDFs.
25.	Regulatory Communication	Whether IRDAI queries are logged, answered on time and internally approved before submission.	Correspondence tracker, responses, approvals.
26.	UIN Controls	Whether the UIN is allotted before sale and correctly quoted in documents, literature, website, returns and correspondence.	UIN register, document samples, website capture.
27.	System Setup	Whether configuration in administration, illustration, calculator,	Configuration tables, UAT evidence,

		underwriting, commission, accounting and claims matches the approved product.	production approvals.
28.	System Setup	Whether UAT covers edge cases — age boundaries, premium modes, riders, discontinuance, surrender, revival, top up, fund switch, tax, claim and maturity.	UAT scripts and results, defect log.
29.	Launch Readiness	Whether the launch checklist is signed by Product, Actuarial, Compliance, Legal, IT, Operations, Claims, Finance and Distribution.	Launch checklist, approval email, release note.
30.	Training	Whether distributors and internal teams were trained before selling, covering exclusions, suitability, surrender, target market and mis selling risk.	Training attendance, LMS completion, test scores.
31.	Website Disclosure	Whether benefits, terms, wording, premium calculator, UIN, prospectus and illustration are uploaded on time.	Website screenshots, upload logs.
32.	Post Launch Review	Whether product MIS reviewed by the PMC includes sales, free look, cancellations, complaints, claims,	PMC MIS, minutes, dashboard.

		persistency, profitability and channel exceptions.	
33.	Post Launch Review	Whether U&F quarterly performance reports and the annual summary/ Appointed Actuary (AA report inputs are prepared and submitted as required.	Submission records, AA annual report extracts.
34.	Complaints and mis Selling	Whether product level complaint analysis identifies misleading features, channel issues, illustration misunderstanding and cancellation reasons.	Complaint MIS, root cause analysis, remedial action.
35.	Modification/ Withdrawal	Whether a withdrawn product cannot be sold for new business and old documents are removed from sales systems and channels.	Stop sale evidence, system lock, distributor communication.

Commonly Observed Irregularities, Violations and Deficiencies

3.8 The deficiencies below recur across life insurers and are a useful prompt during fieldwork. The auditor should, however, treat them as starting hypotheses to be tested against the specific entity rather than as foregone conclusions and should always trace each to its impact pathway before reporting.

S. No.	Area	Common Deficiency
1.	Governance	PMC minutes record “approved” without evidencing any review of pricing, underwriting, capital, reinsurance,

		systems, policyholder impact and conduct documents.
2.	Governance	PMC quorum or composition departs from the prescribed framework the Appointed Actuary or Compliance sign off is absent or obtained only after launch.
3.	Route Determination	The U&F route is chosen on the product's name or category without evaluating the actual benefit design or the impact of a modification.
4.	Route Determination	A change in benefit structure is treated as a minor modification and the UIN version is not changed where it should have been.
5.	Pricing	Assumptions in the pricing model are not reconciled with the underwriting, reinsurance and expense assumptions sensitivity testing is not retained.
6.	Pricing	Commission and expense assumptions are inconsistent with the distribution strategy or the EOM limits, overstating profitability.
7.	Surrender Value	Special surrender value factors are not supported by asset share or notional asset share workings surrender disclosures in the illustration and CIS are unclear.
8.	Documents	Policy wording, CIS, illustration, brochure and website describe benefits or exclusions inconsistently.
9.	Documents	Sales literature uses optimistic or non-guaranteed language that creates an expectation the policy terms do not support.
10.	Filing Pack	Prescribed form sections are left blank, altered or answered generically

		certifications are signed without the supporting checklists.
11.	Regulatory Communication	IRDAI query responses are not tracked the final filing pack does not match the product later configured in the systems.
12.	UIN	An incorrect or superseded UIN appears in sales material, the illustration, the website, the proposal form or the policy schedule.
13.	System	The premium calculator and the administration system use different rate tables rider eligibility is not enforced by the system.
14.	System	UAT is limited to standard scenarios, omitting age boundaries, surrender, revival, discontinuance, riders, modal premiums and group member level cases.
15.	Launch	The product is launched before website disclosure, distributor training or the closure of critical UAT defects is complete.
16.	Training/ Distribution	Distributors sell outside the target market or use outdated or unapproved collateral.
17.	Post Launch Monitoring	High free look cancellations, channel specific complaints or persistency deterioration are not escalated to the PMC.
18.	Product Withdrawal	A withdrawn product remains visible on sales portals, or renewal and product change options are offered without adequate controls.
19.	Record Retention	The product file is not centrally maintained pricing models, prior versions, the approval trail and signed documents are unavailable during the audit.

Key Regulatory References for the Internal Auditor

3.9 The following key regulatory references are relevant to internal auditor in evaluating compliance, governance, framework and operational policies in life insurance business:

Reference	Audit Relevance
Insurance Act, 1938 and IRDA Act, 1999	Primary statutory basis for regulation of insurance business, IRDAI powers and market conduct oversight.
IRDAI (Insurance Products) Regulations, 2024	Principles of product design, pricing, product governance, PMC responsibilities, system/control expectations, annual product review and product withdrawal powers.
IRDAI Master Circular on Life Insurance Products, 12 June 2024	Detailed implementation guidance for product governance, pricing provisions, U&F/F&U process, UIN, document management, application forms, CIS and product changes.
IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 and related Master Circular	Policyholder disclosures, prospectus/ sales process, CIS, benefit illustrations, advertisements, servicing, complaints and customer communications.
IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations, 2024	Appointed Actuary responsibilities, actuarial governance, valuation/ solvency implications and product related actuarial controls.
IRDAI (Expenses of Management, including Commission, of Insurers) Regulations, 2024	Expense and commission constraints relevant to pricing, product profitability and distribution economics.

IRDAI (Corporate Governance for Insurers) Regulations, 2024	Board oversight, governance committees, control environment and accountability of key management persons.

Chapter 4
Actuarial Process

Introduction

4.1 The actuarial process is one of the core control areas in a life insurance company. Unlike most other financial services businesses, a life insurer's financial position depends profoundly on long term estimates of future cash flows-mortality and morbidity experience, persistency, expenses, investment returns, options and guarantees, bonuses, surrender behaviour, reinsurance recoveries and capital requirements. Small changes in actuarial assumptions or in the quality of the underlying data can have a material effect on mathematical reserves, the solvency ratio, surplus emergence, product profitability, policyholder benefits and shareholder transfers.

The actuarial function does not operate in seclusion. It draws inputs from and provides outputs to, product development, underwriting, policy administration, claims, reinsurance, investments, finance, risk management, regulatory reporting and Board oversight. Internal audit of the actuarial process should therefore be planned as an integrated review casing governance, data, models, assumptions, approvals, regulatory compliance, reporting and the interfaces with these other functions not as a narrow check of a single calculation.

The Internal Auditor is not the Appointed Actuary

A point of scope must be settled at the outset. The internal auditor is not expected to substitute for the Appointed Actuary, nor to issue an actuarial opinion on the adequacy of reserves or the fairness of pricing. Where the internal audit team does not itself possess actuarial expertise, the audit should focus on the adequacy of design and the operating effectiveness of controls process governance, documentation, reconciliations, approvals, regulatory compliance, exception handling and the consistency of outputs with the approved bases.

Where re-performance or independent assessment of actuarial calculations is warranted by the materiality and risk profile of the insurer, the internal auditor should consider involving an actuarial specialist. When the work of such a specialist is used, the internal auditor remains responsible for the overall

conclusion and should comply with SIA 270, Experts and Third-Party Engagement in particular, evaluating the expert's competence, objectivity and scope of work and the reasonableness of the expert's findings and their consistency with other audit evidence.

List of Standards on Internal Audit

This Chapter should be read in conjunction with the Preface to the Standards on Internal Audit issued by the ICAI, together with the following Standards on Internal Audit, which are referred to the relevant points:

SIA 110: Basic Principles of Internal Audit

SIA 120: Terms of Internal Audit Engagement

SIA 130: Managing the Internal Audit Function

SIA 140: Internal Controls

SIA 160: Compliance with Laws and Regulations

SIA 210: Knowledge of the Entity and its Environment

SIA 220: Internal Audit Planning

SIA 230: Internal Audit Evidence

SIA 250: Internal Audit Documentation

SIA 260: Review and Supervision of Audit Assignments

SIA 270: Experts and Third-Party Engagement

SIA 290: Communication with Management and Those Charged with Governance

SIA 310: Presentation and Communication of Internal Audit Report

SIA 320: Issuing Assurance Reports

Scope of the Audit

4.2 Subject to the agreed engagement scope, an internal audit of the actuarial process may cover:

- **Governance of the actuarial function** – appointment, independence, reporting lines, access rights and authority of the Appointed Actuary.

- **Adequacy of Board approved policies relevant to actuarial work** – product management and pricing, underwriting, bonus/ surplus distribution philosophy, asset liability management (ALM), reinsurance, risk management and the reserving/ valuation governance framework.
- **Role of the Appointed Actuary** in product design, pricing, filing, modification, withdrawal and periodic product performance review.
- Controls over actuarial valuation of liabilities – mathematical reserves, additional reserves, reserves for options and guarantees, lapsed/ reduced paid up/ revival cases, group products, unit linked (ULIP) and variable products, riders and other product specific liabilities.
- Quality of data used for valuation, pricing, experience analysis, persistency, expense analysis, bonus declaration, solvency computation and regulatory returns.
- Actuarial models, spreadsheets, end user computing (EUC) tools and actuarial systems used for pricing, valuation, projections, ALM, solvency and stress testing.
- **The assumption setting process** – mortality, morbidity, persistency, expenses, inflation, interest/ discount rates, lapses, surrenders, revivals, claims incidence, reinsurance, taxation and margins for adverse deviation (MAD).
- Experience studies and whether their results feed appropriately into pricing, reserving, product review, underwriting, reinsurance and risk management.
- **Participating (with profits) business** – asset share calculations, bonus supportability, policyholders' reasonable expectations (PRE), surplus distribution, terminal and interim bonus, treatment of the Funds for Future Appropriations (FFA) and with profit fund expenses.
- **Solvency computation** – available solvency margin (ASM), required solvency margin (RSM), admissible/ inadmissible assets, capital strain, stress testing and escalation of solvency concerns.
- **ALM and stress testing reports** – consistency of liability cash flows with actuarial models and of asset data with investment records.
- Reinsurance adequacy from an actuarial perspective – impact on pricing, reserving, solvency, claims volatility and concentration risk.

- Actuarial regulatory submissions – the Actuarial Report and Abstract (ARA), solvency forms, persistency reports, the Financial Condition Report (FCR), ALM/ stress testing reports, product certifications and other applicable returns.
- Controls over manual adjustments, management overlays, approximations, model changes, assumption changes and one-off valuation treatments.
- Coordination between actuarial, finance, investments, risk, operations, underwriting, claims, IT and compliance teams.
- Action taken on previous internal audit, statutory audit and peer review observations, actuarial reviewer comments, IRDAI inspection observations and Board/ Audit Committee directions.

Internal Audit Objectives

4.3 The broad objective is to assess whether the control environment supporting the actuarial process is adequately designed and operating effectively. Specifically, the internal auditor assesses whether:

- The actuarial process is governed by clear Board approved policies, defined responsibilities, documented procedures and adequate oversight.
- The Appointed Actuary has sufficient independence, access to records, access to management and Board forums and authority to discharge regulatory duties.
- Actuarial data is complete, accurate, timely, reconciled with source systems and protected from unauthorised change.
- Actuarial models and spreadsheets are controlled, validated, version managed, access controlled and appropriately documented.
- Assumptions used in pricing, valuation and projections are approved, evidence based, consistent with actual experience and carry appropriate prudence where required.
- Mathematical reserves and other actuarial liabilities are computed in accordance with applicable regulatory requirements, actuarial practice standards, approved methodology and documented assumptions.

- Product pricing is fair, not excessive, not inadequate and not unfairly discriminatory and is aligned with underwriting, claims, expense, reinsurance, capital and profitability assumptions.
- Product filing, modification, withdrawal and review are supported by appropriate actuarial sign offs and Product Management Committee (PMC) documentation.
- Surplus distribution and bonus declaration for participating business are consistent with PRE, asset shares, bonus supportability and the approved governance framework.
- Solvency computation is accurate, timely, properly reviewed and escalated whenever solvency stress or capital strain is identified.
- Actuarial reports and regulatory returns are accurate, complete, consistent with the financial statements and submitted within prescribed timelines.
- Interfaces between actuarial and other functions are reliable and subject to adequate maker checker controls.
- Key actuarial risks are identified, monitored and reported to the Board and its committees.
- Deficiencies identified in actuarial processes are tracked to closure and the corrective actions are effective.

Understanding the Actuarial Process

4.4 Obtaining and documenting an understanding of the process is a prerequisite to designing effective tests and is consistent with the internal control evaluation expected under SIA 140, Internal Controls. A typical actuarial process in a life insurer comprises of the streams mentioned below. For each, the auditor should walk through the process end to end at least once, identify the key controls and record the walkthrough as a working paper.

Figure 1 provides a control-oriented overview. Individual actuarial workstreams may operate in parallel the common control architecture should include controlled data, approved assumptions, controlled models, review and reconciliation and appropriate actuarial/ governance sign off.

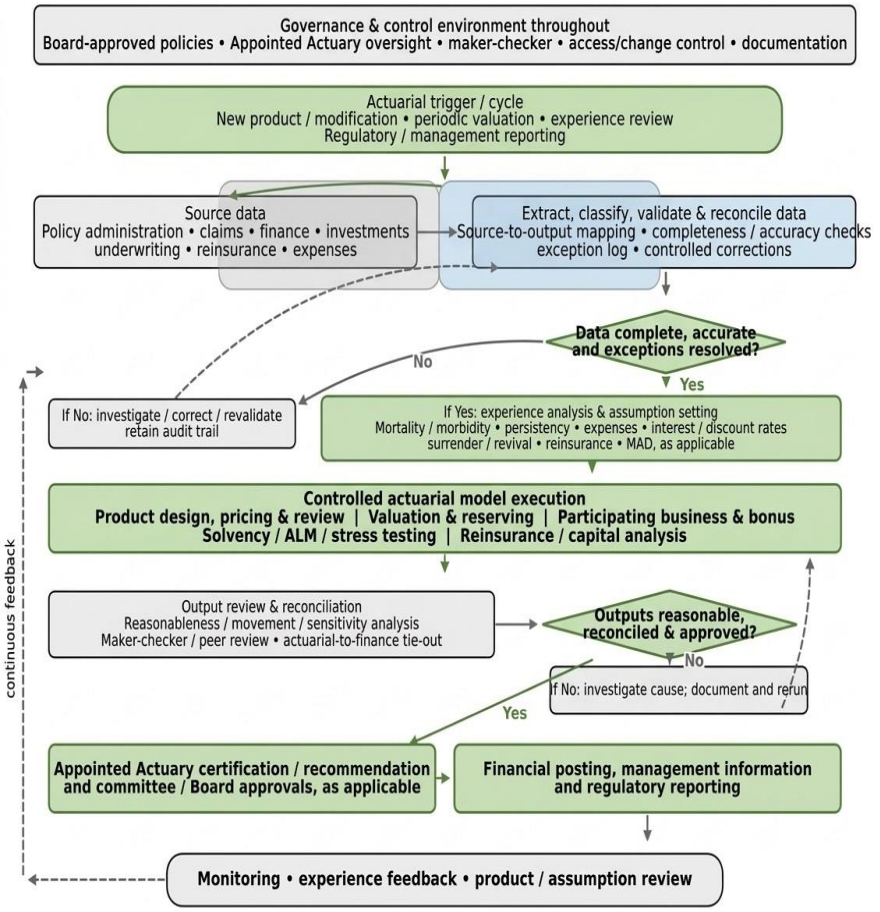


Figure 1: Illustrative Actuarial Process in a Life Insurance Company

Product Design and Pricing

The actuarial team, led or reviewed by the Appointed Actuary, supports product design and pricing by evaluating benefits, premium rates, charges, guarantees, surrender values, options, mortality/ morbidity assumptions, persistency, expenses, commissions, investment returns, taxation, reinsurance, capital requirements and profitability.

The auditor should assess whether pricing is supported by documented assumptions, model outputs, sensitivity analysis, approval notes and sign offs from the Appointed Actuary and the PMC and whether it is consistent with the

underwriting policy, claims philosophy, reinsurance arrangements, investment strategy and expense (expenses of management) assumptions.

Product Filing, Modification and Withdrawal

The insurer should maintain records of product filing, UIN allotment, approvals, modifications, withdrawal decisions and version control of product documents and should ensure consistency between the approved product design, the policy bond, the benefit illustration, sales literature, the customer information sheet, the system configuration and the pricing file. The auditor should verify that products are periodically reviewed for performance, complaints, persistency, profitability, claims experience, surrender behaviour and regulatory compliance.

Actuarial Valuation and Reserving

Valuation typically involves: extraction of policy data data validation classification by product/ fund/ status application of approved assumptions running the valuation models review of outputs posting of reserves certification by the Appointed Actuary and reporting to management, the Board and the regulator. The auditor should focus on data lineage, controls over policy data, model and assumption governance, movement analysis, reconciliations with finance records and the approval of manual adjustments.

Participating Business and Bonus Declaration

For participating products, the process includes asset share calculation, analysis of surplus, bonus supportability, smoothing, terminal and interim bonus, special surrender values, treatment of the FFA, allocation of expenses to the with profit fund and assessment of PRE. The auditor should assess whether the bonus recommendation is supported by documented calculations, sensitivity analysis, With Profit Committee review, Board approval and consistency with the approved bonus philosophy.

Solvency, Capital and Stress Testing

The process supports computation of the RSM, ASM and solvency ratio and also capital planning, new business strain analysis, stress and scenario testing, ALM and financial condition reporting. The auditor should assess whether solvency computation is based on complete data, correct classification of business, correct valuation of assets and liabilities,

appropriate treatment of inadmissible assets, documented review and timely escalation of solvency risks.

Actuarial Reporting

The actuarial team prepares or contributes to several internal and regulatory reports the ARA, solvency forms, persistency reports, ALM/ stress testing reports, the FCR, product certifications, bonus reports and management information. The auditor should assess whether reports are prepared from controlled data sources, reviewed by appropriate officials, digitally signed/ submitted where required, reconciled with the financial statements and submitted within timelines.

Key Risks in the Actuarial Process

4.5 The internal auditor should perform a risk assessment to focus efforts where its potential impact is greatest. The principal risks and why they matter are summarised below:

S. No.	Risk	Description and why it Matters
1.	Governance Risk	The Appointed Actuary is not adequately independent, or is not involved in relevant decisions weakening the most important single control over reserves and pricing.
2.	Data Risk	Incomplete or inaccurate policy, claims, premium, expense, reinsurance, fund or investment data flows into actuarial calculations, corrupting every downstream output.
3.	Model Risk	Errors in models, spreadsheets, macros, coding logic, formulae, product mapping or methodology distort reserves, pricing and solvency.
4.	Assumption Risk	Assumptions are not aligned with actual experience or are not updated for emerging trends, producing systematically wrong estimates.

5.	Regulatory Risk	Non-compliance with IRDAI requirements, actuarial practice standards, product filing norms or reporting timelines.
6.	Reserving Risk	Mathematical reserves are understated or overstated owing to inappropriate methodology, assumptions or data.
7.	Solvency Risk	Incorrect solvency computation, or delayed escalation of a deteriorating solvency position.
8.	Product/ Conduct Risk	Product design or pricing is not sustainable or not fair to policyholders, or product terms, charges, surrender values or sales literature are inconsistent with actuarial approvals.
9.	Participating Fund Risk	Bonus declaration is not supported by asset shares, or PRE is not considered.
10.	Reinsurance Risk	Reinsurance terms are not properly reflected in pricing, reserving or solvency.
11.	Financial Reporting Risk	Actuarial reserves or surplus are not properly reflected in the financial statements.
12.	Operational/ Continuity Risk	Manual interventions, spreadsheet dependence, weak change control, poor documentation, or excessive dependence on key personnel without succession planning.

Indicative Risk Control Matrix (RCM)

4.6 The following RCM is intended to support risk control mapping during planning and walkthroughs. It is indicative and should be tailored to the insurer's product mix, systems, materiality, regulatory obligations and risk profile. It does not replace the detailed fieldwork procedures in Section 9.

S. No.	Process/ Area	Key Risk	Control Objective	Indicative Key Controls	Typical Owner/ Frequency
1.	Governance and Appointed Actuary	Inadequate independence, access or involvement of the Appointed Actuary may impair actuarial oversight and escalation.	Preserve independent actuarial oversight and timely escalation of material matters.	Valid appointment/ regulatory approval reporting line and authority consistent with regulatory duties unrestricted access to records participation in relevant committees documented escalation and contingency/ succession arrangements.	Board/ CEO/ Appointed Actuary ongoing, at appointment/ change and each relevant committee cycle.
2.	Product Design, Pricing and Review	Pricing may be unsustainable, unfair or inconsistent with underwriting, claims, expenses, reinsurance, capital or approved	Ensure pricing is evidence based, supportable, approved and consistently implemented.	Documented pricing assumptions and models profitability, capital strain and sensitivity testing Appointed Actuary sign off PMC/	Actuarial/ Product/ PMC at launch or modification and periodically thereafter.

		product terms.		Board approval as applicable traceability of product documents and system configuration to approved design periodic in force product review.	
3.	Product Filing, Modification and Withdrawal	Unapproved or inconsistent product versions may be filed, configured, sold or continued.	Maintain regulatory and operational consistency with the approved product.	Controlled product file repository and UIN/ filing records version control approval of modifications/ withdrawals reconciliation of policy bond, benefit illustration, customer information and system configuration to the approved product.	Product/ Actuarial/ Compliance each filing, modification or withdrawal.
4.	Data Extraction, Classification and	Incomplete, inaccurate or misclassified policy, claims,	Ensure completeness , accuracy, lineage and	Documented source to output mapping	Actuarial data/ Operations/ IT/ Finance

	Reconciliation	finance, investment or reinsurance data may distort all downstream actuarial outputs.	controlled correction of actuarial data.	reconciliations of policy count, premium, sum assured, fund value and claims to source systems and finance product/ status classification checks exception log authorised corrections access/ change logs data freeze and archival.	each valuation or reporting cycle.
5.	Experience Studies and Assumptions	Outdated, unsupported or inconsistent assumptions may systematically misstate pricing, reserves and projections.	Use credible, approved and appropriately prudent assumptions responsive to emerging experience.	Periodic mortality, morbidity, persistency, expense and other experience studies actual vs expected analysis documented rationale and benchmarks Appointed Actuary approval MAD where	Actuarial/ Appointed Actuary periodic and whenever experience or methodology changes materially.

				required consistency review across pricing, reserving, business plan, ALM and solvency.	
6.	Model and Spreadsheet (EUC) Governance	Model, coding, formula, mapping or spreadsheet errors and uncontrolled changes may distort results.	Ensure critical models are approved, validated, version controlled, secure and reproducible.	Complete model/ EUC inventory ownership and version history role based access formal change, testing and deployment approval independent validation for high impact models protected formula cells and controlled macros/ links run logs, backups and obsolete version controls.	Actuarial/ Model owner/ IT ongoing, each material change and periodic validation.
7.	Valuation and Reserving	Mathematical or other actuarial liabilities may	Compute and review liabilities using	Approved valuation methodology by product	Actuarial/ Appointed Actuary each valuation

		be understated or overstated because of data, methodology, assumption or product treatment errors.	approved methodologies, assumptions and complete product features.	complete capture of benefits, premiums, options and guarantees correct treatment of lapsed/ paid up/ riders/ group/ linked business movement and reasonableness analysis maker checker review reconciliation to prior period and finance Appointed Actuary certification.	cycle.
8.	Manual Adjustments, Overlays and Approximations	Management override or unsupported manual intervention may make results inaccurate or non-reproducible.	Permit exceptional adjustments only when justified, authorised, transparent and traceable.	Central adjustment register documented rationale and quantified impact supporting calculation Appointed Actuary approval independent	Actuarial/ Appointed Actuary/ Finance each adjustment and reporting cycle.

				review finance/ reporting reconciliation retention of pre and post adjustment outputs and evidence.	
9.	Participating Business and Bonus	Bonus or surplus distribution may be unsupported, inequitable or inconsistent with policyholder reasonable expectations (PRE).	Support equitable and sustainable surplus distribution with appropriate governance.	Asset share calculations bonus supportability and smoothing analysis PRE assessment FFA reconciliation appropriate with profit expense allocation With Profit Committee review policyholder/ shareholder surplus split Board approval and reporting consistency.	Appointed Actuary/ With Profit Committee/ Board each bonus/ surplus cycle.
10.	Solvency, ALM and Stress Testing	Incorrect solvency computation, weak liability cash flow	Produce accurate solvency and ALM information	RSM/ ASM and solvency ratio checks asset admissibility	Actuarial/ Risk/ Investments/ Finance at prescribed/

		information or delayed escalation may impair capital and risk decisions.	and escalate capital/ liquidity stress promptly.	review reconciliation of assets and liabilities to investment/ finance/ valuation records movement analysis validated liability cash flows approved stress scenarios and management actions escalation thresholds Board/ Risk Committee reporting.	approved periodicity and on stress events.
11.	Reinsurance	Treaty terms, recoveries or concentration risks may not be properly reflected in pricing, reserving or solvency.	Ensure reinsurance terms and risk transfer are accurately reflected and adequacy is periodically assessed.	Treaty to model reconciliation of premiums, commissions, claims sharing and retentions controlled treatment of recapture/ treaty changes catastrophe and	Actuarial/ Reinsurance/ Finance treaty inception/ change and each relevant valuation cycle.

				concentration adequacy review reconciliation of reinsurance data and recoveries incorporation in solvency/ stress testing.	
12.	Actuarial Finance Interface and Financial Reporting	Actuarial reserves, surplus or movements may be incorrectly posted or inconsistently reflected in financial statements.	Maintain a complete and controlled bridge from actuarial output to financial reporting.	Valuation to GL reconciliation approved actuarial/ finance journal entries reserve and surplus movement bridge investigation of unexplained differences reconciliation of actuarial reports to financial statements and prior period outputs.	Actuarial/ Finance each financial close/ valuation cycle.
13.	Regulatory and Actuarial	Returns may be inaccurate,	Ensure timely, accurate,	Regulatory calendar and responsibility	Appointed Actuary/ Actuarial/

	Reporting	incomplete, inconsistent or late.	consistent and auditable regulatory/ management reporting.	matrix controlled source data and report templates maker checker/ Appointed Actuary review digital signature and submission controls retention of acknowledge ments reconciliation to financial statements/ Board papers documentatio n of manual adjustments and comparative changes.	Compliance each applicable reporting due date.
14.	Issue Remediation and Continuity	Open regulatory/ peer review/ audit issues or key person dependency may allow known weaknesses to persist or prevent reproducibility	Close identified deficiencies timely and maintain continuity of critical actuarial processes.	Central action tracker with owner, due date and closure evidence escalation of overdue/ high impact items revalidation where reserves or	Actuarial/ Compliance/ Internal Audit/ IT monthly or quarterly tracking and periodic continuity testing.

		.		solvency are affected current SOPs and model documentation segregation/ backup arrangements succession, disaster recovery and archival of inputs/ outputs.	

Indicative Audit Evidence

4.7 In accordance with SIA 230, Internal Audit Evidence the auditor should obtain sufficient and appropriate evidence and retain it as working papers under SIA 250, Internal Audit Documentation. The documents commonly examined include:

S. No.	Area	Indicative Documents
1.	Governance	Appointed Actuary approval and appointment documents organisation chart and reporting lines of the actuarial function Board/ Risk Committee/ Audit Committee minutes on actuarial matters.
2.	Policies	Board approved product management and pricing policy underwriting policy reserving methodology manual assumption setting, model governance and other relevant policies.
3.	Assumptions & Experience	Assumption setting papers and approval notes experience study reports.
4.	Pricing & Products	Product pricing reports and filing documents PMC minutes product certifications.

5.	Data	Valuation data extracts data reconciliation working papers.
6.	Models	Model inventory model validation reports model change logs valuation run logs and output files manual adjustment logs.
7.	Reserving & Reporting	Actuarial Report and Abstract solvency computation files and forms ALM and stress testing reports Financial Condition Report persistency reports.
8.	Participating Business	Bonus declaration papers With Profit Committee report asset share workings.
9.	Reinsurance	Reinsurance treaties actuarial reinsurance review notes.
10.	Follow-up	Regulatory submission acknowledgements peer review reports and action taken reports prior internal audit reports and closure evidence.

Red Flags Requiring Immediate Escalation

4.8 The following matters should generally be escalated promptly to senior management and the Audit/ Risk Committee and where appropriate, to the Board, without waiting for the audit report to be finalised:

- The Appointed Actuary is being denied access to required records.
- Material actuarial data is unreconciled with finance or policy administration systems.
- A known model error affects reserves, solvency or regulatory returns.
- The solvency ratio is near or below the control level.
- A product is being sold despite an unresolved pricing, sustainability or policyholder fairness concern.
- A significant reserve movement is unexplained or unapproved, or a manual reserve reduction lacks documented actuarial justification.
- A bonus recommendation is not supported by asset shares or surplus analysis.

- There is a material inconsistency between a regulatory return and the financial statements.
- Actuarial concerns are being suppressed or not escalated.
- A regulatory submission is delayed without an approved mitigation.
- Open peer review or IRDAI inspection observations affect reserves or solvency.

Important: Do Not Express an Actuarial Opinion

Unless the audit team includes competent actuarial specialists and the scope specifically provides for it, the conclusion should not express an opinion on the adequacy of reserves or the appropriateness of actuarial judgement. Consistent with the nature of assurance principle in SIA 120, Terms of Internal Audit Engagement, the report should instead state whether the control environment supporting the actuarial process is adequately designed and operating effectively and whether the exceptions identified may have a material impact on reserves, solvency, policyholder interests, financial reporting or regulatory compliance.

Commonly Observed Irregularities and Deficiencies

4.9 The following are the irregularities most frequently observed in practice, grouped by area. They serve both as a prompt during fieldwork and as a library of potential findings. Presence of any item is an indicator, not a conclusion the auditor should establish the facts, the root cause and the impact before reporting.

Governance

- The Appointed Actuary is not involved in key product, pricing, reinsurance, investment, ALM or solvency discussions.
- The appointment letter or internal reporting structure indirectly restricts the independence of the Appointed Actuary.
- The Appointed Actuary does not have full access to policy, claims, finance, investment or reinsurance data.
- Actuarial concerns raised to management are not placed before the Board or the relevant committee.

- The Appointed Actuary position is vacant, or regulatory approval is delayed, without an adequate contingency plan.
- PMC minutes do not evidence actuarial discussion or dissent.
- Board approved policies are not updated for current regulations the linkage between actuarial and risk management is weak.
- There is no formal process for tracking regulatory, peer review or internal audit observations.
- There is excessive dependence on one or two actuarial personnel without documented handover or model documentation.

Product Pricing and Filing

- Pricing assumptions are not supported by actual experience or credible external data premium rates are not demonstrably fair or sustainable.
- Pricing is not aligned with the underwriting policy or claims experience reinsurance cost is not correctly reflected expense assumptions are inconsistent with actual expense levels or expenses of management limits.
- Product profitability is not tested under adverse scenarios capital strain and solvency impact are not presented to the PMC.
- The benefit illustration does not match the pricing model or product filing policy document, brochure, customer information sheet and approved terms are inconsistent.
- Product features are changed in operational systems without actuarial sign off surrender values are not supported by actuarial calculations or reviewed for fairness.
- Products are continued despite adverse experience without documented review withdrawal/ modification lacks formal PMC approval.
- Discounts/ loadings are not objectively defined, raising a risk of unfair discrimination riders are priced or configured without considering interaction with the base product.

Data

- Policy counts do not match between the policy administration system and the valuation data premium and claims data are not reconciled with finance/ claims systems.

- Policy status (in force, lapsed, paid up, surrendered, discontinued, matured, death claimed) is incorrect product mapping to par/ non-par/ linked/ group/ rider categories is incorrect.
- Key fields (sum assured, premium term, policy term, date of birth, commencement date, fund value) are missing or incorrect.
- Lapsed policies are excluded despite possible future liability reduced paid up policies are not separately identified revival options are not captured.
- Manual data corrections are made without an audit trail data from outsourced providers or legacy systems is inadequately validated.
- The post valuation data freeze is not maintained, making re performance difficult there is no reconciliation between actuarial, finance and regulatory reporting data.

Assumptions

- Assumptions are not reviewed periodically persistency assumptions do not reflect actual lapse/ surrender experience mortality/ morbidity assumptions are not updated for emerging claims.
- Expense assumptions are not reconciled with actual expenses interest rate assumptions are inconsistent with the investment portfolio or the ALM view.
- Manager for Adverse Deviations (MAD) is not documented or is inconsistently applied assumption changes are made without Appointed Actuary approval the same assumption is used across products with materially different risk profiles.
- Management overlays are not supported by rationale there is no sensitivity analysis for key assumptions experience investigation results are not reflected in pricing/ reserving.
- Assumptions across pricing, reserving, business plan and solvency are inconsistent without explanation pandemic/ catastrophe uncertainty is not considered where relevant tax or commission assumptions are outdated.

Valuation and Reserving

- Mathematical reserves are not computed using the approved methodology options and guarantees are not fully valued negative reserves are not treated as required.
- Surrender value deficiency reserves are not correctly considered additional reserves are not held for risks not captured at policy level riders are not valued appropriately.
- Group policies are valued using simplified assumptions without validation lapsed and reduced paid up policies are not treated correctly Unit Link Insurance Plan (ULIP) fund values are not reconciled with unit/ investment records.
- Variable product policy account and general fund reserves are not separately reviewed foreign currency liabilities are not appropriately translated or provided for.
- Manual reserve adjustments are made without Appointed Actuary approval large reserve movements are unexplained reserve outputs are not reconciled with the financial statements prior period errors are corrected without adequate documentation or governance.

Internal Audit Checklists

4.10 The following checklists are intended to be carried into fieldwork, marked up and retained as working papers. “Y/ N” records whether the control is present and operating “W.P. Ref.” cross references the supporting working paper. A “No” answer is a potential finding to be developed. These checklists are a baseline and should be tailored to the insurer’s products, systems and risk profile.

Governance and the Appointed Actuary

Sr. No.	Audit Check/ Procedure	Y/ N	W.P. Ref.	Auditor's Remarks
1	Is there a valid IRDAI approval and appointment in place for the Appointed Actuary and has the role been continuously filled during the period?			

2	Does the Appointed Actuary report to the CEO and is the role free of reporting lines that could restrict independence?			
3	Does the appointment letter/ authority matrix leave the Appointed Actuary's regulatory duties unrestricted?			
4	Does the Appointed Actuary have evidenced access to policy, claims, finance, investment and reinsurance data and systems?			
5	Do Board/ RMC/ PMC/ Investment/ ALM/ With Profit Committee minutes evidence the Appointed Actuary's participation or input where relevant?			
6	Were material actuarial concerns escalated to the Board/ relevant committee and acted upon?			
7	Were any cessation/ leave/ vacancy/ transition events in the role handled per regulatory expectations (notice period, cessation date restriction)?			
8	Is minimum actuarial staffing met, with maker checker segregation and supervision in place?			

Policies and Procedures

Sr. No.	Audit Check/ Procedure	Y/ N	W.P. Ref.	Auditor's Remarks
1	Is each required policy (product & pricing, underwriting, valuation methodology, assumptions, model governance, bonus, ALM, reinsurance,			

	risk, data governance, EUC) documented and Board/ appropriately approved?			
2	Is each policy current (reviewed within its stated review cycle)?			
3	Is there a regulatory reporting calendar and a responsibility/ maker checker matrix?			
4	On test, does actual practice agree with the approved policy for at least one transaction per policy?			

Data Governance and Reconciliations

Sr. No.	Audit Check/ Procedure	Y/ N	W.P. Ref.	Auditor's Remarks
1	Is the data flow from source systems to the actuarial models documented (flowchart/ data dictionary/ source to output mapping)?			
2	Are completeness/ accuracy reconciliations performed (policy count, premium, sum assured, fund value, claims) between valuation data and source systems?			
3	Does the valuation data reconcile with finance records, policy administration records and prior period data?			
4	Is policy classification (product, fund, status, par/non-par/linked, rider, channel) tested and correct on the sample?			
5	Are lapsed, paid up, surrendered, discontinued, revived, death claimed and matured policies handled correctly?			

6	Are data exceptions logged, investigated, corrected, approved and traced to closure?			
7	Are manual data adjustments supported by evidence and duly authorised?			
8	Is regulatory return data frozen, archived and traceable for re performance?			
9	Is access to actuarial data restricted and are changes logged?			

Model and Spreadsheet (EUC) Governance

Sr. No.	Audit Check/ Procedure	Y/ N	W.P. Ref.	Auditor's Remarks
1	Is there a complete inventory of actuarial models, spreadsheets, macros and vendor tools and is it complete against the reports actually produced?			
2	For the sample, are model ownership, version history, access rights and change logs maintained?			
3	Are model changes approved, tested and documented before deployment?			
4	Are high impact models independently validated/ reviewed?			
5	Are product features, charges, benefits, guarantees, surrender values and riders correctly configured (traced to the product file)?			
6	Are critical spreadsheet formula cells protected and are manual inputs, linked files and macros controlled?			

7	Are outputs subjected to reasonableness checks, movement analysis, sensitivity analysis and peer review?			
8	Are obsolete versions disabled/ archived and do backups/ disaster recovery exist?			
9	Is key person dependence mitigated by adequate documentation?			
10	Were past model errors remediated and their prior period impact assessed?			

Assumptions and Experience Analysis

Sr. No.	Audit Check/ Procedure	Y/ N	W.P. Ref.	Auditor's Remarks
1	Are assumptions based on credible internal experience, industry data or supportable benchmarks?			
2	Are periodic experience studies performed (mortality, morbidity, persistency, surrender, expense, claims, revival, paid up)?			
3	Are assumption changes approved by the Appointed Actuary and documented with rationale?			
4	Is MAD applied where required and does it not have the effect of reducing reserves?			
5	Are assumptions internally consistent across pricing, reserving, business plan, ALM and solvency (or differences documented)?			
6	Are actual vs expected deviations analysed and reported and emerging risks reflected?			

7	Do reinsurance, tax, commission and expense assumptions align with actual arrangements?			
8	Are assumption files controlled/ access restricted and overlays/ approximations approved and justified?			

Product Pricing and Governance

Sr. No.	Audit Check/ Procedure	Y/ N	W.P. Ref.	Auditor's Remarks
1	For the sample, are premium rates, charges, benefits and surrender values supported by the pricing model?			
2	Do pricing assumptions include mortality/morbidity, expenses, commissions, investment returns, persistency, tax, capital, guarantees, options and reinsurance?			
3	Do the benefit illustration, policy bond, sales literature and customer information sheet agree with the approved product design?			
4	Are target market/ suitability considerations documented?			
5	Were profitability, capital strain, sensitivity and risk analysis presented to the PMC, with Appointed Actuary sign off and (where needed) Board approval?			
6	Is pricing aligned with the underwriting and claims policies?			

7	Is in force product performance reviewed periodically, with corrective action for adverse experience?			
8	Are product withdrawals/ modifications supported by formal PMC approval?			

Valuation of Liabilities

Sr. No.	Audit Check/ Procedure	Y/ N	W.P. Ref.	Auditor's Remarks
1	Is the valuation methodology for each major product category documented and approved?			
2	Are all prospective benefits, premiums, options, guarantees and policyholder expectations considered?			
3	Are negative reserves and surrender value deficiency reserves treated as required?			
4	Are additional provisions held for risks not captured at policy level (substandard lives, guarantees, options, FX, pandemic)?			
5	Are riders, group, ULIP, variable and fund-based group products reserved appropriately?			
6	Is a reserve movement analysis prepared, with major movements explained (new business/ experience/ assumption/ methodology) and are unexplained movements challenged?			
7	Do reserves reconcile to the financial statements and are valuation journal entries approved by finance and actuarial?			

8	Are valuation outputs retained, archived and traceable to input data and assumptions?			
9	Are manual reserve adjustments approved by the Appointed Actuary?			

Participating Business and Bonus

Sr. No.	Audit Check/ Procedure	Y/ N	W.P. Ref.	Auditor's Remarks
1	Is the bonus/ surplus distribution philosophy Board approved and current?			
2	Are asset share calculations performed, with any methodology change approved and justified?			
3	Are bonus earning capacity, smoothing, terminal and interim bonus supported by analysis?			
4	Is PRE documented and considered and are with profit fund expenses appropriate?			
5	Does the FFA reconcile (opening to closing) with movements explained?			
6	Is the policyholder/ shareholder surplus split in accordance with requirements?			
7	Is the With Profit Committee report prepared, shared with the Board, with any differences documented?			
8	Is the Board approval of the bonus consistent with the financial statements, policyholder communications and regulatory submissions?			

Solvency, ALM and Stress Testing

Sr. No.	Audit Check/ Procedure	Y/ N	W.P. Ref.	Auditor's Remarks
1	Are RSM, ASM and the solvency ratio computed correctly (re performed or inspected)?			
2	Is asset admissibility classification correct and do asset/ liability values agree to investment/ finance records and the valuation output?			
3	Is the solvency ratio movement explained and is solvency monitored at the required frequency and reported to the Board?			
4	Does an escalation mechanism for solvency stress exist and operate?			
5	Are ALM liability cash flows generated from validated models and does the ALM report reconcile to investment data?			
6	Are stress scenarios approved, relevant and is feasibility of assumed management actions evidenced?			
7	Are stress test results placed before the Board/ Risk Committee and used in capital, product, investment and reinsurance decisions?			

Reinsurance

Sr. No.	Audit Check/ Procedure	Y/ N	W.P. Ref.	Auditor's Remarks
1	Was actuarial input obtained in designing the reinsurance arrangements?			

2	Do pricing and valuation models reflect actual treaty terms, premiums, commissions, profit commission, claims sharing and retention limits?			
3	Are recapture, treaty changes and non-renewals treated correctly?			
4	Is reinsurance adequacy reviewed for catastrophe, concentration, large sums assured and adverse mortality/ morbidity?			
5	Do reinsurance data and recoveries reconcile to finance and reinsurance administration records and is reinsurance risk reflected in solvency/ stress testing?			

Regulatory Reporting

Sr. No.	Audit Check/ Procedure	Y/ N	W.P. Ref.	Auditor's Remarks
1	Were the ARA, solvency forms, persistency report, ALM/ stress testing report, FCR and other actuarial returns submitted within timelines?			
2	Are digitally signed returns and submission acknowledgements retained?			
3	Do the regulatory returns reconcile with the financial statements and Board approved reports?			
4	Are submissions, public disclosures, Board papers and management information mutually consistent?			

5	Are IRDAI/ peer review observations tracked to closure?			
6	Are prior year comparatives unchanged, or changes explained and are manual adjustments in returns documented?			

Chapter 5
New Business

Introduction

5.1 Insurance sector has embarked upon the journey to achieve the vision of 'Insurance for All' by 2047. Various regulatory reforms have been undertaken in this direction by taking up measures to protect interests of policyholders, prioritizing ease of doing business, encouraging innovation, competition, strengthen governance framework to foster growth and self-reliance in the insurance sector. The interests of policyholder have been at the core of all the initiatives undertaken which emphasize insurers and distribution channels to fulfill their obligations towards policyholders, including effective grievance redressal mechanisms and governance structures centred around the welfare of the policyholder. Regulations on these aspects have been reviewed comprehensively and the Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 (hereinafter called "Regulations") was notified on 20th March, 2024.

Scope and Objective

5.2 The objective of the internal audit is to evaluate adequacy and effectiveness of internal controls over the following:

- Fair treatment of prospects at the stage of solicitation and sale of insurance policies.
- Interests of policyholders are protected and conduct of the insurer and distribution channel are not prejudicial to the interests of policyholders.
- Insurers and distribution channel have in place standard procedures including best practices for sale and service of policy holders with emphasis on grievance redressal.
- Insurers follow prudent practices on management of risks arising out of outsourcing with a view to preventing negative systemic impact, adequate due diligence to protect the interests of the policyholders.

The scope of the review shall cover governance, monitoring and control over:

- Acceptance of proposals at various touch points

- Prospectus explaining the features for each product offered for sale
- Provide customized benefit illustration to the prospective policyholder
- Proposal form and supporting documentation including Know your customer
- Processing of proposal forms and receipt of premium
- Issuance of policy and preparation of Customer Information Sheet (CIS)
- Refund of premium

The Process Flow is Enumerated Below:

1	Lead Generation/ Solicitation (Prior to Sale)	Life Insurance products can be sold only by Life Insurers registered with IRDAI. Insurers are required to make suitable products/ riders to cater the needs of the customer which will include all ages, occupational categories, persons with disabilities and their affordability.
2	Proposal Sourcing and KYC Validation	A prospect can buy life insurance policy from the life insurer directly or through any of the distribution channels. Every insurer shall develop and maintain a prospectus for every retail insurance product including benefits, exclusions offered in the insurance products. KYC validation of the prospective policyholder needs to be done.
3	Underwriting Review and Medical Requirements	Proposal form to be filled up by the prospect along with benefit illustration sheet to be submitted. Proposal forms need to be processed within the TAT prescribed (7 days from receipt of form).
4	Receipt of Premium	Premium is required to be paid only after decision of acceptance of premium. Risk cover will commence only after receipt of premium.

5	Policy Issuance, CIS	Issue policy in electronic form digitally signed. Physical policy to be issued if policyholder requests for the same. Customer Information sheet is to be prepared along with the policy. It is a statement that provides in simple terms important information and basic features of the policy.
6	Cancellation of Policy and Refund of Premium	Policy holder will have 30 days called as *Free look period* for reviewing the conditions of the policy. Policy holder has an option to return the policy within 30 days for cancellation. The premium shall be refunded within 7 days of cancellation. Interest at bank rate plus 2% would have to be paid for delay beyond 7 days.

Internal Audit Checklists

5.3 Illustrative internal audit checklist containing risks, controls and internal audit procedures is as follows:

Risk	Control Objective	Illustrative Audit Procedures
Lead Generation/ Solicitation/ Prior to Sale		
• Life insurers are required to make suitable products/ riders available to provide wider choice to the policyholders/ prospects catering to: ▪ the needs of the customers suitably, ▪ all ages,	Regulatory Compliance	• Review all products offered with suitability/rider conditions • Review sample policies and map to the product terms

▪ all regions, all occupational categories, persons with disabilities and any other categories, ▪ the policyholders/ prospects as per their affordability, • insurer shall not have one product to cater to all of the above. • Insurers shall allow flexibility to customers to choose products/ riders as per his/ her needs.		
Purchase of Life Insurance Policy		
• Life Insurance products are offered only by Life insurers registered with IRDAI • Prospect can buy such products from a life insurer directly or through any of the distribution channels. Such purchase can be made either by visiting the office of an Insurer/	• Regulatory Compliance • Digital acknowledgement and version controls • Maker checker validation, mandatory system field, Central KYC integration • PAN/Aadhar dedupe /AMLscreening	• Verify mode of purchase of insurance policy • Verify prospectus to check if the benefits, exclusions are mentioned. Also check if BI is calculated and presented as per IRDA protection of Policyholder Regulations 2024 • Verify whether KYC validation has been

distribution channel or online by visiting the website of the insurer/ distribution channel. • Features, benefits, exclusions and other details offered in insurance products are detailed in the prospectus for each of the products offered for sale. • Proposal forms as per section 45 of Insurance Act and IRDA Protection of Policyholder Regulations 2024 filled with mandatory fields along with KYC documents. • Create client ID after checking duplicate client IDs and AML screening • Life insurer/ distributer channel to provide customized benefit illustration to proposer at the point of sale duly signed by the		done. Check if Dedupe checks/ AML have been conducted. (Duplicate client ID creation leading to wrong sum at Risk calculations • Check if mandatory fields completed in the proposal form. • Check for medical/non-medical underwriting compliance. Error in updation of proposal details could lead to erroneous underwriting decision. Further check if all alterations are routed through underwriting. Also check TAT of 7 day for acceptance of proposals • For Group Policies Actuarial approval and receipt of member data. • Check for Benefit Illustration (BI)/ revised BI for loadings

proposer and the insurer. • Splitting of Policies to be done at the specific request of the prospect after recording the consent (applicability of discount in premiums) • Additional cost not to be levied for splitting of policies • Group Policies Approval of Actuary • Receipt of member data for group policies • NAV for ULIP policies		• Check if splitting of Policies is done only after recording of the prospects consent. Check for splitting as discounts would not be applicable • Check for the NAV date applied
Policy Issuance		
• Receipt of Premium • Mandatory Nomination • Commencement of risk • Recovery of stamp duty • TAT for Policy Issuance	• Risk commencement after receipt of premium • Regulatory Compliance • Digital tracking and Proof of Delivery (POD) controls	• Obtain a dump of the policies logged during the audit period and check whether Premium has been received along with applications. (Sec 64VB of Insurance Act). Stale cheque analysis. Bank realization matching

• Customer Information Sheet (CIS) • Dispatch of Policy		• Nominee details mandatory to be filled up in the proposal form • Verify that Risk cover commences only after receipt of premium • Reconcile the stamp duty collected with the total stamp duty paid to the Authority, check the stamp duty calculations for various types of products, check the stamp duty amount and the revenue receipt number printed on the Policy document for correctness. • Policy to be issued in electronic form digitally signed by the insurer. Physical policy to be issued if policyholder requests for the same. Check if Policy is issued within 15 days of acceptance of proposal. Check ageing analysis for policies issued

		• Customer Information Sheet (CIS)to be prepared and given to policy holder. CIS to provide important and basic features of the policy • Check PODs and e delivery policies. Policy to be dispatched directly to the customer. Check if any policy has been dispatched to the intermediatory. Check dispatch ageing
Refund of Premiums		
• Free look period • Refund Processing • Review reconciliations	• Regulatory Compliance • Maker checker activity • Excess Payouts	• Policyholders have 30 days for reviewing terms and conditions and can return the policy • Refund of premium after deducting proportionate risk premium to be made within 7 days. • Check for delay in refund check if interest at bank rate plus 2% on the refundable amount is paid.

		• Check for duplicate/ incorrect refund, refund to be given effect to only if premium is received • Review unidentified amounts lying in premium suspense account
Specific Points on Group Insurance		
• Group insurance provided to a group other than a group formed with a common purpose • Adherence to group size • Insurance cover continues even after exit from the group • Policy issued without specifying the names of members covered	Regulatory Compliance	• Check that the clients to whom the policy has been issued are qualified to be a group • Obtain data of policies issued. Check whether initial size was in conformity. Check whether any group has fallen below the minimum required limit as a result of deletion of members • Check whether list of members is attached to the contract
ULIP Guidelines		
• ULIP statement to be sent along with policy contracts • Correct NAV applied	Regulatory Compliance	• Check if statement is sent

		• NAV applied is of date of conversion of ULIP policies
Married Women's Property Act (MWP)		
• MWP policies issued to contain names of Trustee and beneficiary in the proposal form • A married woman can buy a policy on her own life or her husband's life. The benefits legally belong to her as her sole, independent property, carrying the same validity as if she were unmarried (regulation 5 of MWP Act)	Regulatory Compliance	• Check Trustee and beneficiary in MWP. • Check to see if married woman is the beneficiary
Other Areas		
• Outsourcing	• SLA Compliance • Data Security	• Evaluate policy on outsourcing • Check for Service level Agreements • Vendor audits • Verify Access log

Audit Analytics/ CAATs

5.4 Audit Analytics/ CAATs for various areas of Life Insurance Companies:

Sr. No	Area	Audit Analytics
1	Proposal forms	OCR validation, mandatory field exception reports
2	KYC &AML	Duplicate PAN analytics, AML rule engine review
3	Underwriting	Override analytics, deviation reports
4	Benefit Illustration	Document matching tools
5	Group policies	Member data completeness analytics
6	ULIP NAV Allocation	System date analytics and exception reports
7	Premium Controls	Bank realization matching
8	Refunds	Refund ageing dashboards
9	Dispatch	POD available, e policy delivery

Commonly Observed Irregularities/ Violations

5.5 Commonly Observed Irregularities/ Violations is various areas of Life Insurance companies are as follows:

- Policies issued before premium realization in violation of Section 64VB.
- Incomplete KYC/ PAN documentation for high value policies.
- Duplicate customer IDs leading to incorrect exposure aggregation.
- Unsigned or outdated Benefit Illustrations.
- Policy issuance delays beyond defined Turnaround Time (TAT).
- Incorrect ULIP NAV allocation date.
- Refunds/ duplicate refunds processed without proper approvals.
- Inadequate maker checker controls in policy alterations.
- Outsourced vendors having excessive system access rights.
- Group insurance issued without adequate member data validation.

- Non dispatch or delayed dispatch of policy documents.
- Mismatch between proposal form, underwriting approval and issued policy.
- Commission paid to the licensed agents and intermediaries before the free look in period.

Regulatory References

Reference	URL
IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024	https://irdai.gov.in/document detail?documentId=5542428
IRDAI (Insurance Products) Regulations, 2024	https://irdai.gov.in/document detail?documentId=5542415
IRDAI Master Circular on Protection of Policyholders' Interests (05 September 2024)	https://irdai.gov.in/document detail?documentId=5625747
IRDAI AML/CFT Guidelines and Master Circulars	https://irdai.gov.in/document detail?documentId=391184
Bima Sugam/ Digital Insurance Initiatives	https://www.bimasugam.in
IRDAI Regulations & Guidelines Repository	https://irdai.gov.in/regulations guidelines

Chapter 6
Underwriting Process

Introduction

6.1 Underwriting is one of the core risk selection functions of a life insurance company. It is the process through which the insurer evaluates a proposal for insurance and determines whether the risk should be accepted, declined, postponed, accepted at standard rates, accepted with extra premium, accepted with lien/ restriction, or referred for reinsurance.

In life insurance, underwriting has a direct bearing on policyholder protection, claims experience, profitability, solvency, reinsurance recoverability, persistency, fraud control and market conduct. Weak underwriting may result in anti-selection, acceptance of lives beyond the insurer's risk appetite, avoidable claim repudiations, customer grievances, regulatory non-compliance and reputational risk. Overly restrictive or inconsistent underwriting may, on the other hand, result in unfair customer outcomes, discrimination, poor business conversion and regulatory scrutiny.

The role of internal audit is to evaluate whether the underwriting governance framework, systems, processes, controls and documentation are adequate and operating effectively. The audit should verify whether underwriting decisions are made in accordance with the Board Approved Underwriting Policy, product specific underwriting rules, delegated authority matrix, reinsurance arrangements, regulatory requirements and principles of fair treatment of policyholders.

Scope of Internal Audit of Underwriting

6.2 The scope of internal audit should be risk based and should be determined after considering the insurer's product mix, underwriting model, channel mix, scale of new business, proportion of straight through processing, claims experience, complaints, persistency, reinsurance structure and past audit/ regulatory observations.

The internal audit scope may include the following areas:

Governance and Policy Framework

- Existence, adequacy and periodic review of the Board Approved Underwriting Policy.
- Alignment of underwriting policy with risk appetite, product pricing, product design, reinsurance strategy and regulatory requirements.
- Approval and review of product specific underwriting guidelines.
- Underwriting delegation of authority, approval limits and escalation matrix.
- Roles and responsibilities of underwriting, sales, operations, medical, actuarial, claims, compliance, risk and reinsurance teams.
- Reporting of underwriting performance, deviations, early claims, non-disclosure trends and exception approvals to senior management/ Board level committees.

Medical Underwriting

- Applicability of medical tests based on age, sum assured, product, occupation, health disclosures and underwriting grid.
- Selection, appointment and monitoring of medical examiners, diagnostic centres and tele medical vendors.
- Review of medical reports, MER, ECG, TMT, HbA1c, lipid profile, urine tests and other tests as applicable.
- Controls over repeat medicals, adverse findings and abnormal reports.
- Waiver of medical requirements and approval thereof.
- Handling of pre-existing conditions, lifestyle risks, BMI, smoking/ alcohol disclosures and family history.

Financial Underwriting

- Assessment of income, financial eligibility and insurable interest.
- Verification of income documents such as ITR, Form 16, salary slips, bank statements, audited financial statements, GST returns, net worth statements and other documents.
- Human Life Value/ income multiple calculations.

- Aggregation of existing insurance cover with the insurer and other insurers.
- Controls over high sum assured cases, keyman insurance, employer employee insurance, partnership insurance and non-individual proposers.
- Review of premium paying capacity, especially for high premium savings products, ULIPs, single premium policies and annuity products.
- Identification of moral hazard, suspicious financial profile or mismatch between income and proposed cover.

Occupational, Avocational and Geographical Underwriting

- Assessment of hazardous occupations such as mining, aviation, shipping, armed security, chemical handling, construction, oil and gas, high voltage electrical work and other high-risk occupations.
- Assessment of hazardous hobbies such as mountaineering, scuba diving, racing, aviation sports and adventure sports.
- Evaluation of travel/ residence in high-risk geographies, where applicable.
- Application of occupational extra premium, exclusions or postponement as per underwriting guidelines.

Automated Underwriting and Straight through Processing

- Configuration of rule engine and underwriting rules.
- Mapping of product specific underwriting limits into the policy administration system.
- System controls over age, sum assured, income multiple, medical grid, non-medical limits, occupation, rider eligibility and premium calculation.
- Maker checker approval for rule changes.
- Audit trail for automated decisions, overrides, referrals and manual interventions.
- Monitoring of STP cases for early claims, misrepresentation, complaints and exception trends.
- Governance over AI/ predictive models used in underwriting, including model validation, bias testing, explainability, data quality and human override controls.

Manual Underwriting and Deviations

- Allocation of proposals to underwriters based on authority level.
- Documentation of underwriting rationale.
- Approval of deviations, counter offers, ratings, postponements and declines.
- Escalation of high-risk cases and cases beyond delegated authority.
- Review of sample underwriting decisions for consistency with underwriting manual and reinsurer guidelines.
- Segregation between sales and underwriting decision making.

Premium, Acceptance and Risk Commencement

- Communication of underwriting decision and premium payable to the prospect.
- Compliance with requirements relating to premium collection after acceptance of proposal, except where specifically permitted.
- Confirmation that risk cover commences only after receipt of premium, unless the product/ regulatory framework provides otherwise.
- Explicit consent for premium deduction from bank account.
- Controls over short/ excess premium collection.
- Controls over backdating, risk commencement date, policy issue date and receipt date.

Group Underwriting

- Master policy underwriting guidelines.
- Free cover limit approval.
- Eligibility criteria for members.
- Anti selection controls, especially for voluntary schemes.
- Member data validation.
- Evidence of insurability for members above free cover limit.
- Controls over employer employee, creditor, micro insurance and affinity group schemes.

- Premium reconciliation with member data and coverage commencement.

Revival/ Reinstatement underwriting

- Medical and non-medical requirements for revival.
- Evidence of continued insurability.
- Approval of revival within delegated authority.
- Application of interest, unpaid premium and risk commencement on revival.
- Controls over revival shortly before claim.
- Review of high-risk revival cases.

Objectives of Internal Audit of Underwritting

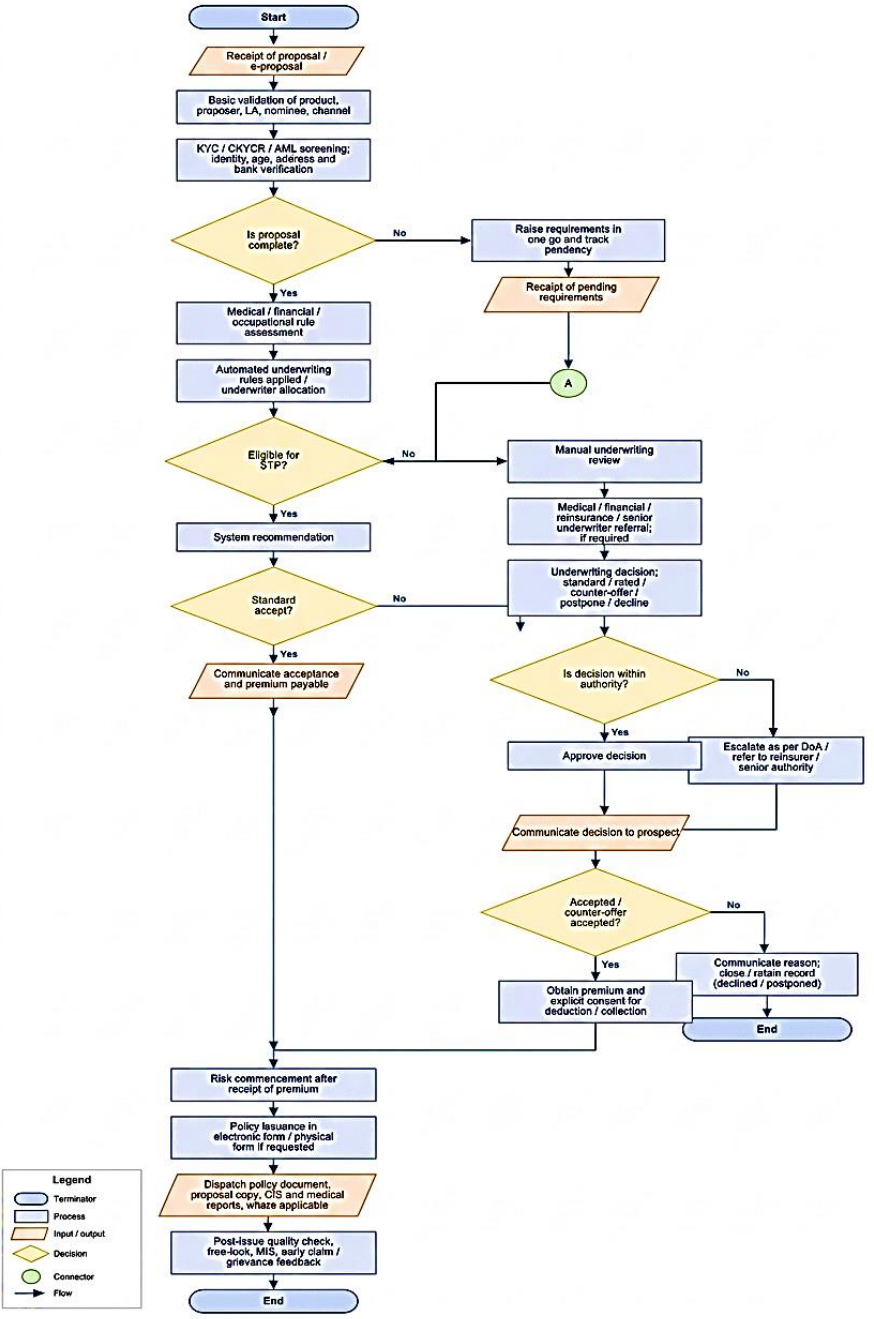
6.3 The objectives of internal audit of underwriting are to provide assurance as whether:

- The insurer has an adequate Board Approved Underwriting Policy and the policy is aligned with risk appetite, product pricing, reinsurance strategy and regulatory requirements.
- Underwriting decisions are made in accordance with approved policy, product specific guidelines, delegated authority and applicable laws/ regulations.
- Proposal forms and supporting documents are complete, authenticated, verifiable and retained.
- Medical, financial, occupational, avocational and moral hazard assessments are performed adequately.
- Automated underwriting rules are correctly configured, approved, monitored and subject to appropriate audit trail.
- Deviations, overrides, ratings, postponements and declines are properly justified and approved.
- Premium is collected, risk has commenced and policies are issued in accordance with regulatory and internal requirements.
- Reinsurance referrals, cessions and acceptance conditions are complied with.

- Customer communication is timely, transparent and fair.
- Underwriting TAT, pendency, early claims, repudiations, grievances and exception trends are monitored and acted upon.
- Adequate controls exist over outsourcing, vendor management, medical service providers and third party technology platforms.
- Underwriting data is complete, accurate and available for actuarial valuation, experience studies, claims review, reinsurance and regulatory reporting.
- Prior audit observations, regulatory observations and quality assurance findings are tracked to closure.

Flowchart of Underwriting Process

6.4 The following flowchart represents a typical underwriting process. The actual process may differ by insurer, product, distribution channel and degree of automation.


Start
Receipt of proposal / e-proposal
Basic validation of product, proposer, LA, nominee, channel
KYC / CKYCR / AML screening; identity, age, address and bank verification
Is proposal complete?
No
Raise requirements in one go and track pendency
Receipt of pending requirements
Yes
Medical / financial / occupational rule assessment
Automated underwriting rules applied / underwriter allocation
A
Eligible for STP?
No
Manual underwriting review
Yes
System recommendation
Medical / financial / reinsurance / senior underwriter referral; if required
Standard accept?
No
Underwriting decision; standard / rated / counter-offer / postpone / decline
Yes
Communicate acceptance and premium payable
Is decision within authority?
No
Yes
Approve decision
Escalate as per DoA / refer to reinsurer / senior authority
Communicate decision to prospect
Accepted / counter-offer accepted?
No
Yes
Communicate reason; close / retain record (declined / postponed)
Obtain premium and explicit consent for deduction / collection
End
Risk commencement after receipt of premium
Policy issuance in electronic form / physical form if requested
Dispatch policy document, proposal copy, CIS and medical reports, where applicable
Post-issue quality check, free-look, MIS, early claim / grievance feedback
End
Legend
Terminator
Process
Input / output
Decision
Connector
Flow

Risk Control Matrix for Underwriting

S. No.	Process Area	Key Risk	Expected Control	Internal Audit Procedure
1.	Underwriting Policy Governance	Underwriting performed without approved risk appetite or inconsistent practices	Board Approved Underwriting Policy covering risk appetite, tolerance, underwriting philosophy, delegation, reinsurance interaction and Board reporting	Verify Board approval, version control, review frequency and alignment with product/ reinsurance documents
2.	Product Underwriting Rules	Product accepted outside approved product design/ pricing assumptions	Product specific underwriting grid approved and mapped to product filing	Select products and compare underwriting rules with filed product documents and pricing assumptions
3.	Proposal Completeness	Incomplete information leading to poor risk assessment and claim disputes	Mandatory fields, document checklist, validation controls and exception workflow	Test sample proposals for completeness and system validations
4.	Medical Underwriting	High risk lives accepted without proper	Medical grid, empanelled medical providers and	Test cases for medical trigger, report availability and

		medical assessment	underwriter review of reports	underwriter conclusion
5.	Financial Underwriting	Over insurance, moral hazard or poor premium paying capacity assessment	Income verification, HLV calculation and existing insurance aggregation	Reperform HLV/ income multiple for sample high sum assured cases
6.	Automated Underwriting	Incorrect rule configuration causing inappropriate STP acceptance	Approved rule engine configuration, UAT and change control	Review rule changes, UAT evidence and STP sample cases
7.	Manual Override	System recommendations bypassed without rationale	Override reason code, senior approval and exception MIS	Review override report and approvals
8.	Risk Commencement	Risk commenced before receipt of premium or wrong commencement date	System control linking risk commencement with premium receipt	Test policy schedule dates against premium receipt
9.	Group Underwriting	Anti selection and incorrect member coverage	Approved FCL, eligibility checks, member data validation and EOI above FCL	Test master policies and member records

10.	Revival Underwriting	Revival of impaired lives without adequate evidence	Revival underwriting grid, health declaration and medical requirement	Test revival cases, especially high sum assured and recent claims
11.	Mis and Board Reporting	Management unaware of underwriting risk trends	Periodic MIS on TAT, deviations, early claims, grievances, STP, ratings and declines	Reconcile MIS to source data and review management actions
12.	Claims Feedback Loop	Repeated underwriting defects not corrected	Root cause analysis of early claims and repudiations	Review early claim analysis and action taken by underwriting
13.	Record Retention	Inability to defend underwriting decision or claim repudiation	Document retention and retrieval controls	Perform sample retrieval of proposal, KYC, medical and financial documents

Suggested Audit Analytics

6.5 Internal audit may use data analytics to identify high-risk underwriting exceptions. Illustrative analytics include:

- Policies issued with missing age proof, identity proof, income proof or medical reports.
- Policies issued where premium receipt date precedes underwriting acceptance date.
- Policies where risk commencement date is earlier than premium receipt date.

- STP approved policies with adverse disclosures.
- Policies with sum assured above non-medical limits but no medical tests.
- High sum assured policies with income below underwriting threshold.
- Multiple policies issued to same life assured within a short period.
- High premium policies funded from third party bank accounts.
- Cases approved by users beyond delegated authority.
- Manual overrides by underwriter/ branch/ channel.
- Policies issued immediately before month end with subsequent early cancellation/ free look.
- Early death claims within 12 months of policy issuance.
- Claims repudiated for non-disclosure mapped to originating channel/ branch/ underwriter.
- High decline reversal rate by specific channel or geography.
- High medical waiver rate by specific branch, product, underwriter or sales channel.
- Disproportionate business from high-risk occupations accepted at standard rates.
- Group schemes with sudden member addition before claim event.
- Cases pending for underwriting beyond defined TAT but shown under customer pendency.
- Facultative cases accepted before reinsurer decision.
- Policy documents not dispatched within prescribed timelines.

Commonly Observed Irregularities, Violations and Deficiencies

6.6 The following issues are commonly observed during internal audit of underwriting in life insurance companies:

Governance and Policy Deficiencies

- Board Approved Underwriting Policy (BAUP) not available, outdated or not reviewed periodically.

- BAUP not aligned with current product portfolio, reinsurance treaties, digital underwriting process or regulatory requirements.
- Product specific underwriting rules not documented or not mapped to approved product design.
- Underwriting delegation matrix not clearly defined or not configured in the policy administration system.
- Inadequate reporting of underwriting performance, early claims, deviations and exception approvals to management/ Board committees.
- Underwriting quality review not performed independently.

Proposal and Documentation Deficiencies

- Proposal forms incomplete or accepted with blank/ ambiguous responses.
- Proposal forms filled by intermediaries without adequate customer confirmation.
- Customer mobile number/ email ID belonging to agent, branch staff or third party.
- Inadequate evidence of customer consent in e proposal or tele assisted sales.
- Proposal form not made available/ explained in a language understood by the prospect.
- Required declarations missing where the prospect is not familiar with the language of the proposal form.
- Copy of proposal form not provided to policyholder with policy document.

Medical Underwriting Deficiencies

- Medical requirements waived without approval.
- Medical tests not triggered despite age/ sum assured/ medical disclosure criteria.
- Adverse medical findings ignored or inadequately evaluated.
- Medical reports accepted from non-empanelled/ blacklisted centres.
- Medical reports not traceable in document management system.

- Repeated abnormal findings not escalated.
- Tele MER/ medical questionnaire inconsistencies not investigated.

Financial Underwriting Deficiencies

- Income proof not obtained or not independently verified.
- HLV/ income multiple calculation not documented.
- High sum assured accepted despite insufficient income.
- Existing insurance cover not aggregated while determining insurability.
- Mismatch between occupation, income, premium amount and proposed sum assured not investigated.
- Keyman/ employer employee/ partnership insurance accepted without adequate insurable interest documentation.
- High premium savings products accepted without premium paying capacity assessment.

Group Underwriting Deficiencies

- Free cover limit applied without approval or beyond treaty limit.
- Member eligibility not verified.
- Voluntary group schemes accepted without anti selection safeguards.
- Incomplete member data used for coverage commencement.
- Evidence of insurability not obtained for members above free cover limit.
- Premium received not reconciled with covered lives.

Monitoring and Feedback Deficiencies

- Early claim trends not fed back to underwriting.
- Claim repudiations due to non-disclosure not analysed for proposal form/ sales process weaknesses.
- Grievances relating to underwriting delays, extra premium, decline or medical reports not analysed.
- No root cause analysis of high free look cancellations after rated acceptance.

- No periodic review of underwriting exceptions by risk/ compliance/ internal audit.
- Underwriting MIS prepared manually without reconciliation to source systems.

Internal Audit Checklist for Field Work

6.7 The following working checklist is designed to be used by the internal auditor and audit assistants during fieldwork. It complements and does not replace the risk-based audit procedures. For each checkpoint, record the conclusion (Yes/ No/ Not applicable) and a cross reference to the working paper holding the supporting evidence. A "No" conclusion should be developed into an audit observation in accordance with paragraph 6.6 of this chapter. The checklist should be tailored to the insurer's products, systems, distribution channels and risk profile and the sample sizes should be determined having regard to SIA 230, Internal Audit Evidence.

Governance and Policy

Sr. No.	Checkpoint	Y/ N/ NA	W/P ref.
1	Board Approved Underwriting Policy (BAUP) is in place, Board approved and reviewed within the period prescribed by the insurer's own policy.		
2	BAUP covers risk appetite, risk tolerance limits, underwriting philosophy, reinsurance interaction, delegation and Board reporting.		
3	Each live product has documented, approved underwriting rules consistent with the filed product and pricing assumptions.		
4	Delegation of authority (DoA) matrix is defined and enforced in the policy administration system.		
5	Underwriting performance, deviations, early claims and exception approvals are		

	reported to the designated management/ Board committee.		
6	An independent underwriting quality assurance/ quality control process exists and its findings are acted upon.		

Proposal Capture and Onboarding

Sr. No.	Checkpoint	Y/ N/ NA	W/P ref.
1	Sample proposal/ e proposal forms are complete, authenticated and supported by required documents.		
2	Customer's mobile number and email ID are captured and verified (not those of the intermediary or staff).		
3	Evidence of customer consent exists for e proposal and tele assisted sales.		
4	Proposal form is available/ explained in a language understood by the prospect, with required declarations where applicable.		
5	KYC, CKYCR and AML screening are performed and evidenced high-risk customers undergo enhanced due diligence.		
6	PAN/ Form 60 controls are enforced by the system.		

Medical and Financial Underwriting

Sr. No.	Checkpoint	Y/ N/ NA	W/P ref.
1	Medical requirements are triggered as per the medical grid (age, sum assured,		

	product, disclosures) and reviewed by a competent underwriter.		
2	Any waiver of medical requirements is approved within authority and documented.		
3	Adverse/ abnormal medical findings are evaluated, escalated and documented.		
4	Medical reports are sourced only from empanelled centres and are retrievable in the document management system.		
5	Income is verified independently Human Life Value/ income multiple is documented for sampled cases.		
6	Existing insurance cover is aggregated high sum assured and high premium cases are assessed for premium paying capacity and source of funds.		
7	Insurable interest is documented for keyman, employer employee and partnership proposals.		

Occupational, Avocational and Risk Classification

Sr. No.	Checkpoint	Y/ N/ NA	W/P ref.
1	Hazardous occupations and avocations are identified and appropriately rated, excluded, postponed or declined.		
2	Travel/ residence in high-risk geographies is considered where applicable.		

Automated Underwriting and Straight Through Processing (STP)

Sr. No.	Checkpoint	Y/ N/ NA	W/P ref.
1	Rule engine configuration is aligned with the underwriting manual and product specific limits.		
2	Changes to underwriting rules pass through maker checker control and User Acceptance Testing (UAT), with change tickets retained.		
3	Audit trail exists for automated decisions, overrides, referrals and manual interventions.		
4	Sampled STP cases satisfy all STP eligibility criteria and have no unaddressed adverse disclosures.		
5	Governance over AI/ predictive models (validation, bias testing, explainability, human override) is evidenced.		

Manual Underwriting, Deviations and Overrides

Sr. No.	Checkpoint	Y/ N/ NA	W/P ref.
1	Proposals are allocated to underwriters within their authority level.		
2	Underwriting rationale, ratings, counter offers, postponements and declines are documented.		
3	System overrides carry a reason code and approval of the appropriate authority.		

4	Sales and underwriting decision making are segregated.		

Premium, Risk Commencement and Issuance

Sr. No.	Checkpoint	Y/ N/ NA	W/P ref.
1	Premium is collected only after acceptance, except where specifically permitted.		
2	Explicit consent is held for any bank account deduction.		
3	Risk commencement date is not earlier than premium receipt date.		
4	Backdating, risk commencement, issue and receipt dates are controlled and reconciled.		
5	Policy document, copy of proposal form, Customer Information Sheet and medical reports (where applicable) are dispatched within prescribed timelines.		

Reinsurance Interface

Sr. No.	Checkpoint	Y/ N/ NA	W/P ref.
1	Cases above retention or outside treaty terms are referred to the reinsurer before acceptance.		
2	Facultative terms and special conditions are incorporated into the final underwriting decision.		
3	Reinsurance cession is timely and reconciled with the policy administration system.		

4	Material medical/ financial disclosures are shared with the reinsurer.		

Group and Revival Underwriting

Sr. No.	Checkpoint	Y/ N/ NA	W/P ref.
1	Master policy underwriting, free cover limit (FCL) approval and member eligibility are evidenced.		
2	Anti selection safeguards exist for voluntary schemes evidence of insurability is obtained above FCL.		
3	Premium received is reconciled with covered lives/ member data.		
4	Revival decisions are supported by required health declaration/ medical evidence and approved within authority.		
5	High sum assured revivals shortly before a claim received.		

Monitoring, Feedback and Records

Sr. No.	Checkpoint	Y/ N/ NA	W/P ref.
1	Underwriting TAT, pendency, early claims, repudiations, grievances and exceptions are monitored and acted upon.		
2	Early claims and non-disclosure repudiations are fed back to underwriting with root cause analysis.		
3	Underwriting MIS to management/ Board reconciles to source systems.		

4	System access rights are role based with maker checker and audit trail.		
5	Proposal, KYC, medical, financial and underwriting records are retained and retrievable on sample testing.		
6	Prior internal audit, regulatory and QA observations are tracked to closure.		

Note: "W/P ref." denotes the working paper reference. Each completed checklist should be reviewed and signed off in accordance with SIA 260, Review and Supervision of Audit Assignments and retained as part of the audit documentation under SIA 250, Internal Audit Documentation.

Relevant IRDAI Circulars

Reference Number	Name of the Circular	Date
IRDAI/SDD/MISC/CIR/128/05/2026	Circular on Implementation of Risk Based Supervision (RBS)	01 May 2026
IRDA/NL/CIR/F&U/077/04/2016	Circular on Adherence to Declared Underwriting Philosophy	22 Apr 2016

Chapter 7
Reinsurance

Introduction

7.1 Reinsurance is an essential risk management mechanism for life insurance companies through which a portion of the insurance risk is transferred to reinsurers to protect capital, stabilize underwriting results, manage mortality and catastrophe exposures, improve underwriting capacity and support solvency and policyholder protection. From an internal audit perspective, reinsurance is a critical function involving governance, risk transfer, regulatory compliance, financial reporting and operational controls and not merely an accounting activity.

Weaknesses in reinsurance processes may lead to ineffective risk coverage, excessive retention exposure, concentration risk, delayed claims recoveries, financial misstatements and non-compliance with regulatory requirements. Accordingly, internal audit should evaluate whether the reinsurance framework operates within Board approved policies, IRDAI regulations and sound risk management practices, while ensuring effective treaty administration, facultative placements, claims recoveries, reconciliations and regulatory reporting.

Regulatory Framework

7.2 The regulatory framework governing reinsurance for life insurance companies in India is primarily driven by the Insurance Act, 1938, the IRDAI Act, 1999, the IRDAI (Re-insurance) Regulations, 2018 (as amended), the Master Circular on Reinsurance, 2024 and related IRDAI regulations on solvency, financial reporting, actuarial matters and corporate governance. Key requirements include Board approved retention and reinsurance policies, timely filing of annual reinsurance programmes with IRDAI, maintenance of reinsurer documentation, compliance with obligatory cession requirements and adherence to the prescribed order of preference for placement.

Concept and Types of Reinsurance

7.3 Reinsurance is a risk mitigating tool whereby the risk underwritten by one insurer (the cedant) is transferred partially or wholly to another insurer (the

reinsurer). The reinsurer, in consideration of a premium (the ceded premium), agrees to indemnify the cedant against part or all of the losses it may incur under the original policies.

Primary Purposes of Reinsurance

- Risk capacity expansion: enables the cedant to underwrite risks larger than its own capital would otherwise permit
- Catastrophe protection: shields the cedant from extreme loss aggregation arising from natural or man-made catastrophes
- Stabilisation of underwriting results: smooths annual loss volatility and gives the insurer more predictable profitability
- Capital management: reduces the Required Solvency Margin (RSM), freeing capital for business growth
- Underwriting expertise access: reinsurers share risk knowledge, pricing data and technical guidance

Types of Reinsurance Arrangements

S. No.	Type	Structure	When Used
1	Treaty – Quota Share	Cedant cedes fixed % of every risk and premium reinsurer accepts automatically	Standard life and non-life products within agreed parameters
2	Treaty – Surplus	Cedant retains defined amount surplus above retention is ceded proportionally	Large commercial/industrial risks where sums insured vary widely
3	Treaty – XL	Reinsurer pays losses above cedant's retention up to cap non-proportional premium	Motor, health, catastrophe — to cap per event or aggregate losses
4	Facultative	Case by case negotiation risk ceded at agreed % and premium	Individual large risks not fitting within treaty parameters

Scope and Objectives of Internal Audit

7.4 The internal auditor should evaluate whether the reinsurance function operates within the approved business and regulatory framework, whether the intended risk transfer is effective and properly documented and whether placements are made with eligible counterparties in the prescribed manner.

Key Audit Objectives

- Reinsurance premium calculations and payments are accurate and in accordance with signed treaty/facultative agreements
- Necessary provisions for outstanding reinsurance premiums are properly made and correctly accounted for
- Risk placement with reinsurers is timely, complete and correctly routed per Board approved reinsurance programme
- Reinsurance recoveries on claims are sought promptly, fully and correctly accounted for
- All IRDAI regulatory reporting obligations relating to reinsurance are fulfilled accurately and on time

Audit Coverage Areas

S. No.	Coverage Area	Description
1	Agreement Management	Process for entering into, updating and maintaining reinsurance treaties and facultative agreements
2	Underwriting Guidelines	Board approved retention limits, quota limits and facultative thresholds
3	System Configuration	Accuracy and completeness of rates, limits and routing rules loaded into system
4	Premium & Claims	Accurate calculation of ceded premiums timely intimation and recovery of reinsured claims

5	Regulatory Compliance	IRDAI LR 8 returns, annual programme filing, CBR compliance, Appointed Actuary certification

Reinsurance Process Flow

7.5 The reinsurance operational cycle follows a structured flow from treaty negotiation through to settlement and regulatory reporting. Understanding each step is essential for effective risk-based audit planning.

Step	Process Description	Internal Audit Focus
1	Treaty Negotiation: rates, terms, conditions, retention limits, profit sharing arrangements agreed	Verify Board approval of strategy, actuarial involvement and proper documentation of agreed terms
2	Programme Filing: annual reinsurance programme certified by Appointed Actuary filed with IRDAI 45 days before FY	Verify filing date, IRDAI acknowledgement, completeness of annexures, Board approval and CEO/CFO certifications
3	System Updation: reinsurance rates, product mappings and routing limits uploaded into policy administration system	Verify UAT sign off, maker checker controls on uploads, audit trail of changes and version control
4	Risk Placement: upon policy issuance, system automatically routes risk to reinsurer based on Sum at Risk and treaty limits	Test sample policies near retention thresholds verify correct routing check for missed or misrouted cessions
5	Premium Reporting: monthly data extract generated showing reinsurance premium payable for all policies placed during period	Reconcile system extract with bordereaux sent to reinsurer verify completeness and accuracy
6	Claims Recovery: when claim payable, claims team notifies reinsurer reinsurance recovery accounted separately	Verify timely notification of claims confirm recovery computations track outstanding recoveries

Key Risks and Control Framework

7.6 This para identifies the principal risk areas in reinsurance operations, their potential impact and the expected preventive and detective controls. The internal auditor should assess the adequacy and operating effectiveness of each control.

1. Governance & Regulatory Compliance Framework

Risk ID	Risk Description	Control Objective	Illustrative Internal Audit Procedures	Regulatory/ Statutory Reference
GOV 01	Inadequate or outdated Reinsurance Policy leading to excess net exposure, corporate strategy mismatch, or regulatory breach.	Ensure the reinsurance framework aligns with corporate risk appetite and statutory limits.	• Obtain the Board approved retention and reinsurance policy. Verify it contains segment wise thresholds for life products (Individual/Group Term, Endowment, ULIPs). • Check for annual review, version control and formal approval before the start of the financial year. • Verify that retention limits match parameter setups in the Policy Administration System (PAS).	• IRDAI (Re-insurance) Regulations, 2018 • Master Circular on Corporate Governance, 2024

GO V 02	Non compliance or delayed filing of the Annual Reinsurance Programme with the regulator.	Adherence to statutory filing timelines to avoid regulatory penalties and enforcement.	• Check regulatory portal receipts to ensure the proposed/final programme was filed at least 45 days before the financial year starts. • Verify the programme is certified by the Appointed Actuary and contains CEO/CFO sign offs. • Confirm mid year product addenda were filed promptly.	• Chapter II, IRDAI Master Circular on Reinsurance, 2024
GO V 03	Violation of the mandatory regulatory Order of Preference during risk allocation.	Ensure statutory compliance by prioritizing domestic markets before overseas placement.	• Review the placement log, offer letters and right of first refusal logs for a sample of ceded risks. • Verify that GIC Re was given first preference and minimum obligatory cessions were met. • Confirm domestic market options were	• IRDAI (Re-insurance) (Amendment) Regulations, 2023

			exhausted before routing to Cross Border Reinsurers (CBRs).	
GOV 04	Placement of risk with financially unstable or unapproved reinsurers, leading to recovery risk.	Mitigate counterparty credit risk and comply with minimum rating rules.	• Inspect due diligence files for active reinsurers. Verify credit ratings (S&P, AM Best, etc.) meet the minimum regulatory threshold (e.g., BBB+ or equivalent). • Cross check FRN or CBR IDs against the official IRDAI portal to confirm active status. • Check compliance with internal credit risk concentration limits per reinsurer.	• IRDAI (Registration and operations of FRBs and Lloyd's India) Regulations, 2024

2. Treaty Operational Controls & System Configuration

Risk ID	Risk Description	Control Objective	Illustrative Internal Audit Procedures	Regulatory/ Statutory Reference
OPS 01	Risk bound or placed before the formal	Prevent legal disputes and potential claim	• Match treaty execution dates against	• Insurance Act, 1938 (Section

	execution of reinsurance agreements/ slips.	denials from undocumented treaty terms.	the effective risk inception dates for a sample of policies issued near renewal windows. • For facultative placements, verify formal written acceptance (slips) was on file before the risk was bound.	64VB comparison) • IRDAI Re-insurance Regulations, 2018
OPS 02	New products launched without executed treaty addenda or agreed reinsurance rates.	Prevent unhedged mortality or morbidity exposure on new product lines.	• Cross verify a list of all products launched during the audit period against executed treaty addenda. • Check for gap periods where policies were issued before a treaty addendum was finalized quantify any	• Guidelines on filing of Re-insurance arrangements with IRDAI

			unhedged exposure.	
OPS 03	Erroneous configuration of retention thresholds, auto/facultative limits, or premium rates in the system.	Ensure correct routing of cessions and accurate premium pricing.	• Perform a rate by rate reconciliation between signed treaties and system master rate tables (checking age, gender, smoking status and Sum at Risk [SAR] bands). • Test edge cases with high sums assured near retention limits to confirm automated routing to surplus or facultative channels works correctly. • Check system logs to verify changes to master rates require IT	• Master Circular on Actuarial, Finance and Investment Functions, 2024

			change management approval and actuarial sign off.	
OPS 04	Failures in "Per Life Accumulation" system logic, allowing aggregated exposures to breach the individual net retention limit.	Prevent unintended risk concentration on a single life across multiple policy types.	• Run a data analytics query to aggregate total sum assured by unique customer identifiers (PAN, Aadhaar, DOB). • Identify individuals with multiple active policies and verify the system automatically triggered reinsurance cessions once their combined retention threshold was crossed.	• IRDAI Consolidated Re-insurance Regulations, 2024

3. Financial Premium Administration & Accounting

Risk ID	Risk Description	Control Objective	Illustrative Internal Audit Procedures	Regulatory/ Statutory Reference
FIN 01	Inaccurate calculation of Sum at Risk (SAR) on Yearly Renewable Term (YRT) structures, leading to incorrect premium cessions.	Ensure ceded premiums are calculated correctly based on actual risk exposure.	• Independently recalculate SAR using the formula: $SAR = \text{Sum Assured} \text{Actuarial Reserve}$ for a sample of active policies. • Verify that the PAS dynamically updates this calculation as reserves change over the policy lifecycle.	• IRDAI Financial Statements Regulations, 2002
FIN 02	Failure to process reinsurance premium reversals/clawbacks on lapsed, surrendered, or free look cancelled policies.	Prevent leakage and financial overpayment to reinsurers.	• Match the system lapse/cancellation register against subsequent reinsurance premium bordereaux extracts. • Verify that proportionate premium refunds or clawbacks were	• IRDAI Financial Statements Regulations, 2002

			processed according to treaty terms. • Check that renewal premiums stop accruing for lapsed policies within the reinsurance module.	
FIN 03	Lack of segregation of duties or maker checker overrides during premium billing and invoicing.	Prevent unauthorized payouts and fraudulent data manipulation.	• Review user access rights for master rate modifications and payment approvals. • Test the transaction log to confirm the system prevents the same user from both generating and approving a reinsurance payout.	• Master Circular on Corporate Governance, 2024
FIN 04	Long outstanding unreconciled balances, missing confirmations, or uncollected profit commissions.	Ensure accurate financial presentation and timely recovery of balances due.	• Inspect quarterly balance confirmation letters from reinsurers and match them to general ledger records. • Review ageing schedules for	• Master Circular on Submission of Returns, 2024

			long outstanding items, evaluate dispute resolution logs and check the justification for any written back liabilities. • Independently recalculate profit sharing clauses using the treaty formula to confirm accrued receivables are accurate.	

4. Claims Recovery & Reserving Controls

Risk ID	Risk Description	Control Objective	Illustrative Internal Audit Procedures	Regulatory/ Statutory Reference
CLM 01	Delayed or missed claims intimation to the reinsurer, increasing the risk of claim rejection.	Secure full indemnification by notifying reinsurers within contractual deadlines.	• Reconcile the paid/outstanding claims register against the reinsurance claims notification log. • Identify claims that exceed net retention thresholds and check the date of notification against treaty	• Insurance Regulatory and Development Authority (Preparation of Financial Statements) Regulations, 2002

			deadlines (e.g., 90 days). • Check for any claims currently disputed or rejected by reinsurers due to late notification.	
CLM 02	Inaccurate estimation or missing provisions for reinsurance recoveries on Outstanding Claims and IBNR.	Ensure the accuracy of financial statements and regulatory solvency margins.	• Recalculate reinsurance recovery credits taken for outstanding claims reserves. • Review actuarial valuation reports to ensure IBNR reinsurance recovery factors align with the company's underlying treaty terms and historical recovery ratios.	• IRDAI Master Circular on Actuarial, Finance and Investment Functions, 2024

5. Ind AS 117/ IFRS 17 Modernized Compliance Framework

(Effective from April 1, 2026 reporting cycles)

Risk ID	Risk Description	Control Objective	Illustrative Internal Audit Procedures	Regulatory/ Statutory Reference
IFRS 01	Incorrect portfolio classification and cohort grouping of reinsurance	Ensure compliance with aggregation mandates	• Check that reinsurance contracts held are separated from gross insurance liabilities.	• Ind AS 117 Standard/ IFRS 17

	contracts held.	under Ind AS 117.	• Verify they are divided into distinct portfolios of similar risks and managed together. • Confirm that annual cohorts and profitability groupings (onerous vs. non-onerous) are maintained separately in the sub ledger.	
IFRS 02	Flawed Contractual Service Margin (CSM) calculation and release mechanics for reinsurance held.	Prevent misstatements in net income from incorrect CSM accounting.	• Review the initial recognition calculation: $CSM = \text{Premium} \text{Fulfilment Cash Flows (FCF)}$. • Confirm that any net gain on reinsurance contracts held is deferred and recognized over the coverage period, while loss recovery components are handled correctly. • Recalculate the periodic release	• Actuarial Reserving Guidelines & Ind AS 117

			of CSM based on coverage units provided during the period.	
IFRS 03	Use of unvalidated actuarial assumptions or inconsistent discount rates within Fulfilment Cash Flows (FCF).	Maintain consistency and data integrity across valuation frameworks.	• Review the probability weighted cash flow projections, checking that underlying life parameters (mortality, lapse, expenses) align with historical data. • Verify that the discount rate curve and illiquidity premiums used for reinsurance contracts match the assumptions used for the underlying insurance contracts. • Ensure Non Financial Risk Adjustments (RA) use recognized methods (e.g., VaR) and are disclosed clearly.	• Ind AS 117 Valuation Rules

Emerging Risks in Reinsurance

7.7 Reinsurance arrangements are increasingly in flushed by emerging risks arising from technological developments, alternative risks transfer mechanisms and evolutions financial reports mechanism. Some of emerging risks in reinsurance are as follows:

Cyber Reinsurance

Cyber insurance is one of the fastest growing lines globally reinsurance of cyber portfolios introduces aggregation risk where a single cyber event can trigger thousands of simultaneous claims.

Audit Focus: Verify cyber reinsurance treaties include adequate sub-limits and aggregation clauses. Check silent cyber exposure in non-cyber treaties and verify claims monitoring is linked to reinsurer notification protocols.

Catastrophe Bonds and Alternative Risk Transfer

Insurers are increasingly supplementing traditional reinsurance with CAT bonds and Insurance Linked Securities (ILS). Auditors must assess basis risk the risk that the parametric trigger does not match actual losses.

Audit Focus: Review ILS documentation, trigger mechanism, collateral arrangements and accounting treatment. Verify Board approval and IRDAI compliance for structured arrangements.

Climate Change and Natural Catastrophe Risk

Increasing frequency and severity of natural catastrophes is changing reinsurance pricing and availability dramatically.

Audit Focus: Verify CAT modelling underlying the reinsurance programme reflects updated climate scenarios. Review adequacy of CAT cover limits against maximum probable loss (MPL) estimates. Check whether coverage for emerging climate perils is explicitly addressed in treaties.

IFRS 17/ Ind AS 117 – Reinsurance Contract Held Accounting

IFRS 17 introduces significant changes to reinsurance contract held accounting. Internal audit must assess whether reinsurance contracts are measured consistently with underlying contracts, whether gain at inception

restrictions are complied with and whether recovery of losses is presented separately.

Best Practices in Reinsurance Governance

7.8 Effective reinsurance governance is essential to ensure that reinsurance arrangements are aligned with the insurer's risk appetite, adequately documented, appropriately monitored and supported by robust internal controls. The following practices may be considered by insurers to strengthen reinsurance governance and control:

Governance Framework Essentials

- Board approved Reinsurance Policy defining risk appetite, minimum retention, counterparty concentration limits and minimum credit rating
- Dedicated Reinsurance Committee for oversight of strategy and programme
- Appointed Actuary annually certifies adequacy of reinsurance programme
- Separation of reinsurance placement from accounting, payment and reconciliation functions
- Annual independent review by external reinsurance broker/consultant
- Formal treaty management system with digital repository and automated expiry alerts

Preventive Controls

S. No	Control	Description
1	Pre-binding Authority Check	System blocks risk placement above treaty limits without facultative confirmation logged in system.
2	Rate Lock Control	Reinsurance rates in system can only be changed through authorised IT change request with actuarial sign off.
3	Dual Authorisation for Payment	Two senior officials required to authorise reinsurance premium payment above defined threshold.

4	New Product Clearance	Product launch checklist includes mandatory sign off by reinsurance team confirming treaty coverage exists.

Detective Controls

S. No	Control	Description
1	Monthly RI Premium Reconciliation	Reinsurance premium per system reconciled to reinsurer invoices and accounting entries monthly.
2	Quarterly Intercompany Confirmation	Balance confirmations obtained from all reinsurers quarterly unreconciled items escalated within 30 days.
3	Claims Recovery Ageing Report	Monthly ageing report of outstanding reinsurance recoveries items older than 90 days reviewed by CFO.
4	Unplaced Risk Report	Monthly report of policies with SAR above retention limit not placed with reinsurer.
5	Regulatory Filing Dashboard	Monthly dashboard tracking LR 8 submission, programme filing and Appointed Actuary certification status.

Commonly Observed Irregularities and Deficiencies

7.9 The internal auditor should remain alert to the following aspects:

- Non-approval or late approval of retention policy or reinsurance programme
- Late filing of proposed or final programme
- Absence of evidence for placement hierarchy or lead term selection
- Incomplete treaty wording or delay in receiving signed originals incorrect product wise mapping in system
- Missed cession of risks above retention

- Duplicate or excess cession erroneous premium or commission computation
- Omission of reinstatement premiums or profit commission
- Delayed notification of reinsured claims
- Aged or disputed claims recoverable without escalation
- Non-reconciliation of balances with reinsurers
- Incorrect financial statement classification and
- Non-disclosure of reinsurance obligations not provided for.

Sample Audit Observations

Observation 1: New Product Launched Without Reinsurance Treaty Addendum

Risk Rating: HIGH — Unhedged Mortality/Morbidity Risk Exposure

Finding: A new product was launched with 2,347 policies issued over 53 days before the reinsurance treaty addendum was executed. Total Sum At Risk on these unhedged policies: Rs. 94.2 crore.

Root Cause: The new product launch checklist did not include mandatory gate requiring reinsurance team confirmation before launch approval.

Recommendation: (1) Immediately assess claim risk on unhedged policies and negotiate retroactive coverage. (2) Amend Product Launch Governance Framework to include mandatory Reinsurance Team sign off. (3) Notify CFO of outstanding unhedged exposure.

Observation 2: Reinsurance Premium Reversal Not Processed for Lapsed Policies

Risk Rating: MEDIUM HIGH — Financial Loss (Overpayment)

Finding: 1,182 lapsed policies for which reinsurance premium reversal had not been processed. Estimated overpaid ceded premium: Rs. 31.4 lakhs.

Root Cause: System configuration error for policies with specific premium modes (half yearly and quarterly) caused automated reversal trigger to fail.

Recommendation: (1) Raise debit note on reinsurer for Rs. 31.4 lakhs recovery. (2) Raise IT defect for immediate resolution. (3) Implement monthly reconciliation control: lapse register vs. RI reversal entries.

Observation 3: Excess Cover Not Declared to Reinsurer

Risk Rating: HIGH — Coverage Gap & Potential Claim Rejection

Finding: 45 policies with Sum At Risk exceeding the treaty retention limit of Rs. 5 crore were not declared to the reinsurer. Total excess SAR: Rs. 28.6 crore. One claim of Rs. 4.2 crore already paid entirely by the ceding company. **Root Cause:** Underwriting system did not automatically flag policies exceeding retention limit manual review was skipped during high volume period.

Recommendation: (1) Immediately notify reinsurer and negotiate retroactive cover for the 45 policies. (2) Configure underwriting system to block/flag policies exceeding retention limit automatically. (3) Train underwriters on retention limits and implement dual approval for excess cases.

Observation 4: Reinsurance Commission Not Received for 892 Policies

Risk Rating: MEDIUM — Financial Loss (Under Receival)

Finding: Reinsurance commission of Rs. 22.7 lakhs due on 892 policies (issued in Q3–Q4 2025) was not credited by reinsurer. Reconciliation statement not prepared since June 2025.

Root Cause: No periodic reconciliation between ceding company's premium register and reinsurer's statement commission calculation sheet not updated for product wise sliding scale.

Recommendation: (1) Prepare reconciliation statement and raise debit note for Rs. 22.7 lakhs. (2) Implement monthly reconciliation control with variance escalation. (3) Automate commission calculation using product wise sliding scale in ERP.

Observation 5: Anti Selection Risk Not Assessed Before Bulk Reinsurance

Risk Rating: HIGH — Adverse Selection & Poor Risk Pooling

Finding: 1,560 policies from a corporate group (higher morbidity due to age profile) were ceded under standard treaty without separate anti selection assessment. Expected loss ratio 35% higher than treaty average.

Root Cause: Group bulk cession treated as standard portfolio no separate underwriting review or rating adjustment.

Recommendation: (1) Request reinsurer to review and adjust premium rate for the corporate block. (2) Amend treaty guidelines to mandate anti selection assessment for bulk cessions >500 lives. (3) Implement age wise and occupation wise risk grading before cession.

Observation 6: Claim Notice to Reinsurer Delayed Beyond Contractual Limit

Risk Rating: MEDIUM HIGH — Claim Rejection Risk

Finding: 23 death claims (total SAR Rs. 18.4 crore) were reported to reinsurer after 90 day contractual notice period. 5 claims already disputed by reinsurer.

Root Cause: Claims department not linked to reinsurance module no automated alert when claim amount exceeds retention.

Recommendation: (1) Expedite notice for remaining 18 claims and negotiate waiver of delay. (2) Integrate claims module with reinsurance system for automatic notice trigger. (3) Implement weekly claim vs. reinsurance register review.

Observation 7: Facultative Certificate Not Execrated for High Risk Case

Risk Rating: HIGH — Unhedged Risk Exposure

Finding: A key executive life cover (Sum At Risk Rs. 12 crore, smoker with hypertension) was issued without facultative reinsurance certificate. Policy retained entirely on company books.

Root Cause: Underwriter unaware that case exceeded both treaty retention and mandatory facultative threshold (Rs. 8 crore).

Recommendation: (1) Immediately approach reinsurer for late facultative placement. (2) Update underwriting manual with clear facultative threshold matrix. (3) Add mandatory facultative checklist in underwriting approval workflow.

Observation 8: Reinsurance Premium Not Paid Within Discount Period

Risk Rating: LOW MEDIUM — Financial Loss (Lost Discount)

Finding: Reinsurance premium of Rs. 4.8 crore for FY 2024–25 was paid 45 days late, resulting in foregone early payment discount of 2% (Rs. 9.6 lakhs).

Root Cause: Finance team not alerted about payment due date no calendar reminder for reinsurance premium deadlines.

Recommendation: (1) Negotiate with reinsurer for partial discount restoration. (2) Implement automated payment reminder 30 days before due date. (3) Assign ownership to Reinsurance Manager for premium payment tracking.

Observation 9: Data Mismatch Between Policy Admin System and Reinsurance Schedule

Risk Rating: MEDIUM — Reporting Inaccuracy & Regulatory Risk

Finding: 312 policies showed mismatch in date of birth, sum assured, or premium mode between policy admin system and reinsurer's annual schedule. Error rate: 4.2%.

Root Cause: Manual data entry at cession no automated data validation between systems.

Recommendation: (1) Conduct data cleansing exercise for all mismatched policies. (2) Implement system to system interface with automated validation rules. (3) Perform quarterly data quality audit with error rate tracking.

Observation 10: Treaty Expiry Not Tracked Renewal Negotiation Delayed

Risk Rating: HIGH — Coverage Gap at Renewal

Finding: Proportional treaty expired on 31 Dec 2025 renewal agreement not signed until 15 Mar 2026 (74 day gap). 1,089 policies issued during gap were unhedged.

Root Cause: No treaty renewal tracker responsibility not assigned negotiations started only 2 weeks before expiry.

Recommendation: (1) Negotiate retroactive renewal cover for 74 day gap period. (2) Implement treaty expiry tracker with 180 day, 90 day and 30 day alerts. (3) Assign treaty renewal ownership to Head of Reinsurance with board level escalation.

Ind AS 117 Compliance for Life Reinsurance Companies

7.10 Ind AS 117 compliances for a Life Reinsurance Company are effective from April 1, 2026. This framework streamlines the transition from Ind AS 104 focusing on system changes, actuarial models and financial reporting.

Internal Audit Framework

S. No	Audit Phase/Component	Key Focus & Internal Audit Procedures
1	Planning, Scope & Risk	• Verify application to all insurance, reinsurance issued, ceded reinsurance (held) and investment contracts with discretionary participation features. • Establish materiality thresholds for contract portfolios, CSM balances and disclosure items. • Assess high-risk areas: CSM calculations, cash flow assumptions, discount rates and contract grouping.
2	Contract Classification & Grouping	• Test that contracts transfer significant insurance risk. • Separate non-insurance components where required. • Confirm contract aggregation into distinct portfolios (similar risk), annual cohorts (same year of issue) and three profitability cohorts (onerous, no significant loss risk, remaining).
3	Measurement Models	• Validate the selection of the General Measurement Model (GMM), Variable Fee Approach (VFA), or Premium Allocation Approach (PAA). • For PAA, confirm coverage period is less than or equal to 1 year or that

		results do not materially differ from GMM.
4	Fulfilment Cash Flows (FCF) & Risk Adjustment	• Test life actuarial assumptions (morbidity, mortality, lapse rates, expenses) against historical data and market benchmarks. • Audit probability weighted cash flow projections, discount rate methodologies and illiquidity premiums. • Verify non-financial risk adjustments use appropriate methods (Confidence level, VaR, or momentum) and are disclosed separately.
5	Contractual Service Margin (CSM) Mechanics	• Recalculate initial recognition: CSM = Premium Fulfilment Cash Flows. • Ensure negative CSM (onerous contracts) is immediately recognized in P&L. • Audit period roll-forwards, locked-in interest rates and systematic release over the coverage period based on services provided (not premium timing).
6	Reinsurance Specific Risks	• Ensure ceded reinsurance (reinsurance held) is measured separately with its own CSM, recognizing gains/losses systematically. • Audit counterparty risk assessments and impairment testing for reinsurance receivables.

		• Test the accounting treatment of retroactive reinsurance contracts covering historical events.
7	IT Systems & Data Integrity	• Validate data processing accuracy across new actuarial and accounting systems. • Ensure contract-level data granularity for cash flow projections and CSM calculations. • Review model change management, version controls and user access controls.
8	Transition, Parallel Reporting & Disclosures	• Validate retrospective application methods and the calculation of opening CSM balances. • Verify compliance with the 2-year parallel reporting mandate (Ind AS + existing framework) • Check disclosures for significant judgments, CSM reconciliation schedules and risk sensitivities.
9	Internal Controls Testing	• Test management review controls over actuarial assumptions and model outputs. • Verify regular reconciliations between actuarial data and finance data. • Confirm appropriate segregation of duties among actuarial, finance and IT functions.

Substantive Testing Sampling Guide

7.11 For detailed transaction and contract testing, select audit samples from the following categories:

- **Top 10 largest reinsurance contracts** measured by premium or CSM volume.
- **Onerous contracts** displaying a negative CSM at inception.
- **Contracts with significant assumption changes** during the financial period.
- **Reinsurance held (ceded)** portfolios to check separate asset asset/CSM tracking.
- **Boundary contracts** that are running close to the end of their designated coverage period.

Conclusion

Reinsurance is the financial bedrock of any insurer's risk management architecture. A well designed and effectively operated reinsurance programme protects policyholders, stabilises financial results and supports IRDAI's mandate of ensuring solvency across the industry. Internal audit of reinsurance must evolve beyond mechanical treaty compliance to encompass governance adequacy, structural integrity, operational accuracy, regulatory adherence, counterparty risk management, emerging risk coverage and technology leverage. The procedures and checklists in this guide are intended to support comprehensive and effective internal audit practice in this critical area.

List of Important Acts, Regulations, Circulars, Guidelines and Other References

Source	Issuing authority	Date/ year	Relevant section/ regulation / chapter	Link
IRDAI (Re-insurance) Regulations, 2018	IRDAI	12 December 2018	Regulations 3 to 8 and 10 read with amendments	**https://irdai.gov.in/document detail?documentId=390206**

IRDAI (Re-insurance) (Amendment) Regulations, 2023	IRDAI	23 August 2023	Amendments to Regulations 3, 4, 5 and 6.	**https://irdai.gov.in/document detail?documentId=3791151**
IRDAI Consolidated Re-insurance Regulations	IRDAI	Consolidated version hosted 31 May 2024	Consolidated text of the 2018 regulations as amended up to 23 August 2023	**https://irdai.gov.in/document detail?documentId=5170524**
Master Circular on Reinsurance	IRDAI	31 May 2024	Chapter II and appendices on reinsurance programme and related submissions	**https://irdai.gov.in/document detail?documentId=4974650**
Master Circular on Submission of Returns, 2024	IRDAI	14 June 2024	Return matrix including IRDAI_RET_51 to IRDAI_RET_60	**https://irdai.gov.in/document detail?documentId=5050759**
IRDAI (Registration and	IRDAI	1 April 2024	Relevant chapters on	**https://irdai.gov.in/web/guest/document**

operations of Foreign Reinsurers Branches and Lloyd's India) Regulations, 2024			registration and operation of FRBs and Lloyd's India	**detail?documentId =4591301**
Guidelines on filing of Re-insurance arrangements with the IRDAI, Ref. IRDAI/RI/ GDL/MISC /038/01/2020	IRDAI	31 January 2020	Entire guideline	**https://irdai.gov.in/ document detail?documentId =393531**
Master Circular on Corporate Governance for Insurers, 2024	IRDAI	22 May 2024	Provisions on Audit Committee, Risk Management Committee and internal audit	**https://irdai.gov.in/ web/guest/document detail?documentId =4916164**
Master Circular on Actuarial, Finance and	IRDAI	17 May 2024	Chapter on finance function and accounting	**https://irdai.gov.in/ document detail?documentId =4907769**

Investment Functions of Insurers			guidance, including ART substance over form discussion	
Insurance Regulatory and Development Authority (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002	IRDAI	30 March 2002	Regulation 3 Schedule A Schedule B Schedule C	**https://irdai.gov.in/document detail?documentId =603541**

Chapter 8
Policy Servicing

Introduction

8.1 Insurance policy servicing means managing an insurance policy after it is bought. It includes everyday tasks like updating personal information or paying premiums. When you buy an insurance policy, it's not just a one-time transaction. Insurance policy servicing keeps the policy active and fit for your needs over time. This includes making changes, answering questions and handling claims. Good servicing means you get the right coverage when you need it and avoid missed payments or outdated info.

Insurance policy servicing covers many tasks, such as:

(i) Processing and accounting of renewal premium

(ii) Processing premium payments

(iii) Renewing policies

(iv) Handling claims or certificate issuance

(v) Policy Lapse and processing of revival requests

(vi) Processing of surrender requests

(vii) Processing of change of name/ address/ payment mode, nomination/ assignment requests

(viii) ULIP policy servicing–Fund top up and switch in

Renewal Premium Processing

8.2 **Renewal premium** means "a premium paid to renew insurance". It is a fixed amount that is paid for a fixed period in consideration of insurance policy. A life insurance policy remains active only if renewal premiums are paid on or before the due date (or within the grace period allowed by the insurer).

Typical Renewal Process

- Insurer sends premium due reminders through SMS, email, WhatsApp, or physical notice.

- Policyholder pays the renewal premium through the chosen payment channel.
- Payment is acknowledged immediately or within a few working days, depending on the mode used.
- A premium receipt is generated and sent to the policyholder.
- The policy continues uninterrupted if the premium is received within the due date or grace period.

IRDAI Guidelines & Policy Protection

If the Renewal payment, the IRDAI allows a grace period (usually 15 days for monthly modes and 30 days for quarterly, half yearly and annual payment modes). The policy remains fully active during this time.

Revival Period

Under the IRDAI Master Circular on Life Insurance Products dated 12 June 2024 (Ref: IRDAI/ACTL/MSTCIR/MISC/89/6/2024), for discontinued/lapsed policies, insurers are required to provide a revival period of three years from the date of the first unpaid premium in specified cases, particularly ULIPs and discontinued policies covered under the circular. A lapsed policy may be revived within the revival period specified in the policy document and applicable IRDAI regulations by payment of all due premiums together with applicable interest/late fee and fulfilment of underwriting requirements, including submission of a declaration of good health and/or medical examination, wherever required. Standardized Disclosures: The IRDAI mandates that insurers clearly disclose all terms, rider details and surrender values to policyholders

Renewal Payment Modes

Life insurance renewal payment can be made through several secure, standard channels as follows:

Online Payment Methods

- **Insurer's Official Portal:** Visit your life insurance provider’s official and use the "Pay Premium" or "Renewal" section.
- **Net Banking & UPI:** Use your bank’s Net Banking portal, or apps like Google Pay, PhonePe and Paytm. Navigate to the "Insurance" or "Bill Payments" category, select your provider and enter your policy number.

- **Auto Debit Setup:** You can register a standing instruction or auto debit on your Credit/Debit Card or Bank Account to avoid missing due dates.

Offline Payment Methods

- **Branch Office:** Visit the nearest branch office of your life insurance provider to pay by cash, cheque, or Demand Draft (DD).
- **Authorized Kiosks/Partners:** Premium payments can often be processed at retailer shops enabled on the Bharat Bill Payment System (BBPS) up to specific transactional limits.
- **Authorised Collection Centres/ Agents:** Payment through authorized collection centres or agents

Audit Objectives

The primary objective of the audit is to check and confirm that renewal premium is received as per the due dates and has been processed in time and updated against the correct policy number in the system, appropriate Net Asset Value (NAV) has been applied while unitizing the premium received and that the necessary accounting entries have been passed in the accounting system for the premium received during the day.

The internal audit in this regard would normally cover the following:

(i) Process for receipt of premium through different mode necessary updation in system

(ii) Monitoring of premium due dates and sending of notices to the policy holder

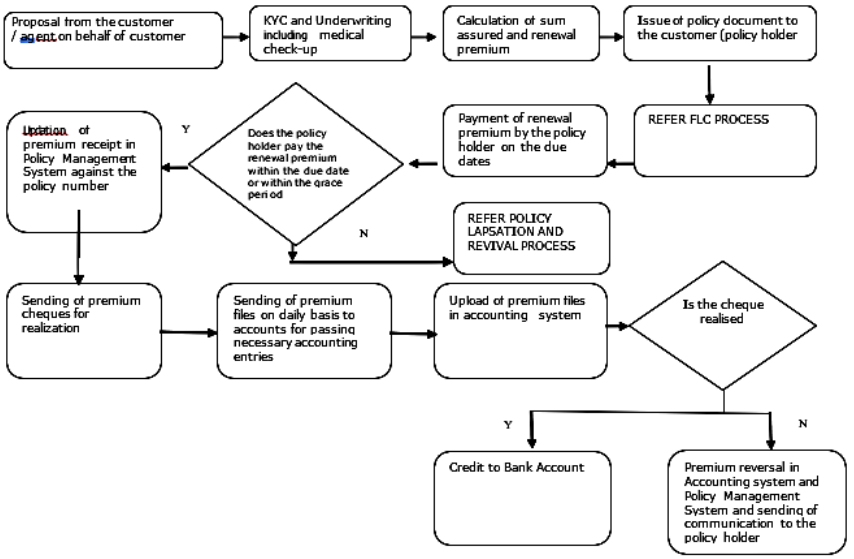
(iii) Timeliness for processing of premium proceeds received and consequent unit allocation

(iv) Application of correct NAV

(v) Process of updation of EFT/ECS against the policy number

(vi) Process for revenue recognition

(vii) Process and controls for marking lapsation in case of non-receipt of premium.



Illustrative Internal Audit Checklist

S. No	Risks	Internal Audit Procedures
1	Incorrect billing of premium	• Check existence of adequate controls at new business stage for updation of correct details of the policy and accurate due dates in the system • Check whether the system generates notices based on the due dates entered • Check whether adequate monitoring is in place in the form of checklist to ensure that notices are generated with accurate due dates and premium amounts from the system • Whether these notices are verified by the policy servicing department to

		ensure correctness and dispatched on timely basis. • Check the TAT for dispatch of notices.
2	Incorrect NAV application	• Check whether NAV is correctly applied.
3	Data entry errors/ incorrect updation of renewal premium like the following may lead to incorrect "lapsation" of the policy: • Against different policy number • Incorrect amount	• Check existence of adequate controls at branches/processing centers. • Adequate checking of policy number, cheque number, signature, etc. on receipt of instruments. • Check the condition of the instrument — mutilated/stale cheques, post-dated cheques. • Ensure adequate maker-checker controls exist at the receiving point for verification of instruments. • System controls for entering details — whether available only with selected employees. • Existence of maker-checker control for entering the details in the PMS. • Also check whether the branch checklist contains all the above points and is signed-off by the maker and the reviewer.
4	Delays in processing of renewal premium: Since the number of transactions involving renewal premiums is voluminous, there may be delays in entering the details of the cheques	• Check whether the process for data entry in PMS is clearly defined as part of the Standard Operating procedures and is monitored on regular basis. • Check whether adequate checklists are in place to monitor the daily activities in the branches.

	received at the branches/ processing centres. Also there is possibility of certain cheques missed out for entry in the PMS.	• Check whether instruments received are entered in the system on the same day especially in the case of ULIPs. • Check whether reconciliation is done on daily basis between the instruments received and details entered in the system. • Check whether MIS of the instruments received on daily basis is maintained and tallied with the number of instruments before sending the details to accounts team.
5	Incorrect revenue recognition	• Premium received before due date shouldn't be recognized as premium. • Whether premium due but not received is monitored on monthly/fortnightly basis and appropriate changes in the policy status is verified. • All the premium recorded in PMS to be matched with the premium account in the books of account. • Check whether daily premium reconciliation is in place for various products vis ULIP/ Non ULIP/Group products between PMS and accounting system. Ensure there is no manual intervention of data repair during this process. • Check completeness of accounting of all the cheques received at branches. Whether MIS is maintained at the branches for cheques received and the same is

		tallied with the entries made in the PMS and accounting system. • Check the process of passing reversal entries in the system. Whether reversal entries are supported with valid reasons such as the payments rejected due to insufficient funds in the customer account, signature mismatch, invalid accounts, etc. Check whether the reversal entries are passed in both the PMS and the accounting system. • Also check the impact of NAV in case of reversal. • Premium received is accounted on due date. • Check procedures for monitoring of Suspense Accounts i.e. partial premium received or premium received in advance.
6	Non receipt of premium thereby affecting the insurer's business	• Imparting of regular trainings to the agents about the product features and in turn communication with the policy holders. • Rewards and recognition for the agents who are able to recover policy premiums from the policy holder on timely basis. • Check whether adequate follow up is done by the insurer with the policy holders on regular basis by sending letters/emails.
7	Incorrect updation of credit card details/ credit card not in the name of policy holder	• Check whether the insurer has adequate controls in place to check whether the credit card is only in the

		name of policy holder and that the credit card is valid. • Whether signature verification is done with the original proposal form. • Whether credit card as a mode of payment is activated in the PMS only after checking the above details. • Whether activation letters are sent to the policy-holder on timely basis. • Check whether credit card number is recorded in PMS or any other equivalent system with encryption. As per PCI DSS (Payment Card Industry Data Security Standards), the numbers should not be captured by the merchant in an open form.
8	Incorrect updation of account details in case of ECS payments	• Check existence of adequate controls in place to ensure that the bank account details provided by the policy holder are correct. • Check whether there are maker checker control to ensure that details regarding bank accounts sent to the vendor are correct.
9	Policy premiums in case of group policies	• Check whether renewal premiums are received from the master policy holder/ authorized person within the due dates. • Check whether addition/ deletion to the policy cover is signed by the master policy holder/authorized person.

Free look Cancellation (FLC)

8.3 As per clause 6(2) of IRDA (Protection of Policyholders Interest) Regulations, 2002, "the insurer shall inform by the letter forwarding the policy that he has a period of 15 days from the date of receipt of the policy document to review the terms and conditions of the policy and where the insured disagrees to any of those terms or conditions, he has the option to return the policy stating the reasons for his objection, when he shall be entitled to a refund of the premium paid, subject only to a deduction of a proportionate risk premium for the period or cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges."

Accordingly, FLC is an option provided to the policyholder wherein he has a period of 15 days from the date of receipt of the policy document to review the Terms & Conditions of the policy and in case of disagreement to any of the terms & conditions, he/ she has the option to return the policy stating the reason for policy's cancellation.

FLC requests can be received through any mode — e-mail, fax and letters depending on insurer's policy. In case of written letters, the signature of the policy holder should be matched with the original proposal form. FLC request is processed only when the policy holder is not satisfied with the terms and conditions of the policy document and not for any other reasons. FLC refund is paid either by cheque or in case the policy holder wants direct credit, then consent for direct credit along with cancelled cheque for bank account details is submitted.

FLC refund is calculated as follows:

First Premium Paid – Proportionate Risk Premium – Medical Examination Expenses (if any) – Stamp Duty Charges (and ULIP related adjustments, where applicable).

The primary objective of the audit is to check and confirm that FLC requests are received within 15 days from receipt of policy document by the policy holder, verification of signatures of the policy holder and processing of FLC request within TAT defined by the insurer. Also checking of appropriate accounting entries are recorded for refund.

The internal audit in this regard would normally cover:

(i) Process for receipt of FLC requests

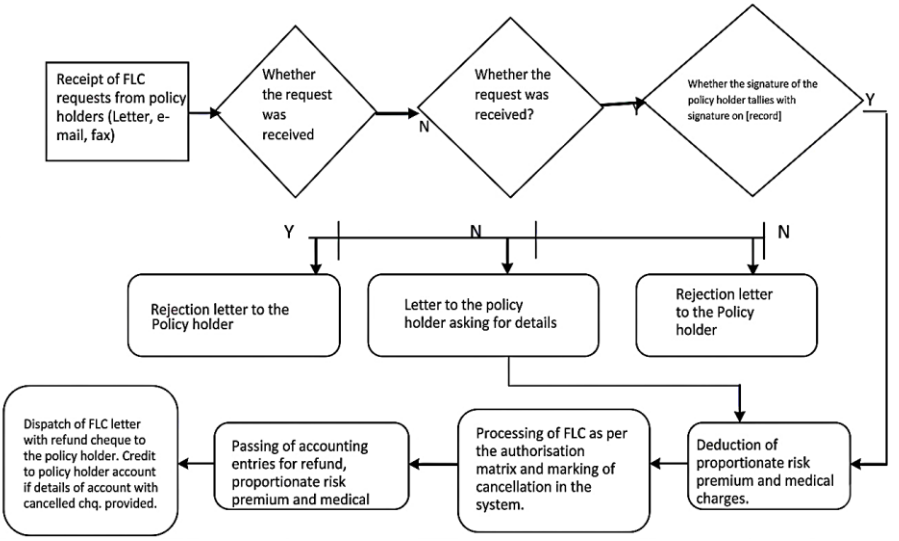
(ii) Signature verification and genuineness of request — whether it was due to non-satisfaction with the terms and conditions of the policy

(iii) Timeliness for processing of FLC

(iv) Process of updating of FLC against the policy number

(v) Process for passing accounting entries

(vi) Checking of FLC refund amount and dispatching to the policy holder



Illustrative Internal Audit Checklist

S. No	Risks	Internal Audit Procedures
1	FLC request is not received withn 15 days from receipt of policy documents	• Check whether stamp is affixed on the FLC requests received at the Branches • Check whether FLC is processed only if it is received within 15 days from receipt of policy document. Since in most of the situation the policy receipt date is not available, the period within which FLC request can be received should be mentioned in the insurer's policy.

2	Forged signatures on FLC requests	• Check existence of checklists for FLC processing which would involve signature verification with the original proposal form, witness signature in case of thumb impression/ request in vernacular language • Check existence of maker checker control for FLC processing.
3	Duplicate FLC requests	• Check whether FLC is marked in the system immediately on verification of relevant documents and signature verification • Check whether the insurer has a system of affixing "cancelled" stamp on the original policy document once FLC has been processed.
4	Delay in processing FLC request	• Whether checks are in place to ensure that in case of ULIP product, the FLC has been processed on the same day • Whether date and time of inward should be affixed on the requests and sent to CPC for further processing • Check the timeliness for processing of FLC request.
5	Incorrect calculation of FLC amount	• Check whether adequate maker checker controls are in place for processing of FLC. If the refund amount is calculated through system, check whether system parameters for calculation of refund are reviewed on regular basis. • Whether authorization for approving the refund amount in the system is available only with few people

		• Check whether appropriate risk premium and medical charge are deducted from the premium amount.
6	Incorrect refund of FLC	• Check whether FLC refund cheques are verified for name and amount before dispatch to the policy holder.
7	Incorrect credit of FLC amount. Since FLC amount can also be directly credited to policy holder account on receipt of request from him, there is risk of the amount being credited to incorrect bank account.	• Whether the insurer has adequate checks in place to ensure that the account number mentioned in the FLC request form matches with the cancelled cheque provided by the policy holder • Check whether the account number mentioned is that of the agent by checking it with the agent master data.
8	Non-deduction of commission	• Check whether adequate information is flowing back to commission processing system for recovery • Check if FLC under processing just before commission cycle are informed separately to commission processing team to withhold commission.
9	Reputational risks due to mis-selling	• Adequate monitoring of agent wise FLC requests, since there is a possibility that the agents may not have explained the correct policy features to the policy holder and may have got the business by mis selling the product • Check action taken by the insurer on the agent having large number of FLC requests • Check whether FLC is processed only if it is received due to non-satisfaction of terms and conditions of the policy document and not for any other reason

Policy Lapse and Revival

8.4 "Lapse" is the discontinuance of the policy owing to non-payment of premium dues. The term "lapse" is not defined in the insurance legislation, except stating that *"a policy which has acquired a surrender value shall be kept alive to the extend of the paid up sum assured"* vide section 113(2) of the Insurance Act, 1938.

An insurance policy lapses when a premium payment is missed and the grace period expires. Under IRDAI guidelines, the typical window is up to 3 years from the date of the first unpaid premium to revive an insurance policy. Reactivating it restores your coverage, though it requires paying overdue premiums with interest.

Lapsation affects all the stakeholders Lapsation affects all the stakeholders the policy holder, agents and the insurer. A lapsed policy ceases to provide insurance protection to the insured. It forfeits the benefits under the policy and cost of new policy is higher. Agents do not get renewal premium commission if the policy is lapsed. It is permanent and irreparable loss to the agent. Lapsation means a loss of goodwill to the insurer. With early lapse, the insurance companies are not able to recover the procuration cost. The agents' compensation in terms of high first year commission, bonuses and rewards prove unproductive. The cash flows get impacted and hits profitability and embedded value.

The terms and conditions of the policy stipulate, that where the premium is not paid within the grace period, the policy lapses but may be revived during the life time of the life assured. Some insurers do not allow revival, if the policy has remained in lapsed condition for more than three years. This is because of the possibility that the arrears of premiums on such a policy would be too heavy and that it would be better to take out a fresh policy.

As per clause 3 of IRDA (Treatment of Discontinued Linked Insurance Policies) Regulations, 2010 pertaining to ULIPs, *"The grace period for payment of the premium for all types of linked insurance policies shall be as follows:*

(i) Fifteen days, where the policyholder pays the premium on monthly basis,

(ii) Thirty days, in all other cases."

As per clause 1(vi) of the said regulation, *"Discontinuance means the state of the policy that could arise on account of non-payment of the contracted premium due before the expiry of the notice period,"* The notice has to be sent

by the insurer within a period of fifteen days from the expiry of the grace period to the policy holder to exercise the option within a period of thirty days of receipt of such notice

As per clause 1(vii) of the said Regulation, *"Lock in period means the period of five consecutive years from the date of commencement of the policy, during which the proceeds of the discontinued policies cannot be paid by the insurer to the policy holder or to the insured, as the case may be, except in the case of death or upon the happening of any contingency covered under the policy,"*

As per clause 4 of the Regulation, *"A policyholder shall be entitled to exercise one of the following options upon the discontinuance of the policy:*

(i) Revival of the policy, or

(ii) Complete withdrawal from the policy without any risk cover.

For revival of polices, generally, policy holder as to:

(i) Provide pay the arrears of outstanding premiums with interest

(ii) proof of health

(iii) pay a fee for reinstatement or revival

The Revival Process

To revive a lapsed policy, the following steps are followed:

- **To contact the Insurer:** To reach out to the service provider to get the exact outstanding amount and requirements.
- **Clear Overdue Premiums:** To pay all missed premiums along with applicable late fees or interest (usually between 12% to 18%).
- **Submit Health Proof:** If the policy has been lapsed for more than 6 months, one may need to submit a Declaration of Good Health (DGH) or undergo a medical examination to prove insurability.

Key IRDAI Guidelines and Exceptions

- **Traditional Term Plans:** The IRDAI mandates a standard revival period of up to 3 years for continuous coverage and full sum assured.
- **Unit Linked Policies (ULPs):** If the policy is a ULIP, it can be revived within a 2-year window from the date of discontinuance, regardless of whether the initial lock-in period has expired.

- **Paid-up Value:** If the policy is not revived, it may acquire a paid-up status with a reduced sum assured or the surrender value may be paid to you.

Consequences of a Long Lapsation

The longer the wait to revive a policy, the more difficult and expensive the process becomes. If the policy is lapsed for a prolonged period, insurers have the discretion to apply fresh terms, increase premiums or request more rigorous medical checks.

The IRDAI Master Circular on Life Insurance Products mandates specific timelines and protections to help policyholders restart their coverage.

General Revival Windows

If the grace period is missed, the policy transitions into a lapsed state. The IRDAI protects the right to revive it within a specific legal timeframe:

- **Traditional Plans:** Insurers offer a 3 to 5-year revival window from the date of the first unpaid premium, depending on the specific product design.
- **Unit Linked Plans (ULIPs):** ULIPs get a 3-year window to reactivate one's investments and risk cover.
- **Mandatory Communication:** Under current IRDAI guidelines, the insurance provider must formally alert the insured of the policy lapse and outline a revival options within 3 months of the missed due date.

Requirements and Medical Forms

Bringing a policy back to life requires fulfilling precise administrative and underwriting criteria:

Days Since Lapse	Typical Requirement	Medical Evidence Needed
1 to 180 Days	Arrears + Interest	None (Usually a simple online auto revival)
181 Days to 1 Year	Arrears + Interest + Minor Penalty	Declaration of Good Health (DGH)
Over 1 Year	Full Arrears + Compound Interest	Fresh Medical Examination/ Full Health Reports

- **Standard Health Declarations:** Major public insurers like LIC require specific physical paperwork, such as **Form 680** or **Form 700**, depending on how long the plan has been inactive.
- **Special Revival Campaigns:** Insurers like LIC frequently run Special Revival Campaigns that provide **late fee concessions of up to 30%** (capped around ₹5,000) and allow reactivations up to 5 years down the line. However, these campaigns do not waive health verification checks.

Legal Position

IRDAI Master Circular, 2024

The governing rule is continued in the IRDAI Master Circular on Life Insurance Products, Ref IRDAI/ACTL/MSTCIR/MISC/89/6/2024, dated 12 June 2024, issued by the Insurance Regulatory and Development Authority of India (IRDAI) under the Insurance Act, 1938. (Refer irdai.gov.in and policyholder.gov.in.)

This circular fixes four protections every policyholder should know:

- **Grace period:** The Circular specifies a grace period of 15 days for monthly premium mode and 30 days for other modes. A policy lapses only after this period ends with the premium still unpaid.
- **Revival period:** All discontinued or lapsed policies must be given a revival period of three years from the date of the first unpaid premium.
- **Status communication:** The insurer must communicate the status of the policy to the insured within three months of the first unpaid premium and offer the revival option.
- **Restoration:** Reviving within the revival period restores the full sum assured and benefits, subject to the policy terms.

IRDAI and the Life Insurance Corporation (LIC) are public authorities under the RTI Act, 2005, so one can therefore invoke the RTI to obtain his/her policy and complaint records, even though revival itself is the insurer's process.

Step by Step Revival

1. **Read the Lapse or Status letter:** Note the date of the first unpaid premium. The three-year clock runs from that date, not from when the insured got the letter.

2. **Ask for a Revival Quote:** Contact the insurer branch, app, or call centre and ask for the exact overdue amount, including premiums plus interest or late fee.

3. **Check the Health Requirement:** For short lapses many insurers accept a simple declaration of good health. For longer lapses you may need a fresh medical examination.

4. **Fill the Revival Form:** Get Form for revival from the branch or website, attach the health declaration and sign it.

5. **Pay All Dues Together:** Pay all overdue premium plus interest or late fee in one go. Keep the receipt and transaction reference.

6. **Get Written Confirmation:** Insist on a revival endorsement or letter confirming the policy is in force and the sum assured restored.

7. **If Refused, Escalate:** Use the grievance route given below:

insurer GRO, > IRDAI Bima Bharosa portal, > Insurance Ombudsman.

Documents Required

- Lapse or discontinuance letter from the insurer
- Original policy document or policy number
- Revival form and declaration of good health
- Medical reports, if the insurer requires a fresh examination
- Proof of payment for all overdue premiums plus interest
- Identity and address proof and a recent bank statement
- Nominee details, if any update is needed

Common Mistakes by a Policy Holder

- **Waiting past three years:** Once the revival period ends, the insurer is not bound to revive on the old terms.
- **Paying only one premium:** Revival needs all overdue premiums plus interest cleared together, not just the latest one.
- **Hiding a health change:** A false health declaration can void the revived policy at claim time. Disclose honestly.

- **Ignoring the status letter:** The insurer must write within three months under the Master Circular 2024. Use that letter do not bin it.
- **No written endorsement:** Verbal assurance is not proof. Get the revival confirmed on paper or by email.

RTI Angle

RTI cannot force an insurer to revive any policy, but it is a powerful tool to obtain records held by IRDAI or LIC as public authorities under the RTI Act, 2005. If one's complaint stalls, he/she can file an RTI application to get the complaint file, the policy status noting, or the dates on which the insurer communicated the lapse and revival options. This builds evidence for your Ombudsman case.

Grievance route, if revival is refused:

- **Insurer Grievance Redressal Officer (GRO):** Write to insurer's GRO first. Contact lists are at irdai.gov.in/list of gros.
- **IRDAI Bima Bharosa Portal:** If unresolved, register at bimabharosa.irdai.gov.in and track the token number generated.
- **Insurance Ombudsman:** If still unresolved, approach the Insurance Ombudsman, an independent mediator. Find offices at cioins.co.in.

Internal Audit of Lapsed and Revived Insurance Policies

The primary objective of the internal audit is to check and confirm that due dates are recorded and monitored properly and polices are marked as "lapsed" on non-receipt of renewal premium within due dates/grace period. In case of revival request, check whether adequate checks are in place for receipt of outstanding amounts and adequate documents are obtained before reviving the policy.

The insurer should have taken persistent measures for monitoring receipt of renewal premium within the due dates. In case of most of insurers, policy lapsation is tracked over the Policy Management System (PMS), wherein premium due dates are monitored by the system once initial data of the policy is entered in the system.

The internal audit process should cover:

(i) Process for updation and tracking due dates

(ii) Marking of “lapsed” status in the system

(iii) Process of issuance of lapse notice and records of dispatch as it is a mandatory requirement

(iv) Signature verification of revival request

(v) Timeliness for processing of revival request

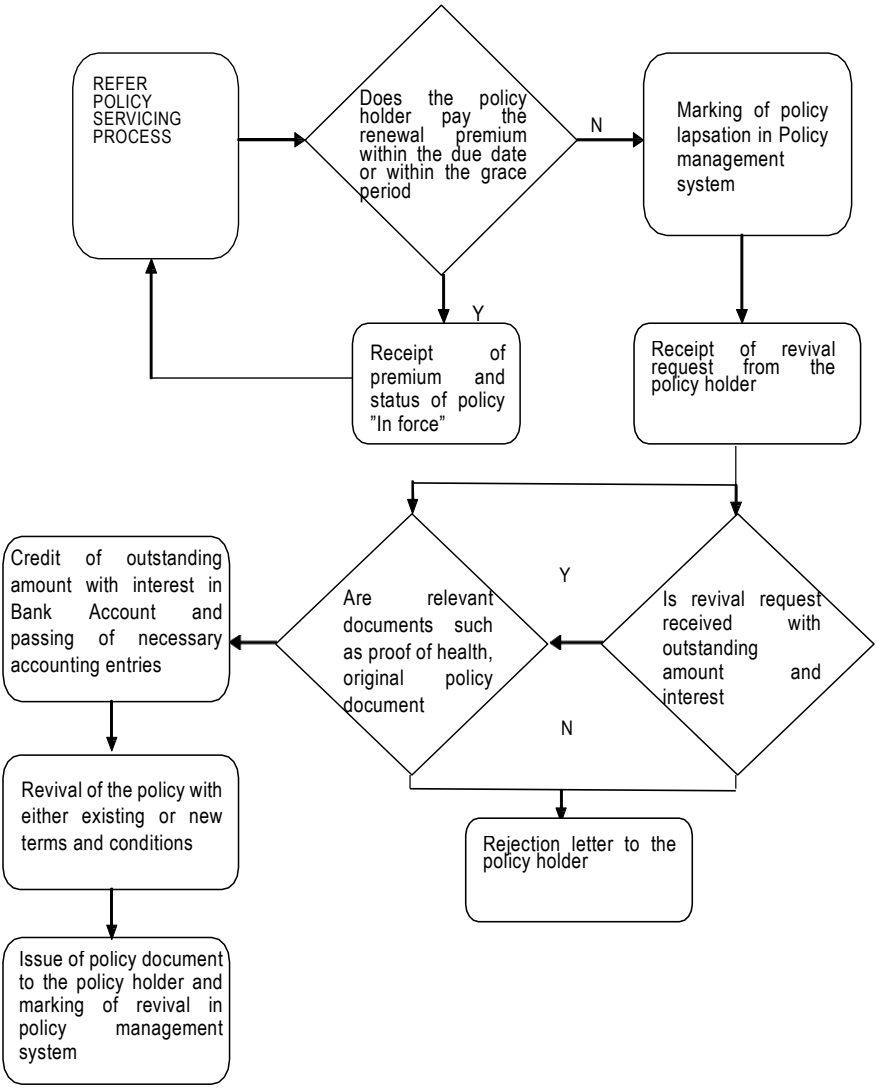
(vi) Process of updation of revival against the policy number

(vii) Process for passing accounting entries

(viii) Communication to the policy holder

(ix) Calculation of outstanding amount, interest and revival charges Agent wise policy lapsation.

Process Flowchart of Lapsed and Revived Insurance Policies



Internal Audit Checklist

S. No	Risks	Internal Audit Procedures
1	Incorrect tracking of due dates in the system	• Check whether maker — checker controls are in place for entering the details in the system when a new policy is issued to ensure that details such as premium amount, renewal premium due dates, etc. are correctly updated in the system as per the policy document. • Whether periodic reviews of the system is done to check whether the due date calculation is done properly. • Check whether grace period of 15/30 days is given to the policy holder for payment of renewal premium. If the premium amount is not paid during the grace period also whether the policy is marked as “lapsed”.
2	Incorrect updation of policy details	• Check the controls at the Branches and processing centre for receiving premium cheques and recording of relevant entries in the PMS for receipt of premium. • Check existence of maker checker controls to ensure the premium received is updated against the correct policy number.
3	Processing of revival request without receiving relevant documents	• Check as per the insurer's internal policies whether declaration of health is received and checked by the medical officer of the insurer. • Check whether Proof of Health is signed by life assured/ policy holder and duly witnessed. In thumb impression cases,

		check whether it is witnessed by a bank manager/ gazetted officer. In the case of minor life assured becoming a major the revival request is signed by life assured only. Also check whether his/her signature is attested by a bank manager/ gazzetted officer. • Check whether all such cases are routed through underwriting or a similar department to ensure a fresh look at the health of the life assured.
4	Incorrect Lapsation in System	• Check whether system set up for lapsation of policy is correct. The policy should be lapsed only after grace period is over. • Check post lapsation, lapse notices are printed for all cases. • Check all the notices are dispatched and properly recorded.
5	Professionalism in marketing. High instances of surrender requests of policies sold by particular agent	• Check whether agents are provided with adequate trainings to keep updated with the policy features and recent amendments. Most of the policies get lapsed due to inadequate communication regarding policy features to the policy holders.
6	Processing of policy claims requests during lapsation period	• Check whether the policy is marked as “lapsed” immediately on non-receipt of renewal premium within due dates. • Check whether claim requests are automatically rejected by the system when the policy is in “lapsed” status.

7	Non receipt of interest charges for revival of policy	• Check whether all the outstanding dues along with interest amount is received before reviving the policy. • In case the insurer policy refers to waiver of interest, check adherence to approval matrix.
8	Receipt of death claim within the grace period in the case of group policies	• Check whether due and unpaid renewal premium for the entire group is received from the master policy holder before processing of claim request.
9	Processing of revival request received after 5 years of policy lapsation	• Check the date of receipt of revival requests vis à vis the date of policy lapsation in the system. Revival request should not be processed if the first unpaid premium is for > 5 years as on date of revival and rejection letters should be sent to the policy holder.
10	Incorrect accounting entry for policy surrender	• Check whether correct details are sent to accounts for recording appropriate accounting entries . • Check whether correct amount is paid to the policy holder.

Policy Surrender

8.5 Surrender of a life insurance policy refers to the voluntary termination of the insurance contract by the policyholder or lawful assignee before the maturity date, resulting in payment of the surrender value, if any, as determined in accordance with the policy terms and applicable regulations.

Surrender Process

The policyholder or legally entitled assignee may submit a surrender request through physical, electronic, or digital modes prescribed by the insurer. The insurer shall obtain and verify such documents, declarations and proofs as may be necessary for establishing the identity of the claimant, policy

ownership, assignment status, bank account details and compliance with anti fraud requirements.

Submission of the original policy document may not be mandatory where electronic policy records, dematerialized policies, or alternate verification procedures are available. The surrender request shall be processed in accordance with the insurer's Board approved policy and applicable IRDAI regulations.

The policy may be surrendered only by the policyholder, assignee, or any other person legally entitled to receive the policy benefits.

Relevant Legal and Regulatory Provisions

- **Section 113(1) of the Insurance Act, 1938** provides that a policy of life insurance shall acquire surrender value as per the norms specified by regulations.
- **Section 113(2) of the Insurance Act, 1938** requires every life insurance policy to contain the formula approved by IRDAI for calculation of guaranteed surrender value.
- **Section 113(3) of the Insurance Act, 1938** provides that a non-linked life insurance policy which has acquired a surrender value shall not lapse merely due to non-payment of future premiums and shall continue as a paid-up policy in accordance with the formula approved by IRDAI.
- **IRDAI (Insurance Products) Regulations, 2024** define "Surrender Value" as the amount payable, if any, on surrender of a policy during its term in accordance with the terms and conditions of the policy.
- **Schedule relating to Non-Linked Insurance Products under IRDAI (Insurance Products) Regulations, 2024** prescribes acquisition of guaranteed surrender value, minimum surrender value factors, special surrender value requirements and paid-up value provisions.

Internal audit Scope & Objectives

The internal audit shall cover all surrender transactions relating to individual and group life insurance products, including participating, non-participating, linked, pension and annuity products, wherever surrender benefits are available under the policy contract and applicable regulations.

Objective

The primary objective of the internal audit is to ascertain whether:

- surrender requests are received from the rightful claimant,
- surrender eligibility is determined in accordance with the Insurance Act, 1938, IRDAI Regulations and policy conditions,
- surrender values are computed accurately and consistently,
- payments are made only to eligible recipients through approved channels,
- policy records and accounting records are updated correctly and
- all regulatory and internal control requirements are complied with.

Regulatory Requirements Relevant for Internal Audit

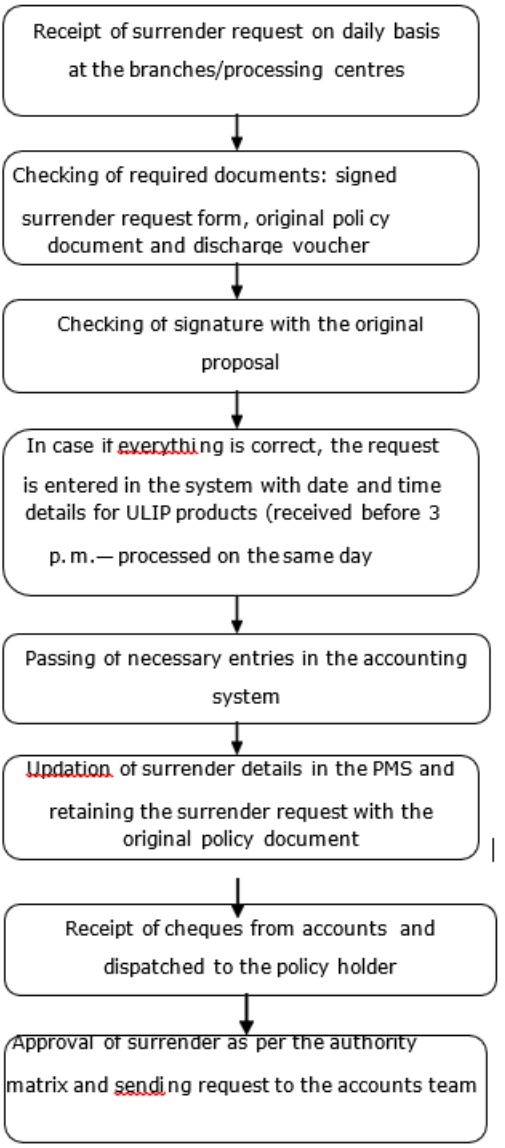
- The Internal auditor should specifically verify compliance with the following:
    - Section 113 of the Insurance Act, 1938.
    - IRDAI (Insurance Products) Regulations, 2024.
    - Board approved Policy relating to Servicing and Claims/Surrender Settlement.
- Anti Fraud Policy and KYC/AML guidelines.
- IRDAI (Protection of Policyholders' Interests and Allied Matters) Regulations, 2024.

Areas Covered Under Internal Audit

The internal audit should, inter alia, cover the following aspects:

- Verification and authentication of surrender requests
- Validation of policy status and surrender eligibility
- Verification of identity, assignment, nomination and banking details
- Calculation and payment of surrender value
- Verification of maker checker and authorization controls
- Timeliness of processing and settlement
- Updation of policy administration records
- Accounting and financial reporting entries

- Customer communication and disclosures
- Monitoring of agent/intermediary wise surrender patterns and persistency indicators
- Detection of suspicious, fraudulent, or induced surrender transactions and
- Compliance with applicable IRDAI regulations and internal policies.



Illustrative Risks and Internal Audit Procedures of Surrender Process– Regulatory References

S. No	Risk	Audit Procedures	Regulatory Reference
1	Unauthorized surrender request	**Verify policyholder/assignee identity and authority:** • Verify existence of controls for authentication of policyholder/ assignee identity. • Verify assignment records before processing assigned policies. • Check whether digital requests are authenticated through approved electronic verification mechanisms. • Review exception reports for rejected and suspicious requests. • Verify compliance with anti fraud and KYC requirements.	IRDAI (Protection of Policyholders' Interests and Allied Matters) Regulations, 2024
2	Incorrect surrender eligibility	**Verify acquisition of surrender value as per product regulations:** • Verify that system controls determine eligibility based on product specific rules approved by IRDAI. • Check that policies are not rejected solely on the basis of outdated three year premium criteria where	Section 113(1) of Insurance Act, 1938

		such criteria are not applicable. • Review treatment of paid up, reduced paid up and discontinued policies.	
3	Incorrect surrender value calculation	**Verify Guaranteed Surrender Value (GSV)/ Special Surrender Value (SSV) calculations and system parameters:** • Verify that surrender values are calculated in accordance with approved actuarial factors and product terms. • Review system parameter settings governing guaranteed surrender value and special surrender value. • Check maker checker controls and independent validation procedures. • Verify that the higher of applicable surrender values is paid as per under policy conditions.	Section 113(2) Insurance Act, 1938 IRDAI Insurance Products Regulations, 2024
4	Incorrect paid-up treatment	Verify conversion to paid up value where applicable.	Section 113(3) of Insurance Act, 1938
5	Non-compliance with policy conditions	Verify adherence to approved product filing and policy terms.	IRDAI Insurance Products Regulations, 2024

6	Delayed settlement	**Verify compliance with prescribed turnaround times and internal (SLAs):** • Review turnaround times against regulatory and internal service standards. • Verify monitoring of pending surrender cases. • Examine reasons for delays and corrective actions taken.	IRDAI (Protection of Policyholders' Interests and Allied Matters) Regulations, 2024
7	Fraudulent or induced surrender	**Review agent wise surrender patterns and exception reports:** • Analyse agent wise and intermediary wise surrender trends. • Review high frequency surrender and replacement transactions. • Examine controls for detection of mis selling, twisting, or churning of policies. • Verify compliance with customer suitability and fair treatment requirements.	IRDAI Anti Fraud Framework and Board approved Anti Fraud Policy
8	Incorrect accounting entries	**Verify accounting treatment and reconciliation controls:** • Verify accounting entries relating to surrender payments and reserve adjustments.	Insurer's Accounting Policy and applicable IRDAI reporting requirements

		• Confirm that policy status is updated correctly in the policy administration system. • Review reconciliation between policy administration and financial systems. • Review signature verification controls and maker checker procedures. • Verify availability of audit trail for electronic requests. • Examine cases involving changes in bank account details immediately preceding surrender. • Review fraud monitoring reports and escalation procedures.	
9	Processing without proper documentation	• Verify that documents prescribed under the insurer's Board approved policy are obtained and retained. • Review exception approvals wherever standard documentation requirements are waived. • Ensure proper maintenance of digital records and document repositories.	Section 113(1) of Insurance Act, 1938

Nomination/ Assignment

8.6 Policy servicing requests such as nomination, assignment, change of nominee, change of address, change of payment mode, change of name, correction of demographic details and other policy alterations shall be processed in accordance with the following:

(a) Section 38 of the Insurance Act, 1938 (Assignment and Transfer of Policies),

(b) Section 39 of the Insurance Act, 1938 (Nomination by Policyholder),

(c) IRDAI (Protection of Policyholders' Interests and Allied Matters) Regulations, 2024,

(d) Applicable IRDAI Master Circulars, Guidelines and Board approved Policy Servicing Policy.

The objective of the internal audit is to verify that policy servicing requests are received from authorized persons, supported by adequate documentation, processed accurately, approved as per delegated authority, recorded correctly in the policy administration system and communicated to the policyholder within prescribed timelines.

Nomination

Section 39 of the Insurance Act, 1938 (as amended) permits the holder of a life insurance policy on his or her own life to nominate one or more persons to whom the policy proceeds shall be payable in the event of the death of the life assured. A nomination may be made at the inception of the policy or at any time before the policy matures.

Where a nominee is a minor, the policyholder may appoint an adult person to receive the policy monies during the minority of the nominee.

The insurer shall register the nomination, cancellation or change thereof in its records and provide acknowledgement to the policyholder in accordance with applicable IRDAI Regulations and internal procedures.

Thus, nomination is the facility through which a policyholder designates one or more persons to receive policy benefits in the event of the death of the life assured. Nomination facilitates expeditious settlement of death claims and reduces disputes regarding payment of policy proceeds.

A nomination may be created, modified or cancelled in the following circumstances:

(i) Death of the nominee,

(ii) At the request of the policyholder,

(iii) Upon assignment of the policy, subject to the provisions of Section 39 of the Insurance Act, 1938,

(iv) Upon reassignment of the policy to the policyholder, where a fresh nomination may be registered,

(v) When a minor policyholder attains majority and becomes competent to make a nomination.

In accordance with Section 39(7) of the Insurance Act, 1938, where the nominee is the spouse, parent, child or children of the policyholder, such nominee(s) shall ordinarily be treated as beneficial nominee(s), unless otherwise provided by law.

Change or Cancellation of Nomination

Nomination may be changed or cancelled by the policyholder at any time before policy maturity by submitting a request in the prescribed manner.

Fresh nomination may become necessary in the following circumstances:

(i) Death of the nominee,

(ii) Change in the policyholder's intention,

(iii) Assignment of the policy, where nomination is automatically cancelled except in cases specifically provided under Section 39 of the Insurance Act,

(iv) Reassignment of the policy to the policyholder, where a fresh nomination may be registered,

(v) Attainment of majority by a minor policyholder.

The insurer shall maintain complete records of all nominations, modifications and cancellations.

Beneficial Nominee

In accordance with Section 39(7) of the Insurance Act, 1938, where the nominee is the spouse, parent, child or children of the policyholder, such nominee(s) shall be treated as beneficial nominee(s) and shall be beneficially entitled to the policy proceeds unless otherwise provided by law or judicial order.

The insurer shall ensure proper recording of beneficial nominee status in its policy administration system.

Assignment

Section 38 of the Insurance Act, 1938 (as amended by the Insurance Laws (Amendment) Act, 2015) provides that a transfer or assignment of a life insurance policy, whether with or without consideration, may be effected by an endorsement on the policy or by a separate instrument signed by the assignor or his/her duly authorised agent and attested by at least one witness. The assignment becomes complete and effective upon execution of the endorsement or assignment instrument.

However, such assignment shall become operative against the insurer only upon receipt of a written notice of assignment together with the endorsement, assignment instrument or certified copy thereof and registration of the assignment in the records of the insurer.

Assignment is thus process by which a policyholder (assignor) transfers wholly or partially his/her rights, title and interest under a life insurance policy to another person (assignee). Upon registration of the assignment, the assignee acquires such rights and benefits under the policy as are transferred through the assignment.

Assignment may be effected under the following circumstances:

(i) Collateral Assignment – Assignment in favour of a bank, financial institution or lender as security for a loan or other financial obligation.

(ii) Absolute Assignment – Assignment in favour of spouse, children, parents, relatives or any other person, with or without consideration, whereby all rights under the policy are transferred to the assignee.

(iii) Assignment in favour of Trusts or Legal Entities – Assignment to a trust, institution, company or other legal entity for estate planning, succession planning, employee benefit arrangements or other lawful purposes.

(iv) Assignment pursuant to Legal or Statutory Requirements – Assignment arising out of court orders, settlement agreements, insolvency proceedings or other legally enforceable arrangements.

(v) Assignment under Keyman, Partnership or Employer Employee Insurance Arrangements – Assignment undertaken in accordance with the terms governing such policies and applicable laws.

The insurer shall verify the validity of the assignment, identity of the assignor and assignee, completeness of supporting documentation and compliance with applicable legal and regulatory requirements before registering the assignment in its records.

Assignment may be effected by:

(i) Endorsement on the policy,

(ii) Separate assignment instrument,

(iii) Electronic mode permitted under applicable regulations.

Assignment becomes operative against the insurer upon receipt and registration of notice of assignment in accordance with Section 38.

The insurer shall provide acknowledgement of registration of assignment.

Types of Assignment

Assignments may generally be classified as under:

(i) Assignment in favour of banks, financial institutions or lenders as security for loans,

(ii) Absolute assignment in favour of spouse, children, parents or other persons,

(iii) Assignment in favour of trusts or other entities for estate planning or succession purposes,

(iv) Assignment pursuant to judicial orders, settlements or statutory requirements.

The insurer shall verify the nature of assignment and record the same appropriately.

Documentation and Verification

The insurer shall establish Board approved procedures for processing nomination, assignment and other servicing requests.

The documents required may include, as applicable:

(i) Request form or digital request

(ii) Identity and address proof

(iii) KYC documents

(iv) Assignment deed or supporting legal documents

(v) Bank account details

(vi) Any other documents required under applicable regulations.

Physical policy documents shall not be mandatory where electronic records, e policies or alternate verification mechanisms are available.

The insurer shall perform maker checker verification and maintain audit trails for all servicing transactions.

Recording and Communication

Upon approval of the request:

(i) Necessary changes shall be updated in the policy administration system

(ii) Electronic records and servicing databases shall be updated

(iii) Acknowledgement and confirmation shall be communicated to the policyholder through approved communication channels

(iv) Appropriate records shall be retained in accordance with the insurer's record retention policy and applicable regulations.

All changes shall be traceable through a complete audit trail.

Change of Address, Payment Mode, Scope and Regulatory Framework

8.7 Key requirements for processing payment relating to change of address, premium payment mode and name or person detail in accordance with applicable requirements and insurer’s policies are as follows:

Change of Address (COA)

Policyholders are required to keep their contact and communication details updated with the insurer. Any change in residential address, correspondence address, telephone number, mobile number, e mail address or other contact details shall be intimated to the insurer promptly to ensure timely receipt of policy related communications, notices and service requests.

Requests for change of address may be submitted through physical, electronic or digital servicing channels approved by the insurer.

The insurer shall verify the identity of the policyholder and obtain such documentary evidence as may be prescribed under its Board approved Policy Servicing Policy, KYC Policy and applicable regulatory requirements.

Processing of Change of Address Requests

The insurer shall establish appropriate controls for verification, approval and recording of change of address requests.

Address changes may be processed based on:

(i) Self attested proof of address,

(ii) CKYC records,

(iii) Aadhaar based authentication, where permissible,

(iv) Digitally authenticated requests,

(v) Any other document or verification mechanism approved by the insurer.

Upon successful verification, the revised address shall be updated in all relevant systems and confirmation shall be communicated to the policyholder through approved communication channels.

Change of Premium Payment Mode (COP)

A policyholder may request a change in premium payment mode, subject to the terms and conditions of the policy and the insurer's servicing procedures.

Requests may include change from:

(i) Annual to Half Yearly, Quarterly or Monthly mode,

(ii) Half Yearly, Quarterly or Monthly mode to Annual mode,

(iii) Manual payment mode to Auto Debit, ECS, NACH, EFT, Standing Instruction, UPI AutoPay or other electronic payment arrangements approved by the insurer,

(iv) One approved electronic payment mechanism to another.

Where the change involves registration or modification of electronic debit instructions, the insurer shall obtain and verify bank account details, mandate forms and supporting documents as required under applicable banking and regulatory guidelines.

The insurer shall ensure accurate recalculation of modal premiums, updation of policy administration systems and communication of revised premium obligations to the policyholder.

Regulatory Requirements and Audit Objective

In accordance with the IRDAI (Protection of Policyholders' Interests and Allied Matters) Regulations, 2024, insurers are required to maintain efficient policy servicing mechanisms and process policyholder requests in a fair, transparent and timely manner.

The objective of the internal audit shall be to verify that:

(i) Change requests are received from authorized persons only,

(ii) Adequate KYC and verification controls are in place,

(iii) Requests are processed within the turnaround times prescribed under internal policies and regulatory requirements,

(iv) Appropriate maker checker controls exist for approval and system updation,

(v) Changes are accurately reflected in all policy administration systems,

(vi) Audit trails and supporting documents are maintained,

(vii) Confirmation of changes is communicated to the policyholder and

(viii) The insurer complies with the requirements of the Insurance Act, 1938, IRDAI regulations and Board approved policy servicing procedures.

Illustrative Internal Audit Checklist

S. No	Risks	Internal Audit Procedures
1	Mismatch in signature on endorsement of assignment/ nomination/COA/COP request and original proposal document	• Check whether adequate maker checker controls are in place at the branches/ processing centers for signature verification. • If the policy holder has signed in vernacular language, then check whether declaration from witness knowing English is taken. • In case there is a thumb impression on the endorsement form, whether attestation from banker or a public notary is taken. • In case of group insurance policy, check whether any change request given by the group member is signed by the master policy holder/ authorized person.
2	Non receipt of documentary proof for COA/COP	• In case of COA, check whether self attested proof of address is verified and kept on records. • In case of change of payment mode from cheque payment to ECS/EFT, check whether bank account verification is done and relevant proofs such

		as cancelled bank cheque is kept on records.
3	Incorrect assignment	• Assignment request should state the consideration. • Assignment should be made only to blood relatives i.e parents, children and spouse, or in case of loan from banks/ financial institutions.
4	Incorrect updation of nominee/ assignee details Incorrect assignment request (*To people to whom assignment cannot be done and without correct consideration*)	• Check whether nominee/ assignee names are correctly updated in the system as per the requests received. • Check whether maker checker controls are in place for updation of nominee/ assignee name in the system.
5	Duplicate nomination/ assignment requests	• Check whether nomination/ assignment stamp is affixed on the original policy document on processing of request. • Check whether system authorization for marking assignment/nomination is available only with authorized employees. • Check whether maker checker controls are in place for updation in the system. • Check whether "endorsement on the policy document signifying assignment/

		nomination" form is signed off by the policy holder.
6	Delay in processing of nomination/ assignment/ COA/ COP	• Check whether inward stamps are affixed on all the requests received at the branches/ processing centres. • Check whether requests received are processed within 10 days from the date of receipt. Delays if any are justified and communicated to the policyholder before expiry of 10 days.
7	Change of address followed by surrender request	• Check whether change of address request is processed first and then the surrender/claim request is processed to ensure that the cheque is dispatched to the correct address.
8	Nomination request followed by assignment request Section 39(4) of the Insurance Act, 1938 (as amended) provides that a transfer or assignment of a life insurance policy made in accordance with Section 38 shall automatically cancel the nomination. However, such cancellation shall not apply where the policy is assigned to the insurer by way of security for a loan within its surrender value, or where the policy is reassigned by the	• When an assignment request is received, check whether adequate details of the assignee are updated in the system and the nomination is cancelled.

	insurer upon repayment of the loan. In such cases, the nomination shall be deemed to be revived to the extent provided under the Act.	

Fund Switch and Top Up Premium

8.8 Fund Switch is a facility which allows eligible ULIP policy holder to switch the money from one fund to another within the same policy. It is used by the policy holder to capitalize on the capital appreciation opportunities available in other funds or to minimize the risk associated with the present fund portfolio. While a specified number of switches are generally effected free of cost, a fee is charged for switches made beyond the specified number.

Switch requests are usually received at the branches wherein date and time punching is done. If the request is received before 3:00 pm, the request is to be processed on the same day. In case the request is received after 3:00 pm, the request is to be processed on the immediate next working day. (IRDA Guideline for ULIP dated December 21, 2005).

Request Received Date/ Time	**Before 3 PM**	**After 3 PM**
Current day (Working day)	Insurer to take action on the same day after checking relevant documents with current day NAV	Insurer to take action on the immediate next working day after checking relevant documents with next day NAV
Current day & Market is closed	Insurer to take action on the immediate next working day after checking relevant Documents	
Previous Day	Process with the NAV of previous day & if on that day market was closed then with the NAV of next working day	

The primary objective of the audit is to check and confirm that switch form is complete in all aspects and it is duly signed by the policy holder. Fields such as policy number, Scheme from, Scheme to, percentage of fund to be

switched, policy holder signature has to be clearly stated in the switch request form. Adequate care is to be taken with respect to date and time of receipt of form.

The internal audit should cover:

(i) Process for receipt of form and inward date and time

(ii) Necessary updation in the PMS

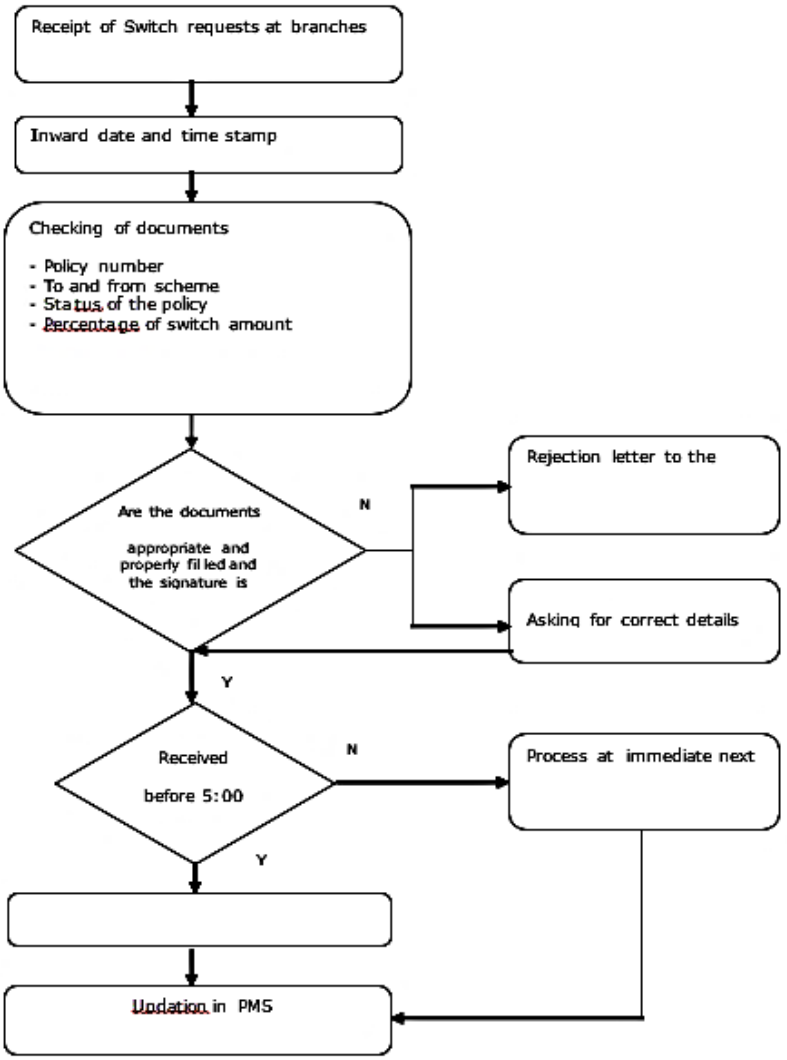
(iii) Timeliness for processing

(iv) Checking of relevant fields in the form

(v) Application of NAV

(vi) Intimation to the policy holder

(vii) Deduction of fund switch charges.


Receipt of Switch requests at branches
Inward date and time stamp
Checking of documents
- Policy number
- To and from scheme
- Status of the policy
- Percentage of switch amount
Are the documents
appropriate and
properly filled and
the signature is
N
Rejection letter to the
Asking for correct details
Y
Received
before 5:00
N
Process at immediate next
Y
Updation in PMS

Illustrative Internal Audit Checklist

S. No	Risks	Internal Audit Procedures
1	Incorrect application of NAV/ Delays in processing	• Check existence of adequate controls at branches/ processing centers, • Whether correct inward date is mentioned on all the forms received • Whether forms received on the same day before 3:00 pm are processed on the same day NAV • With respect to forms received after 3:00 pm, whether these are processed on the immediate next working day. Also check whether the branch checklist contains all the above points and is signed off by the maker and the reviewer.
2	Mismatch in signature as per policy document and switch form	• Check whether adequate controls are in place to verify the signature of the policy holder with the original proposal form. • Check whether "signature verification" stamp is affixed on the switch request form.
3	Incorrect processing of switch request	• Check whether maker-checker controls exist at the branches for updation of details in the PMS vis à vis: o policy number o policy name (To and from) o percentage/Proportion of switch amount as per the product features o date and time of receipt o effective NAV date

		• Check whether checklist is signed off by the maker and checker • Check whether minimum switch amount is as per the product features • Check whether switch facility is available for the product mentioned • If the application of NAV is done through system, check the defined controls and parameters in the system.
4	Switch transaction processed for lapsed/ surrendered policy	• Check whether switch request is processed only when the policy status is "In force." Switch transactions should not be processed if the policy status is "lapsed" or "surrendered".
5	Incorrect deduction of switch charges	• Check whether applicable switch charges are correctly deducted as per the product features. • Check the system master if the switch charges are built in in the system. This can also be verified at product development or can form part of system audit.

Top Up Premium (ULIPs)

A Top Up Premium is an additional premium paid by a policyholder over and above the regular premium specified under a Unit Linked Insurance Policy (ULIP). Top up premiums may be accepted during the currency of the policy subject to the conditions specified in the approved product terms and applicable IRDAI Regulations.

Insurers shall administer top up premiums in accordance with the approved product design, including provisions relating to insurance cover, lock in requirements, fund allocation, applicable charges and disclosures to policyholders.

Where permitted under the policy contract, top up premiums shall be allocated to the policyholder's selected funds using the applicable NAV in accordance

with prevailing regulatory requirements and the insurer's approved product specifications.

The insurer shall ensure that all disclosures relating to top up premiums, including eligibility conditions, minimum and maximum top up amounts, applicable charges, insurance benefits, lock in provisions and surrender implications, are clearly communicated to policyholders.

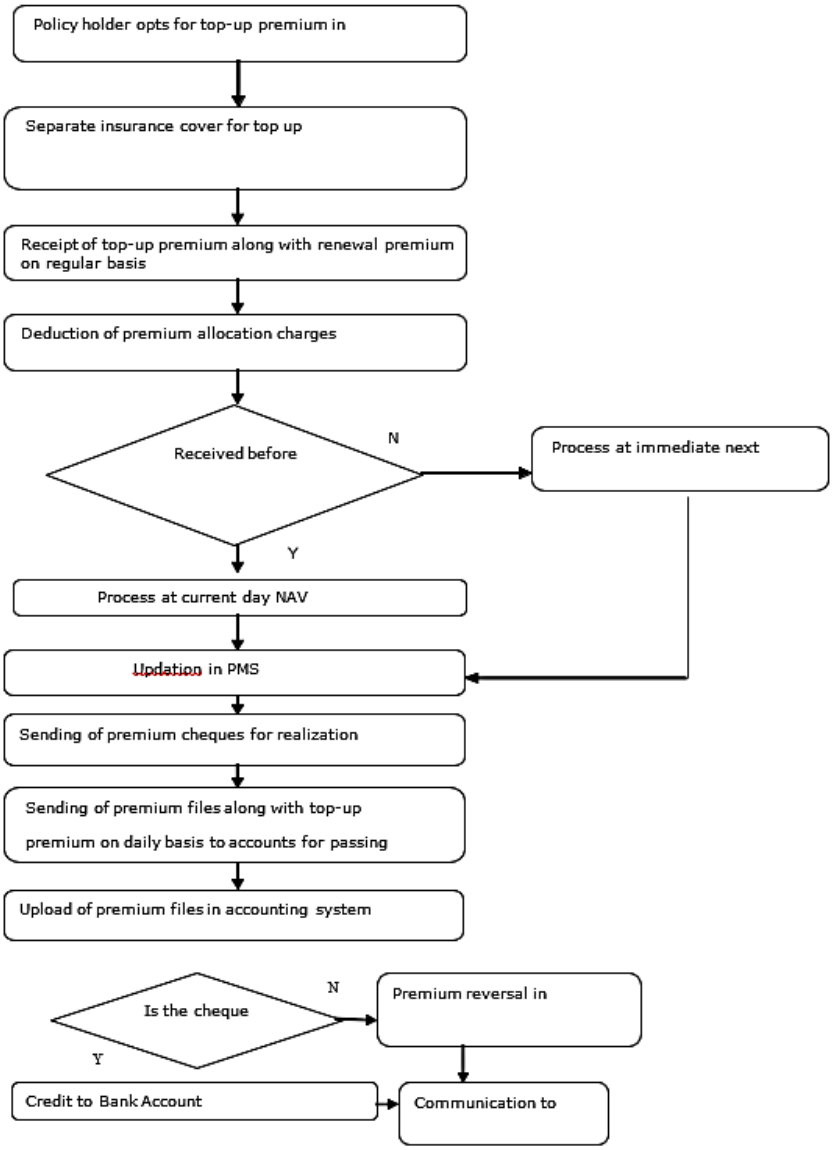
Scope and Objective

- To verify that top up premiums are accepted only in accordance with approved product terms and applicable IRDAI Regulations.
- To ensure that policyholders satisfy the eligibility criteria prescribed under the policy contract before acceptance of top up premiums.
- To verify that top up premiums are accurately recorded, allocated and invested in accordance with the policyholder's fund allocation instructions and the applicable NAV.
- To ensure that insurance cover associated with top up premiums, wherever applicable, is provided in accordance with the approved product design.
- To verify that all applicable charges relating to top up premiums are levied in accordance with approved policy terms and regulatory requirements.
- To ensure compliance with lock in requirements and other restrictions applicable to ULIP top up premiums.
- To verify that policyholders receive adequate disclosures regarding top up premiums and their impact on policy benefits.

Key Compliance Requirements

- Acceptance of top up premiums shall be governed by the approved product specifications and policy terms.
- Insurance cover associated with top up premiums shall be administered in accordance with the approved File & Use document.
- Applicable charges, including premium allocation charges and fund related charges, shall be levied strictly as per approved product terms.
- Lock in provisions applicable to ULIPs and top up premiums shall be complied with.

- Adequate disclosures shall be provided to policyholders regarding top up premium transactions and their impact on fund value and policy benefits.
- The primary objective of the audit is to check and confirm that top up premiums are correctly accounted for in the policy holder's account and to ensure that every top up amount has an insurance coverage and to ensure that top up period also has a lock in period of 5 years.
- The internal audit in this regard would normally cover the following:
  (i) Process for receipt of top up premium form and inward date and time
  (ii) Necessary updation in the PMS
  (iii) Timeliness for processing
  (iv) Checking of relevant fields in the form
  (v) Application of NAV
  (vi) Life cover for all top up premium
  (vii) Deduction of premium allocation charges
  (viii) Intimation to the policy holder.


Policy holder opts for top-up premium in
Separate insurance cover for top up
Receipt of top-up premium along with renewal premium on regular basis
Deduction of premium allocation charges
Received before
N
Process at immediate next
Y
Process at current day NAV
Updation in PMS
Sending of premium cheques for realization
Sending of premium files along with top-up premium on daily basis to accounts for passing
Upload of premium files in accounting system
Is the cheque
N
Premium reversal in
Y
Credit to Bank Account
Communication to

Illustrative Risks and Internal Audit Procedures for Top up Premiums (ULIPs) and Fund Transactions

S. No	Risks	Risk Description	Internal Audit Procedures	Regulatory Reference
1	Acceptance of top up premiums in violation of policy terms or regulatory requirements	Acceptance of top up premiums contrary to approved product specifications may result in regulatory non-compliance, customer grievances, financial adjustments and reputational risk.	Verify whether top up premiums are accepted only for eligible policies and in accordance with approved product terms and IRDAI Regulations.	IRDAI (Insurance Products) Regulations, 2024 IRDAI Master Circular on Life Insurance Products, 2024 Approved File & Use Document.
2	Acceptance of top up premiums where eligibility conditions are not fulfilled	Top up premiums may be accepted despite non-fulfilment of eligibility criteria such as payment of due regular premiums, resulting in policy administration errors and non-	Verify compliance with policy conditions governing payment of due regular premiums and other eligibility requirements before acceptance of top up premiums.	IRDAI Master Circular on Life Insurance Products, 2024 Policy Terms & Conditions.

		compliance with product terms.		
3	Incorrect allocation of top up premiums	Incorrect NAV application, delayed unit creation or erroneous fund allocation may adversely affect policyholder's fund value and lead to financial loss, customer complaints and regulatory breaches.	Check whether units are created using the applicable NAV and allocated to the policyholder's selected funds accurately and within prescribed timelines.	IRDAI Master Circular on Life Insurance Products, 2024 Policy Terms & Conditions relating to NAV applicability and unit allocation.
4	Incorrect insurance cover attached to top up premiums	Failure to provide the correct insurance cover associated with top up premiums may result in underinsurance, overinsurance, claim disputes and regulatory non-compliance.	Verify that the insurance cover associated with top up premiums is provided as per approved product specifications and policy terms.	IRDAI (Insurance Products) Regulations, 2024 Approved File & Use Document Policy Terms & Conditions.
5	Incorrect levy of charges	Charges may be levied incorrectly or in excess of approved limits, leading to	Review whether premium allocation charges, fund management	IRDAI (Insurance Products) Regulations, 2024 IRDAI Master

		customer detriment, financial misstatements, refunds and regulatory observations.	charges and other applicable charges are levied in accordance with approved product terms and regulatory requirements.	Circular on Life Insurance Products, 2024 Approved Product Filing.
6	Non-compliance with lock in requirements	Premature withdrawal, surrender or transfer of funds in violation of lock in requirements may result in regulatory breaches and incorrect policy administration.	Verify compliance with lock in provisions applicable to top up premiums under the approved product structure and prevailing regulations.	IRDAI Master Circular on Life Insurance Products, 2024 Approved Product Filing and Policy Terms & Conditions.
7	Inadequate customer disclosures	Inadequate disclosure of charges, benefits, risks, lock in requirements and policy conditions may lead to customer grievances, mis selling allegations and	Examine whether policyholders are provided adequate disclosures regarding top up premiums, charges, insurance cover, lock in requirements and other	IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 IRDAI Master Circular on Protection of

		regulatory penalties.	relevant terms.	Policyholders' Interests, 2024.
8	Errors in accounting and fund administration	Errors in recording premium receipts, fund allocation, unit creation or reconciliations may result in inaccurate fund values, financial reporting errors and operational losses.	Verify reconciliation between premium receipts, fund allocation records, unit creation records and policy administration systems.	IRDAI (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2024 IRDAI Master Circular on Life Insurance Products, 2024.
9	Inaccurate regulatory and management reporting	Incomplete or inaccurate reporting may result in regulatory non-compliance, incorrect management decisions and adverse audit observations.	Verify completeness and accuracy of records, MIS and regulatory reports relating to top up premium transactions.	Insurance Act, 1938 IRDAI Act, 1999 IRDAI Reporting and Disclosure Requirements IRDAI (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2024.

Loan Against Policy

8.9 Insurance companies not only offer valuable death cover under policy but also extend helping hand by way of granting loan under policies during life time of policyholder when he is in need of funds. As per the privileges and conditions given on the the policy documents, insurer grants loan on the security of policy document to the person who is entitled for the same.

Illustrative Internal Audit Checklist

S. No	Risks	Internal Audit Procedures	Regulatory Reference
1	Loan granted on ineligible policies	Check as per insurer's internal policies whether the policy is eligible for loan. Verify product specific conditions regarding minimum policy term, surrender value requirements, loan eligibility and restrictions on specific product categories including ULIPs.	IRDAI (Insurance Products) Regulations, 2024 IRDAI Master Circular on Life Insurance Products, 2024
2	Inadequacy of loan documents	Verify inward controls for loan applications, signature verification, MWP Act cases, completeness of loan application, collection of original policy document, execution of loan	IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024

		agreement, premium payment status and policy status.	
3	Incorrect updation of policy details	Verify controls over loan processing, recording of loan transactions in policy administration systems and maker checker controls to ensure correct policy mapping.	IRDAI Master Circular on Life Insurance Products, 2024
4	Incorrect amount of loan sanctioned	Verify whether loan amount is computed in accordance with approved product terms and does not exceed permissible limits linked to surrender value or paid up value. Check aggregate exposure where previous loans exist.	Approved File & Use Document Policy Terms & Conditions IRDAI (Insurance Products) Regulations, 2024
5	Incorrect charging of interest	Verify whether interest rates applied are in accordance with approved policy terms and Board approved rates and whether interest is periodically calculated and recovered correctly.	Approved File & Use Document Policy Terms & Conditions IRDAI Master Circular on Life Insurance Products, 2024

6	Non availability of loan repayment schedule	Verify whether loan repayment terms, interest servicing requirements and consequences of non-payment are clearly communicated to policyholders.	IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024
7	Incorrect details in communications sent to customers	Verify that sanction letters, rejection letters, acknowledgements and loan related communications contain correct loan amount, interest details and repayment conditions.	IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 IRDAI Master Circular on Protection of Policyholders' Interests, 2024
8	Non assignment of policy in favour of insurer	Verify that policy assignment in favour of the insurer is appropriately recorded in the policy administration system before disbursement of the loan.	Insurance Act, 1938 (Assignment provisions).
9	Failure to reassign policy and return original documents after loan closure	Verify that assignment is released, reassignment is recorded and original policy	Insurance Act, 1938 IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of

		documents are returned after full repayment of loan and interest.	Insurers) Regulations, 2024
10	Delay in foreclosure when outstanding loan approaches or exceeds surrender value	Verify whether timely notices are issued when loan outstanding approaches surrender value/paid up value and whether foreclosure is carried out in accordance with policy conditions.	Approved File & Use Document Policy Terms & Conditions IRDAI Master Circular on Life Insurance Products, 2024
11	Incorrect or non-adjustment of loan outstanding against money back benefits, survival benefits or claims	Verify that outstanding loan principal and accrued interest are adjusted against policy benefits, survival benefits, maturity proceeds and claim payments wherever applicable.	Policy Terms & Conditions Approved File & Use Document IRDAI (Insurance Products) Regulations, 2024
12	Incorrect accounting entries	Verify that loan disbursement, interest accrual, recovery and closure transactions are correctly accounted for and reconciled with policy administration records.	IRDAI (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2024

13	Incorrect amount reflected in financial statements	Verify that outstanding policy loans, accrued interest and related balances are accurately reflected in books of account, trial balance and financial statements.	IRDAI (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2024 Insurance Act, 1938

Chapter 9
Claims

Introduction

9.1 Life insurance claims represent the ultimate fulfilment of the contractual promise made by an insurer to the policyholder. The efficiency, fairness and transparency of the claims management process directly influence policyholder confidence, insurer reputation and regulatory compliance. Claims constitute one of the most critical operational functions of a life insurance company as they involve significant financial outflows, customer interaction, legal interpretation, actuarial considerations and regulatory oversight.

The regulatory landscape governing claims management has undergone significant changes with the introduction of the IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 and the associated Master Circulars. These regulations place greater emphasis on customer centric claim settlement, timely processing, transparent communication, fraud prevention, grievance redressal and accountability of insurers. Consequently, the internal audit function is expected to provide independent assurance on the adequacy and effectiveness of governance, operational controls, regulatory compliance mechanisms and fraud risk management processes relating to claims administration.

Scope and Objective

9.2 The primary objective of the internal audit of claims is to evaluate whether claims lodged with the insurer are processed, approved, rejected, settled and accounted for accurately, fairly, consistently and in compliance with applicable regulatory requirements. The audit should provide assurance that claims are settled within prescribed timelines, policyholder interests are adequately protected and appropriate controls exist to prevent errors, frauds and operational lapses.

Given that claims constitute the largest expenditure category for most life insurers and directly impact customer trust and solvency management, the audit should adopt a risk-based approach covering the entire claims lifecycle from claim intimation to final settlement, accounting, reporting and closure.

The scope of the internal audit should include evaluation of the following areas:

Governance and Control Framework

- Adequacy of Board approved Claims Policy, Claims SOP, Investigation Policy and Fraud Risk Management Framework.
- Periodic review and updating of claims policies in line with regulatory developments.
- Clearly defined delegation of authority and approval matrix.
- Oversight by senior management and Board Committees over claims performance and exceptions.

Claims Registration and Processing

- Completeness and accuracy of claim registration.
- Timely acknowledgement and communication with claimants.
- Verification of policy status, nominee details, assignment records and claimant eligibility.
- Maintenance of claim records and audit trail.
- Compliance with regulatory timelines for seeking additional documents and claim processing.

Claims Assessment and Adjudication

- Evaluation of claim admissibility in accordance with policy terms and conditions.
- Verification of benefit calculations including sum assured, bonuses, guaranteed additions and riders.
- Compliance with Section 45 provisions relating to contestability of policies.
- Adequacy of review mechanisms for high value, complex and exceptional claims.
- Appropriateness of claim repudiation decisions and supporting documentation.

Fraud Risk Management

- Identification and monitoring of early, suspicious and high-risk claims.
- Adequacy of investigation triggers and investigation procedures.

- Review of fraud referrals, investigation findings and escalation mechanisms.
- Effectiveness of anti-fraud controls and fraud analytics.

Claims Settlement and Payment Controls

- Validation of beneficiaries and bank account details.
- Accuracy of claim payments.
- Compliance with maker checker controls and payment authorization procedures.
- Timeliness of claim settlement and payment of interest for delays, wherever applicable.
- Controls over duplicate, erroneous and unauthorized payments.

Reinsurance Claims Management

- Identification of reinsurance recoverable claims.
- Timely notification and submission of claims to reinsurers.
- Accuracy of reinsurance recoveries.
- Monitoring and follow up of outstanding recoveries.
- Reconciliation between direct claims and reinsurance records.

Financial Reporting and Reserving

- Accuracy of claims accounting entries and general ledger postings.
- Adequacy of outstanding claim reserves, Incurred But Not Reported (IBNR) and Incurred But Not Enough Reported (IBNER) provisions.
- Accuracy of actuarial assumptions and reserve calculations.
- Periodic reconciliations between claims systems, actuarial records and financial books.
- Adequacy of disclosures in financial statements and regulatory returns.

Regulatory Compliance and Policyholder Protection

- Compliance with IRDAI claims settlement requirements.
- Adherence to turnaround times prescribed by regulations.

- Compliance with Ombudsman awards, grievance redressal requirements and policyholder protection measures.
- Monitoring of regulatory exceptions and breaches.

Information Technology and Data Security

- Adequacy of system controls supporting claims processing.
- User access management and segregation of duties.
- Audit trail maintenance and change management controls.
- Data privacy, cyber security and record retention requirements.

Audit Objectives

The Internal audit should check whether:

(a) Claims are processed fairly, transparently and in accordance with policy conditions.

(b) Policyholder interests are protected throughout the claims lifecycle.

(c) Claims are settled within timelines prescribed by IRDAI.

(d) Repudiation decisions are appropriately justified, approved and communicated.

(e) Fraudulent, suspicious and duplicate claims are effectively identified and investigated.

(f) Claims reserves and accounting entries are complete, accurate and adequately supported.

(g) Reinsurance recoveries are identified, accounted for and recovered on a timely basis.

(h) Regulatory reporting and disclosures relating to claims are accurate and complete.

(i) Grievances, Ombudsman awards and regulatory directions are appropriately implemented.

(j) The claims management framework operates effectively and supports fair treatment of policyholders while safeguarding the insurer's financial interests.

Claims Processing Flow

9.3 Claims processing flow is given below:

1	Claim Intimation	Branch/ website/ claims department receives claim and verifies completeness of documents.
2	Claim Registration	Claim registered in system with event date, date of death/ maturity/ surrender and cause, where applicable.
3	Document Scrutiny	Claims operations validates policy status, claimant details, nomination/ assignment and mandatory documents.
4	Assessment	Assessor reviews claim, completes rating sheet and triggers investigation for early/ suspicious/ high value cases.
5	Approval/ Repudiation	Approver decides claim as per delegation matrix repudiation supported by reasoned documentation and legal/ medical inputs where required.
6	Settlement	Approved claim paid through controlled payment process with beneficiary and bank validation.
7	Closure & Reporting	Claim closure, accounting, reserve release, regulatory reporting and grievance/ Ombudsman tracking completed.

Illustrative Internal Audit Checklist

9.4 Illustrative Internal Audit Checklist for claims are as follows:

Risk	Control Objective	Illustrative Audit Procedures
Governance Framework		
Board Approved Policy along with Periodic Review. Following Policies to be in Place: • Claims Policy	Regulatory	• Obtain Board approved policy • Check for Annual review with Version Control

• Claims SOP • Fraud Management Policy • Investigation Policy • Repudiation Policy		
Delegation Matrix along with exception approvals	Ensure approved payouts	• Defined authority levels • Exception Approvals
Claim Registration and Intimation		
Completeness of registration • Unique claim number • Intimation date • Acknowledgement • Claim Category (death/maturity/rider/ annuity) • Claim register maintained as required by Section 14 of Insurance Act	• Ensure complete ness of claims population • Timely processing • Regulatory compliance	• Match claim intimation records with claims system • Verify date captured accurately • Verify acknowledgement sent within prescribed timeline • Verify correct classification • Record of claims which captures the name, address of the claimant, date on which the claim was discharged or in case of rejection the date of rejection and the reasons for rejection
Source recording	• Ensure complete ness of claims population	• Verify channel (branch/web/email/call Centre) captured

Escalation Process	• Ensure management insight	• Review handling of pending registrations
Documentation Verification and Assessment		
Claim form and documents submitted: • Death Certificate • Annual survival certificate (for Annuity policies) • First Information Report and Post Mortem Report (in case of claim due to accident) • Discharge summary (in case of death at (in case of death at the hospital), as applicable. • Policy document • Nomination validation • Assignment Validation • KYC Compliance • Legal Heir Documents • Bank account proof	Validity of claim assessment	• Verify authenticity and completeness • Verify original Policy (check whether Policy Document prescribes the minimum documentary evidence needed to support a claim and whether website displays the same) • Check Nominee as per Policy records • Validate PAN/ Aadhaar • Succession documents • Cancelled cheque
Additional documents requirements sent to the claimant within the timeline prescribed	Regulatory compliance	No claim shall be rejected or closed for want of documents or for delayed intimation of claim.
Claims Assessment		
Check whether: • Policy is Active • Premium is paid • Medical evidence	Validity of claim assessment	• Policy active on event date • Premiums paid and grace period considered

• Compliance with policy Terms		• Verify compliance with policy terms • Consistency with proposal declarations
Benefit Computation: • Sum assured calculation • Bonus calculation • Loyalty additions • Rider eligibility • Exclusion applicability	Regulatory compliance, policy terms compliance	• Recompute claim amount independently • Verify vested/ revisionary bonuses • Verify product specific additions
Policy cannot be contested after the expiry of 3 years from the date of the policy (Section 45 of the Insurance Act)	Regulatory compliance	• Verify adherence to section 45 provisions
• Independent review – assessment quality • Escalation of complex claims	Management oversight	• Verify secondary review of high value claims • Verify legal/ medical referrals
Early Claims & Investigation		
• Identify early claims	Detect fraudulent claims	• Check early claims dashboard
• Investigation trigger • Investigator scope and appointment • Medical investigation' • Financial investigation • Field investigation • Investigation closure • Findings	Robust fraud assessment	• Verify trigger Criteria application • Empanelment review – Due diligence process • Hospital confirmation process • Income verification– Financial underwriting

		• Residence/ employment verification • Timely completion (45 days) • Verify findings considered in decision
• Fraud Escalation	Management oversight	• Review fraud referrals • Escalation to SIU
Claim Approval & Repudiation		
• Claims approved as per approval matrix	Governance compliance	• Verify compliance to approval matrix • Verify escalation of high value claims
Repudiation • Justification • Legal review • Documentation • Communication	Protect policyholder rights	• Rationale/ reasons for repudiation • Check if legal opinion obtained • Check if complete documentation is maintained • Check if repudiation letters have been issued
• Customer rights • Appeal process	Protect Policyholder Rights	• Verify ombudsman rights disclosed • Check if there is an appeal mechanism
• Ex Gratia approvals • Decision changes	Prevent unauthorized payouts	• Verify Board/ Management approvals • Check if any modifications done post approval of claims

Settlement & Payment Controls		
Payment processing: • Beneficiary validation • Bank verification • Payment amount • NEFT controls • Customer communication	• Prevent erroneous settlement • Ensure legal entitlement • Prevent financial loss	• Payment to rightful claimant • Verify Bank account • Reconcile approved v/s paid amount • Maker checker controls for NEFT • Verify settlement advice issued
• Settlement timeline • Delay in settlement	Regulatory compliance	• TAT as prescribed by IRDA Policyholder Protection 2024 • Interest @2% over bank rate for no of days delay
• Duplicate settlement detection	Prevent leakage and fraud	• Verify duplicate payment controls
• Unclaimed payments	Regulatory compliance	• Outstanding payments ageing report, unclaimed guidelines prescribed by IRDAI
• Claim closure process	Regulatory compliance	• Closure controls • Check claim is closed only after settlement
• Group Insurance: • Employer-employee group (except for group fund based products), claims shall be paid directly to the employee or the beneficiary as the case may be.	Regulatory compliance	Check payment is made to the rightful claimant

• non-employer employee group claim payment is made:
  • in the name of the insured member or his/her nominee directly through electronic transfer to the claimant's bank account except for cases referred to clause (b) below.
  • in the name of the master policyholder, if it is a financial institution and there is authorized assignment made by the insured member in favor of the group holder of the policy on the date of event such authorized assignment shall only be to the extent of outstanding dues on loan as per the outstanding loan schedule on the date of occurrence of the event
  • Married Women Policy
  • Claims will be paid directly to the wife and children (not to the creditors) for policies issued under the MWP		

Reinsurance Recoveries		
Identification of Reinsurance cases • Timely filing • Accuracy of amounts recoverable • Long outstanding cases and follow up process	• Regulatory Compliance • Protect insurer profitability	• Check eligible claims • Timely lodgment of claims • Verify the accuracy of recoverable amount Recompute • Check ageing of claims and follow up process, escalation of old outstanding
• Accounting for reinsurance • Treaty reconciliation • Management reporting	Ensure financial accuracy	• Correct accounting entries • Review reconciliation process • Review process of reporting to Management
Claims Accounting & Reserving		
• Accounting for claims – GL posting Accuracy • Manual entries • Disclosure in financial statements • Period end controls • Periodic reconciliation	Ensure financial accuracy	• Reconcile claims system and GL • Check approvals for manual entries • Verify disclosures as per IRDA Actuarial, Finance and Investment Functions of Insurers) Regulations, 2024 • Check process for year end cut offs • Check whether insurer has a process of monthly reconciliation

		and the same is evidenced by sign off
Reserve creations • Reserves for outstanding reserves • IBNR & IBNER • Reinsurance Reserve • Actuarial validation	• Ensure actuarial accuracy	• Verify adequacy of the reserves to be created • Verify the assumptions for reserve creation • Verify reinsurance adjustments • Verify actuarial methodology
Regulatory Compliance, Grievances		
• Timelines for claim • Interest compliance for delay in claim settlement • Compliance monitoring	Regulatory compliance	• TAT prescribed as per IRDA Policyholder Protection 2024 • Interest prescribed as per IRDA Policyholder Protection 2024 to be paid
• Grievances related to claims • Escalation process • Ombudsman cases	• Protect Policyholder interests • Regulatory Compliance	• Review regulatory breaches • Review compliant handling • Process of escalation to Grievance cell • Compliance with awards/ orders
AML, Data Security & Record Retention		
Anti Money Laundering • Suspicious claim monitoring • Sanctions screening	prevention of fraud and money laundering	• Verify AML alerts and STR reviews • Verify claimant screening
• Customer information security • Claims system access	Protect confidential information	• Review access controls • Review role based

• Audit Logs		access (need to know basis) • Verify monitoring of changes
• Record retention • Archived claims • Claims record back up	Ensure Legal and regulatory compliance	• Compliance with record retention • Verify retrievability • Review DR testing and recovery

Audit Analytics/ CAATs

9.6 The following audit analytics and CAATs may be used to identify annualise assess trends and strengthen the effectiveness of claim audit process:

- Duplicate claimant detection.
- Multiple policies linked to same PAN.
- Same bank account used across claimants.
- Claims settled just below approval limits.
- High value claims settled without investigation.
- Claim ageing dashboard.
- Reinsurance recovery ageing.
- Outstanding claim reserve movement analysis.
- Suspicious mortality trend analysis.
- Claim repudiation trend analysis.

Commonly Observed Irregularities/ Violations

9.5 The following are commonly observed irregularities and instance of non-compliance that may arises during the claims process and require appropriate audit attention:

- Claim intimation not captured
- Missing mandatory records
- Beneficiary KYC not completed

- Incorrect claim computation
- Early claims not investigated
- Approval matrix violations
- Delayed settlement
- Interest not paid on delayed claims
- Inadequate fraud detection
- Recoveries not initiated
- Incorrect claim reserves
- Incorrect IRDAI disclosures
- Non-compliance with transfer and disclosure requirements
- Ombudsman orders not implemented

Regulatory References

Reference	URL
Insurance Act, 1938 (Sections 39, 45, 47 and related provisions)	https://www.indiacode.nic.in
IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024	https://irdai.gov.in/consolidated_gazette notified regulations
IRDAI Master Circular on Operations and Allied Matters of Insurers, 2024	https://irdai.gov.in/circulars
IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations, 2024	https://financialservices.gov.in/beta/en/ insurance act associated rules
Master Circular on Actuarial, Finance and Investment Functions of Insurers, 2024	https://irdai.gov.in/circulars

Chapter 10
Investments

Introduction

10.1 Investment management constitutes one of the most critical functions in a life insurance company as insurers act as fiduciaries of policyholders' funds and are responsible for ensuring that such funds are invested prudently, securely and profitably while maintaining adequate liquidity to meet policyholder obligations as and when they arise.

Life insurers manage long term liabilities extending over several decades. Consequently, investment decisions significantly influence solvency, profitability, embedded value, policyholder returns, bonus declarations, product pricing and overall financial stability of the insurer. The investment portfolio therefore assumes strategic importance in balancing risk, return, liquidity and regulatory compliance.

The Investment portfolio of Life Insurance companies comprise of Shareholders' funds and Policyholders' funds. Policyholders' funds can further be segregated as linked and non-linked. Investment regulations are however prescribed separately for the following investment categories:

(i) Linked funds

(ii) Pension and Annuity funds

(iii) Controlled funds.

The Regulatory framework governing investments of insurers has undergone significant transformation with the notification of the IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations, 2024 and the Master Circular on Actuarial, Finance and Investment Functions of Insurers dated 17 May 2024. The revised framework shifts the regulatory focus from prescriptive investment restrictions to a principles based governance framework emphasizing Board oversight, risk management, internal controls, transparency, accountability and policyholder protection.

The Board of Directors remains ultimately responsible for ensuring that investment decisions are aligned with the insurer's risk appetite, asset liability management (ALM) strategy and regulatory requirements.

Scope and Objective

10.2 The objective of investment review is to check that the investment function operates within a robust governance structure supported by clearly documented policies covering investment strategy, risk management, valuation, broker empanelment, delegation of authority, exposure monitoring, stress testing, liquidity management and contingency planning. Such policies should be periodically reviewed and approved by the Board to ensure continued relevance in changing market conditions.

A distinguishing feature of insurance investment operations is the requirement to manage multiple categories of funds. Life insurers typically maintain Shareholders' Funds, Participating Policyholder Funds, Non Participating Policyholder Funds, Unit Linked Funds, Pension Funds and Group Funds. Each category is governed by specific investment objectives, regulatory requirements and liability profiles requiring separate monitoring and accounting.

Scope of the Investment Review should include:

- Investment management structure to ensure adequate segregation of duties between Investment Front office, Mid Office and Back office
- Standard Operating Procedures which are prescribed by the IRDA Regulations and are required to cover the entire gamut of investment related processes and policies
- Review of insurer's Investment policy, functioning and scope and minutes of Investment Committee
- insurer's risk management policies and processes to manage investment risk such as Market risk, Liquidity risk, Settlement risks, etc
- Compliance of all Investment regulations, various other circulars issued by IRDA and other regulations specified in the Insurance Act, 1938
- Review of insurer's Disaster Recovery, Backup and Contingency Plan
- Review of access Controls, authorization process for Orders and Deal execution, etc
- Review of insurer's Cash Management System to track funds available for Investment considering the settlement obligations and subscription and redemption of units, etc. The system should be validated not to accept any

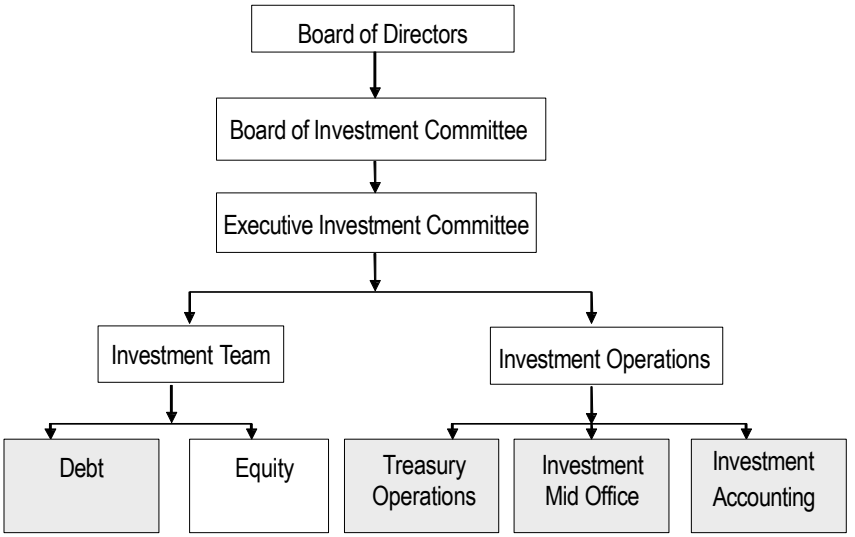
commitment beyond availability of funds and restrict Short Sales at the time of placing the order. Further insurer's system should be able to determine the amount of Investible surplus

- Ensure that the system is be able to automatically monitor various Regulatory limits on Exposure and Rating of debt instruments
- Review of fund wise reconciliation with Investment Accounts, Bank and Custodian records
- Ensure that there is split between Shareholders' and Policyholders' funds and earmarking of securities between various funds namely Life (Participating & Non Participating), Pension & Group (Participating & Non Participating) and Unit Linked Fund
- Review the arrangements and reconciliations of holdings with the insurer's custodian
- Review and check insurer's Investment Accounting and valuation policy and the controls around this process
- Determine the extent of activities outsourced and the controls over such activities
- Controls over NAV computation and declaration
- Controls over various system interfaces such as Seamless integration of data, between front office and back office, in the Investments accounting system
- Flow of data from PMS to the Investment Accounting system
- Controls around personal dealings, insider trading and front running.

Investment Operating Model

10.3 The IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations, 2024 require insurers to establish a robust investment governance framework with adequate segregation of duties between Front Office, Mid Office and Back Office functions. Such segregation is fundamental to ensuring independence, preventing conflicts of interest, minimizing operational risks and safeguarding policyholder funds.

A typical investment operating structure of a life insurer comprises:



Investment operations are generally organized into three independent functions:

Front Office: The Front Office serves as the revenue generating and portfolio management arm of the investment function Responsible for investment research, security selection, asset allocation, portfolio management and trade execution.

The Front Office is typically headed by the Chief Investment Officer (CIO) and comprises fund managers, research analysts and dealers.

Mid Office: Responsible for investment risk management, compliance monitoring, exposure tracking, performance analytics and independent oversight.

The Mid Office acts as the second line of defense and should remain independent of investment decision making.

Back Office: Back Office serves as the operational backbone of the investment function and is responsible for settlement, accounting, custody reconciliation, valuation, NAV computation and regulatory reporting.

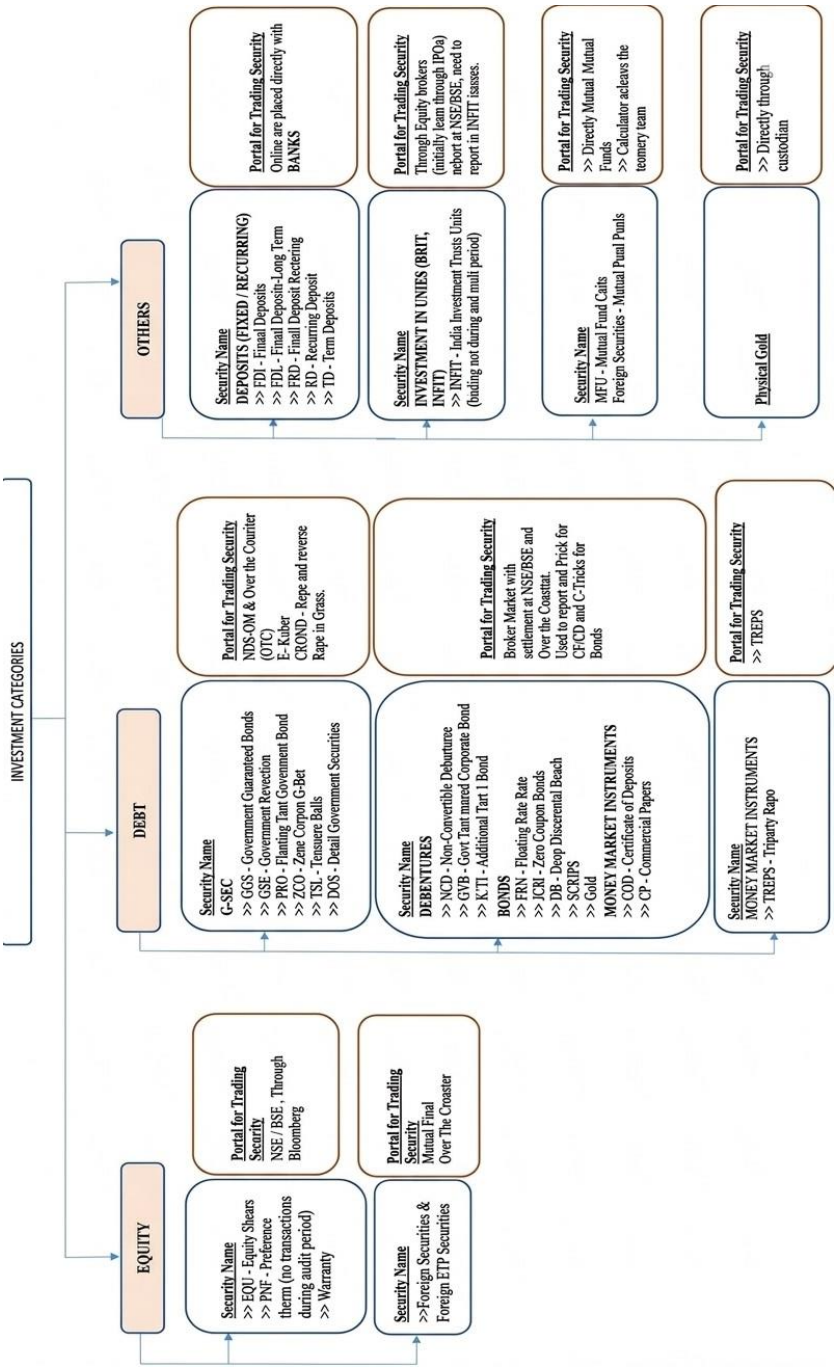
The Back Office should operate independently of the Front Office and report through the Chief Financial Officer (CFO).

Segregation of duties among these functions is essential to mitigate operational, compliance and fraud risks. The Front Office should not have access to accounting records or settlement functions, while Mid Office should function independently of investment decision making.

Modern investment operations are increasingly technology driven and depend on integrated investment management systems, treasury platforms, custodian interfaces, valuation engines and reporting tools. Consequently, internal auditors are expected to evaluate not only investment transactions but also technology controls, cybersecurity measures, data integrity and system generated regulatory monitoring controls.

Given the size and complexity of investment portfolios managed by life insurers, audit procedures must increasingly rely upon data analytics, automated monitoring tools and continuous auditing techniques. Areas such as exposure concentration, rating migration, duration mismatch, unrealized losses, settlement failures and valuation exceptions are particularly suited for analytics driven audits.

Model Investment Universe



Types of Investment Instruments

10.4 The following table set out the major types of investment instruments held by life insurers and the key audit area to be consider while servicing investments:

Sr. No.	Type of Investment Instruments	Key Audit Areas
1	**Government Securities** • Central Government Securities (G Secs) • State Development Loans (SDLs) • Treasury Bills • Floating Rate Bonds • Sovereign Green Bonds	• Lowest credit risk benchmark securities for valuation and ALM.
2	**Corporate Debt Bonds** • Corporate Bonds • Non-Convertible Debentures (NCDs) • Secured Debentures • Perpetual Bonds • Tier I and Tier II Instruments	• Credit rating compliance • Exposure limits • Valuation controls • Downgrade monitoring
3	**Money Market Instruments** • Commercial Papers • Certificates of Deposit • TREPS • Reverse Repo • Call Money	• Liquidity risk • Counterparty risk • Settlement risk

4	**Equity Investments** • Listed Equity Shares • Rights Issues • Bonus Shares • IPO Investments	• Market risk • Volatility • Sector concentration
5	**Mutual Fund Investments** • Liquid Funds • Debt Funds • Gilt Funds • Equity Funds • ETFs	• Exposure limits • Valuation controls
6	**Infrastructure Investments** • Infrastructure Bonds • Infrastructure Debt Funds • InvITs	• Liquidity risk • Counterparty risk • Settlement risk • Exposure limits • Valuation controls
7	**Housing Investments** • HUDCO Bonds • NHB Bonds • Housing Finance Company Debt	• Exposure limits • Valuation controls • Sector concentration
8	**Alternative Investments** • Category I AIF • Category II AIF • REITs • InvITs	• Liquidity risk • Counterparty risk • Settlement risk • Exposure limits • Valuation controls

9	**Derivative Instruments** • Interest Rate Futures • Currency Derivatives • Hedging Instruments	• Liquidity risk • Counterparty risk • Settlement risk • Exposure limits • Valuation controls

The Process Flow is Enumerated below:

1	Investment Strategy & Asset Allocation	• Investment Committee to give Broad guidelines for the asset allocation • Investment policy to define the asset class and the Limits • Well defined Standard Operating Guidelines for the operating departments
2	Fund Availability Assessment	Cash Management System to track funds available for Investment considering the settlement obligations and subscription and redemption of units. Alignment between assets and liabilities ALM monitoring Duration matching, cash flow matching, liquidity assessment, reinvestment risk analysis, interest rate sensitivity analysis
3	Security Research & Recommendation	Analysis of macroeconomic indicators, interest rate trends, inflation, monetary policy, industry developments and company specific factors to identify suitable investment opportunities. • Economic and market research. • Credit evaluation of debt securities. • Equity research and company analysis. • Industry and sector analysis. • Yield curve analysis.

		• Interest rate outlook assessment. • Liquidity analysis.
4	Investment Committee Approval	Investment policy approval by the committee. Policy in line with IRDAI guidelines, Exception reporting and overseeing justification
5	Trade Execution by Dealer	• Obtain market quotations • Executing transactions at best available prices • Investment limits checked before execution • Maintain dealer records • Recording trade details in dealing systems
6	Trade Capture in Investment System	• Timely capture of deals • Approval of deals • Seamless flow of deals from front office, mid office and back office. (No manual intervention)
7	Compliance & Exposure Validation	• Asset class limits • Sector limits • Group Exposure limits • Counterparty exposure limits • Credit rating • Geographic concentrations
8	Settlement through Custodian	• Monitoring settlement dates. • Funding settlement obligations. • Tracking failed settlements.

		• Escalating settlement exceptions. • Monitoring custodian reports. • Verifying holdings. • Reviewing corporate actions. • Reconciling custodian balances.
9	Investment Accounting	The Back Office records all investment transactions in accordance with applicable accounting standards and regulatory requirements. • Purchase accounting. • Sale accounting. • Accrual accounting. • Interest accounting. • Dividend accounting. • Realized gain/loss accounting.
10	Valuation & NAV Computation	Investments should be valued in accordance with IRDAI valuation guidelines and approved valuation policies. Valuation responsibilities include: • Mark to market valuation. • Amortized cost calculations. • Fair value determination. • Valuation exception review. For linked business and mutual fund type structures, accurate NAV computation is critical. The process should include: • Security valuation.

		• Unit reconciliation. • Expense allocation. • NAV verification. • Independent review.
11	Regulatory Reporting	• Investment returns. • Exposure reports. • Regulatory disclosures. • Board reports. • Investment committee reports.
12	Performance Monitoring	The Mid Office independently evaluates portfolio performance and identifies sources of returns arising from: • Asset allocation decisions. • Security selection. • Market movements. • Duration positioning.

Key systems involved:

Sr. No.	System	Purpose
1	Treasury Management System	Deal execution
2	Investment management system	Portfolio Management
3	Custodian Platform	Settlement and safekeeping
4	ALM System	Duration matching
5	ERP/ Finance	Duration matching

6	Risk Monitoring System	Exposure monitoring
7	Regulatory Reporting System	IRDAI returns
8	Concurrent Audit Portal	Continuous monitoring

Illustrative Internal Audit Checklist

10.5 Illustrative internal audit checklist for investments are as follows:

Risk	Control Objective	Illustrative Audit Procedures
Governance Framework		
• Board approved investment Policy aligned with IRDA regulation with periodic review • Delegation of Authority matrix	• Regulatory Compliance • Unauthorized investments • Escalation effectiveness	• Does a Board approved Investment Policy exist and is it reviewed annually. • Is the Policy aligned with IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations, 2024 • Investment governance structure documented. • Roles and responsibilities clearly defined. • Delegation of Authority (DOA) approved and communicated.

		• Verify breach reporting process
Constitution of Investment Committee	Governance oversight	• Committee constituted as per Board approval. • Check investment committee minutes if: ▪ Meetings held at prescribed frequency. ▪ Quorum requirements met. ▪ Minutes maintained and approved. ▪ Investment limit breaches reviewed. ▪ ALM reports reviewed. ▪ Stress testing results reviewed. ▪ Action points tracked to closure.
Compliance to the investment policy	• Regulatory compliance • Conflict of interest	• Asset allocation limits defined. • Exposure norms incorporated. • Credit rating requirements documented.

		• Related party investment guidelines established. • Infrastructure & Social Sector requirements incorporated. • Escalation matrix documented.
ALM Governance	• Governance oversight • Asset liability mismatch	Verify ALCO minutes to check for: • ALCO meetings conducted. • Duration gap reviewed periodically. • Liquidity mismatch reports reviewed. • Corrective actions documented. • Stress scenarios approved.
Risk Management Framework	• Risk Governance • Regulatory Compliance	Verify whether: • Risk appetite approved by Board. • Investment risk limits defined. • Market, credit and liquidity risks monitored.

		• Risk reports submitted to Board. • Early warning indicators established.
Operational Controls		
Investment Approval Process Segregation between front, mid, back office	• Regulatory compliance • Investment quality • Operational integrity	Verify whether: • Investment proposals supported by due diligence. Review investment appraisal notes • Approval hierarchy followed. Maker checker controls • Investment Committee approval obtained where required. • Exceptions documented and approved. • Investments within approved universe
Investment Execution	• Trade integrity	Verify whether: • Authorized dealers only execute trades.

		• Maker checker controls implemented. • Pre trade compliance checks performed. • Exposure validation performed before execution. • Liquidity validation performed. • Counterparty approval verified.
Broker Management	• Governance compliance	Check whether: • Broker empanelment policy approved. Check for unapproved broker usage • Due diligence performed. • Annual review completed. • Brokerage rates approved. • Conflict declarations obtained.
Front Office Controls	• Fraud prevention	Verify whether:

		• Timely Deal capture • Investment limits checked before execution. • Personal dealing declarations obtained. • Insider trading controls implemented • Front running monitoring performed. Personal dealing controls
Mid Office Controls	• Concentration control • Credit risk management • Escalation ineffectiveness	Check whether: • Exposure monitoring performed daily. • Credit rating monitoring conducted. • Compliance breaches escalated. • Investment limit utilization reviewed. • Risk reports generated.
Back Office Controls	• Settlement risk	Check whether:

	• Asset protection	• Trade confirmations obtained. • Settlement instructions verified. • Failed trades monitored. • Corporate actions processed timely. • Accounting entries reviewed.
Custodian Controls	• SLA compliance • Asset protection • Escalation ineffectiveness	Check if: • Custodian agreement valid. • Daily holding reconciliation performed. • Corporate action reporting reviewed. • Differences investigated. • Exception closure tracked.
Liquidity Management	• Liquidity management • Policyholder protection	Check whether: • Liquidity reports generated. • Cash forecasts prepared.

		• Redemption scenarios evaluated. • Liquid assets monitored. • Contingency funding plan maintained.
Monitoring and Reporting Controls		
Exposure Monitoring	• Regulatory Compliance • Appropriate monitoring • Concentration risk control • Timely escalation	Check whether: • Issuer limits monitored. • Group exposure limits monitored. • Sector exposure limits monitored. Stress testing • Counterparty exposures monitored. • Timely escalation of Breaches
Credit Risk Monitoring	• Credit risk management • Credit quality	Check whether: • Credit ratings reviewed periodically. • Downgrades tracked. • Watch list securities identified.

		• Exit strategies documented. Impairment indicators assessed.
Valuation Controls	• Fair valuation	Check whether: • Valuation policy approved. • Independent pricing sources used. • Valuation methodology documented. • Fair value hierarchy applied. • Valuation exceptions reviewed.
Investment Accounting	• Accuracy • True and Fair	Check whether: • Accounting treatment consistent with policy. • Investment ledger reconciled. • Realized gains/losses correctly booked. • Accrued income accurately recorded

		• Investment income recognized appropriately.
NAV Controls	• Accuracy	Check whether: • NAV calculated accurately. • NAV approved before release. • Exception reports generated. • Unit pricing reviewed • Audit trail maintained.
Concurrent Audit	• Corrective action	Check whether: • Coverage includes all asset classes. • Reports issued timely. • Exceptions tracked. • High risk observations escalated. • Closure verified.
Regulatory Compliance Controls		
Investment Pattern Compliance	Regulatory Compliance	Check whether: • Statutory investment pattern maintained.

		• Government Securities allocation complied. • Approved Investments complied. • Policyholder fund requirements complied. • Shareholder fund segregation maintained.
Exposure Norm Compliance	Concentration risk	Check whether: • Single issuer limits complied. • Group limits complied. • Sector limits complied. • Counterparty limits complied. • Breaches reported to Board.
Infrastructure & Social Sector Investments	Regulatory Compliance	Check whether: • Minimum regulatory allocations achieved. • Eligible assets classified correctly.

		• Supporting documentation maintained. • Periodic monitoring performed. • Regulatory reporting completed.
Related Party Investments	Conflict of interest	Check whether: • Investments approved by competent authority. • Arms length basis established. • Disclosures made. • Regulatory approvals obtained where applicable. • Monitoring performed.
IRDAI Reporting & Disclosure	Regulatory compliance	Check whether: • Returns submitted within timelines. • Data reconciled with books. • Disclosure requirement complied. • Certifications obtained. • Management sign off maintained

Audit Analytics/ CAATs

10.6 The increasing size, complexity and diversification of investment portfolios necessitate the use of advanced data analytics and continuous monitoring techniques. Traditional sample based audit approaches may not adequately identify emerging risks, concentration exposures, policy breaches or unusual trading patterns. Consequently, insurers are expected to leverage technology enabled analytics for effective monitoring of investment operations, risk management and regulatory compliance.

Investment analytics provide management, Investment Committee, Risk Management Committee and Internal Audit with actionable insights into portfolio performance, risk concentrations, compliance breaches, operational inefficiencies and potential fraud indicators. The internal auditor should evaluate the design and effectiveness of management's investment analytics framework and independently perform data driven reviews wherever feasible.

The key categories of investment analytics applicable to life insurers are discussed below:

Sr. No.	Area	Audit Analytics	Audit Indicators
1	**Governance Analytics** Evaluating the effectiveness of oversight mechanisms, decision making processes and adherence to Board approved policies.		
1a	Investment Committee Attendance The Investment Committee plays a critical role in overseeing investment strategy, risk management and regulatory compliance. Attendance analytics help	• Review attendance records of Investment Committee meetings. • Identify recurring absenteeism. • Analyse attendance trends across quarters and years.	• Attendance below prescribed threshold. • Frequent absence of key decision makers. • Repeated meetings conducted without full representation. • Delayed review of critical investment matters.

	assess the level of engagement and participation by committee members.	• Compare attendance against Board approved governance requirements. • Identify instances where quorum requirements were not met.	
1b	Policy Exception Reporting Instances where investment transactions deviate from Board approved investment policies.	• Compare transactions against approved investment universe. • Identify investments exceeding delegated limits. • Review temporary deviations approved by management. • Analyse frequency and nature of policy exceptions.	• Repeated policy deviations. • Excessive reliance on management exemptions. • Investments outside approved asset classes. • Delayed reporting of exceptions.
1c	Delegation of Authority (DOA) Breach Analysis Evaluates compliance with approval hierarchies and authorization limits.	• Compare deal size against approval limits. • Review approval workflow logs. • Analyse system override reports. • Identify post facto approvals.	• Unauthorized approvals. • Transactions exceeding delegated authority. • Maker checker violations. • Excessive manual overrides

2	**Portfolio Analytics** Analytics focus on investment performance, diversification and concentration risk.		
2a	Sector Exposure Analysis Identify concentration risks arising from excessive exposure to a specific industry or economic sector. (eg) • Banking Sector Exposure • NBFC Exposure • Power Sector Exposure • Real Estate Exposure • Infrastructure Exposure	• Classify investments by industry. • Compute sector wise portfolio allocation. • Compare actual exposure against policy limits. • Perform trend analysis.	• High exposure to a single sector. • Rapid increase in sector concentration. • Exposure exceeding internal thresholds.
2b	Group Exposure Analysis Identify concentration of investments among companies belonging to the same promoter group.	• Map investments to corporate groups. • Aggregate direct and indirect exposures. • Compare against regulatory and policy limits. • Review changes in group concentration.	• Breach of group exposure limits. • Significant exposure to financially stressed groups. • Increasing concentration trend. •

2c	Issuer Concentration Analysis This analysis evaluates exposure to individual issuers.	• Calculate issuer wise exposure. • Rank issuers by portfolio concentration. • Compare exposure against approved limits.	• Excessive concentration in a single issuer. • Breaches of exposure norms. • High concentration in lower rated issuers.
2d	Modified Duration Analysis Measures portfolio sensitivity to interest rate movements.	• Calculate duration at security and portfolio level. • Compare asset duration against liability duration. • Monitor duration gaps.	• Significant duration mismatch. • Increasing interest rate sensitivity. • ALM deviations.
2e	Yield Variance Analysis Yield analytics evaluate portfolio returns and identify unusual performance variations.	• Compare actual yield against benchmark yield. • Analyse portfolio return trends. • Identify underperforming securities.	• Unexpected reduction in yield. • Significant divergence from benchmark. • Persistent underperformance.
3	**Credit Analytics** Credit analytics assist in assessing deterioration in credit quality and default risk.		
3a	Rating Migration Analysis Rating migration tracks movement of securities across rating	• Monitor rating upgrades and downgrades. • Analyse rating transition matrix.	• Increasing concentration in lower rated securities. • Multiple downgrades within same sector.

	categories over time.	• Review exposure to deteriorating credits.	• Portfolio credit quality deterioration.
3b	Downgrade Monitoring Continuous monitoring of securities experiencing credit rating downgrades.	• Identify securities downgraded during the review period. • Assess compliance with post downgrade actions. • Review Investment Committee decisions.	• Delayed disposal of downgraded securities. • Failure to reassess impairment. • Breach of investment policy thresholds.
3c	Default Monitoring Tracks securities where issuers fail to meet repayment obligations.	• Identify defaulted investments. • Evaluate provisioning adequacy. • Assess recovery actions.	• Delayed recognition of impairment. • Inadequate provisioning. • Weak recovery monitoring.
4	**Operational Analytics** Operational analytics help identify inefficiencies and control failures within investment operations.		
4a	Failed Trade Analysis Failed trades may indicate settlement issues, funding constraints or operational weaknesses.	• Review failed trade reports. • Analyse failure frequency and causes. • Monitor ageing of unresolved failures.	• Repeated settlement failures. • Broker specific concentration. • Increased operational risk.

4b	Delayed Settlement Analysis	• Compare actual settlement dates against due dates. • Identify exceptions. • Review root causes.	• High settlement delays. • Liquidity constraints. • Custodian processing issues.
4c	Reconciliation Break Analysis	• Analyse unreconciled items. • Age reconciliation differences. • Review resolution timelines.	• Long outstanding differences. • Recurring unmatched items. • Custodian discrepancies.
4d	Suspense Account Ageing Analysis Suspense balances may conceal accounting errors or operational lapses.	• Review ageing of suspense items. • Identify recurring entries. • Analyse clearance trends.	• Long outstanding balances. • Significant unreconciled entries. • Unsupported adjustments.
5	**Compliance Analytics** Compliance analytics evaluate adherence to regulatory and internal investment requirements.		
5a	Exposure Limit Breach Analysis	• Compare actual exposures against regulatory limits. • Review near breach situations. • Monitor recurring exceptions.	• Repeated breaches. • Delayed rectification. • Weak monitoring controls.

5b	Regulatory Exception Analysis	• Review all reported exceptions. • Analyse frequency and root causes. • Evaluate corrective actions.	• Repeat observations. • Weak governance framework. • Ineffective escalation.
5c	Investment Pattern Compliance Analysis	• Verify compliance with statutory investment pattern requirements. • Analyse asset allocation trends. • Review deviations.	• Non compliance with prescribed investment pattern. • Excessive allocation to non-approved investments. • Regulatory reporting inconsistencies.
6	**Fraud Analytics** Fraud analytics are designed to identify unusual trading patterns, conflicts of interest and potential misconduct.		
6a	Dealer Wise Trade Concentration Analysis	• Analyse trade volumes by dealer. • Compare dealer activity trends. • Identify unusual trading patterns.	• Excessive concentration with a single dealer. • Unusual increase in trading activity. • Transactions outside normal patterns.
6b	Broker Concentration Analysis	• Analyse transactions executed through each broker. • Review broker market share. • Compare against approved thresholds.	• Excessive broker dependence. • Related party broker transactions. • Reduced competitive execution.

6c	Off Market Transaction Analysis	• Identify transactions executed outside exchanges or approved platforms. • Review approvals and supporting documentation.	• Unusual off market activity. • Lack of documentation. • Pricing anomalies. •
6d	Exception Override Analysis	• Review manual system overrides. • Analyse override frequency. • Evaluate authorization controls.	• Excessive overrides. • Repeated override by same user. • Overrides occurring near reporting dates.

Internal auditors should increasingly leverage data analytics tools such as IDEA, ACL, Power BI, Tableau and SQL based analytical techniques to independently assess investment risks, identify anomalies and validate management reporting. Continuous monitoring dashboards should be encouraged for high-risk areas such as exposure limits, rating downgrades, valuation exceptions, settlement failures and regulatory compliance breaches.

A mature investment analytics framework significantly enhances the insurer's ability to identify emerging risks, strengthen governance, improve investment decision making and protect policyholder interests.

Red Flags

10.7 The following red flags may indicate potential control weakness, regulatory non-compliance of external deficiencies or hightend investment risks and should be considered for audit review:

- Frequent exposure limit breaches.
- Investments approved post facto
- Excessive concentration in a single issuer/group
- Repeated settlement failures

- Persistent custodian reconciliation breaks
- Investments below approved rating thresholds
- Significant year end valuation adjustments
- Large manual journal entries affecting investments
- Delayed reporting of breaches
- Multiple exceptions raised by concurrent auditors
- Investments outside approved universe
- Significant ALM mismatches
- Related party transactions lacking documentation
- High volume of manual overrides in investment systems
- Unexplained fluctuations in NAV

Commonly Observed Irregularities/ Violations

10.8 The following are some commonly observed irregularities of non-compliance in investment operations that may warrant specific attention during internal audit:

- Investment policy not reviewed annually.
- Investment Committee meetings not adequately documented.
- Breach of issuer/group exposure limits.
- Delayed escalation of rating downgrades.
- Investments made without complete due diligence.
- Weak segregation between Front Office, Mid Office and Back Office.
- Unresolved custodian reconciliation differences.
- Delayed settlement of transactions.
- Inaccurate valuation methodology.
- Incorrect NAV calculations.
- Non-compliance with infrastructure/social sector requirements.
- Incomplete regulatory disclosures.

- Delayed submission of returns.
- Inadequate concurrent audit coverage.
- Repeat observations not closed.
- Weak monitoring of outsourced activities.
- Inadequate ALM monitoring.
- Inadequate liquidity stress testing.
- Missing documentation for investment approvals.
- Weak monitoring of related party investments.

Regulatory References

Reference	URL
IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations, 2024 (Notification No. IRDAI/Reg/10/204)	IRDAI Actuarial, Finance and Investment Functions of Insurers Regulations, 2024
Master Circular on Actuarial, Finance and Investment Functions of Insurers (Ref. IRDAI/ACTL/CIR/MISC/80/05/2024 dated 17 May 2024)	Master Circular on Actuarial, Finance and Investment Functions of Insurers (17 May 2024)
IRDAI (Corporate Governance for Insurers) Regulations, 2024	IRDAI Corporate Governance for Insurers Regulations, 2024
Master Circular on Corporate Governance for Insurers, 2024	IRDAI Regulations and Circulars Repository
Earlier Guidelines for Corporate Governance for Insurers in India (still useful as background/reference)	Guidelines for Corporate Governance for Insurers in India

Chapter 11
Legal Framework and Compliances

Scope and Objective

11.1 This chapter guides the internal auditor in reviewing the enterprise level legal and regulatory compliances of a life insurance company: governance, obligation ownership, regulatory change management, filings, certifications, regulatory compliance, litigation, contract controls and evidence of compliance. It should be read with Chapter 2 of this publication. The legal position must be reconciled to IRDAI's live register, the Gazette notifications, applicable master circulars and bare amended Acts as on the testing date.

Objective: The internal auditor's objective is to obtain assurance that obligations are completely identified, owned, risk ranked, monitored for change, implemented, filed or reported accurately and on time and remediated when breached. The engagement is directed primarily to SIA 160, Compliance with Laws and Regulations also draws attention to SIA 150, Risk Management, SIA 220, Internal Audit Planning and SIA 230, Internal Audit Evidence as issued by the ICAI.

Relationship with the process area chapters: Compliance obligations embedded in specific operating processes are tested in the relevant process chapters. This chapter therefore avoids duplicacy and retains the enterprise level layer.

The chapter addresses cross cutting obligations that commonly have no single process owner or require enterprise level coordination: tax, FATCA/CRS, Companies Act, SEBI LODR where applicable, PMLA entity level obligations, DPDP readiness/live compliance, regulatory correspondence, litigation, legal opinions, contract lifecycle controls and compliance certifications.

The Compliance and Governance Operating Model

11.2 The Internal auditor first documents the compliance operating models to obtain an understanding of who owns compliance, how obligations are allocated, how exceptions are escalated and how the Board and its committees receive evidence regarding compliance status.

The Three Lines of Defence

Compliance in a life insurer is built on three lines of defence and the independence of the second and third lines from the first is itself a control the auditor evaluates.

- **The First Line is the Business:** Process owners in underwriting, claims, operations and distribution carry primary responsibility for complying with the rules embedded in the processes they run. Most compliance either succeeds or fails at this line.
- **The Second Line is the Compliance Function:** headed by the Chief Compliance Officer and supported by the Company Secretary and the legal function. It maintains the obligations register, monitors compliance across the organisation, advises the business and reports to the board. The regulations require it to be adequately resourced and independent of revenue ownership.
- **The Third Line is Internal Audit:** which provides independent assurance over the first two. This engagement is an exercise of that role the auditor preserves independence by testing the compliance function rather than performing its work for example, by re performing the reconciliation of the obligations register rather than maintaining the register.

Board and Committee Oversight

The Internal auditor verifies that each required committee:

- Exists,
- Is properly constituted,
- Meets at the prescribed frequency and
- Receives exception based information of sufficient quality. This is especially critical, as here the test is that the committee doesn't merely exist, but is actually functional, evidenced through the fact that known compliance breaches, delayed filings, regulatory changes, policy expiries and inspection issues were actually escalated.

Below is the list of committees, their respective role in compliance oversight and the principal audit evidence that is usually obtained for audit purposes:

Sr. No.	Committee	Role in Compliance Oversight	Principal Audit Evidence
1	Audit Committee	Oversees internal audit, statutory audit, internal financial controls and the compliance reporting that reaches the board	Charter minutes the compliance dashboards and exception reports tabled
2	Risk Management Committee	Owns the enterprise risk framework, within which regulatory and compliance risk is identified, assessed and monitored	Risk register committee minutes risk appetite statement
3	Policyholder Protection, Grievance Redressal and Claims Committee	Oversees the insurer's conduct and policyholder protection obligations	Committee minutes grievance and claims MIS
4	Nomination and Remuneration Committee	Tests the fit and proper status of directors and key management persons and owns the remuneration policy	Fit and proper declarations committee minutes
5	CSR Committee	Oversees CSR spend and compliances	CSR policy, CSR plan/budget, minutes, CSR 2/MCA filings, annual report disclosures, unspent CSR tracking and board oversight.
6	Investment Committee	Governs investment compliance (examined in Chapter 11)	Cross refer Chapter 11

7	With Profits Committee	Governs the participating fund (examined in Chapter 4)	Cross refer Chapter 4

The inventory of board approved policies is tested in Section, The Inventory of Board – Approved Policies. Missing, expired, superseded or non-operational policies are treated as governance control failures, especially where the underlying master circular has changed.

Auditing the Corporate Governance Compliance Framework

11.3 This section tests the insurer's compliance with corporate governance obligations applicable to the Board, committees, KMPs, statutory auditors, related party transactions, conflicts of interest, vigil mechanism and board approved policies. Commercial merits of Board decisions remain outside the internal audit mandate.

IRDAI (Corporate Governance for Insurers) Regulations, 2024 and the Master Circular dated 22 May 2024, read with the relevant provisions of the Companies Act, 2013 and, for a listed insurer, the SEBI (Listing Obligations and Disclosure Requirements) Regulations, 2015 govern this. The auditor tests compliance with the obligations. The substantive merits of the board's commercial decisions are outside the scope of internal audit and are not examined.

Board Composition and the Constitution of Committees

The auditor verifies that:

- The board's size and composition meet the prescribed norms,
- The required proportion of independent directors is present and maintained throughout the year (not merely at a point in time) and
- The separation of the roles of Chairperson and Chief Executive is as required or, where combined that the conditions permitting combination are met.
- Following the 2025 amendments, the auditor also confirms that at least one of the Chairperson, the Managing Director or the Chief Executive Officer is a resident Indian citizen.

The Internal auditor confirms that every committee has been constituted as per regulation. The internal auditor tests four attributes in this regard:

- That its membership and chair meet the prescribed composition (for instance, the required presence of independent directors and the exclusion of executive directors where mandated)
- That it has a board approved charter or terms of reference that reflect the current regulatory mandate
- That it met at the required frequency through the year, with quorum and
- That its deliberations are evidenced by minutes of sufficient quality to show that it applied its mind to the matters within its remit.

Audit Evidence. Board and committee minutes are the primary evidence and should be read, not merely confirmed to exist. The internal auditor corroborates attendance against the register, traces a sample of regulatory matters (a policy approval, a fit and proper confirmation, an inspection response) from the minute that records the board's action on it and notes any matter that should have reached a committee but did not.

Fit and Proper Status as a Continuing Obligation

The fit and proper requirement applies to directors and key management persons and it is a continuing obligation. The auditor confirms that:

- The insurer obtains fit and proper declarations at appointment and refreshes them at the prescribed interval, ordinarily annually
- The declarations are complete and cover the matters the regulations specify
- The board or the Nomination and Remuneration Committee actually considers them and
- Any change in a person's status during the year a disqualification, a regulatory action, an insolvency, a conflict is captured, assessed and, where required, intimated to IRDAI. For this purpose, the audit procedure must mandate checking the minutes of the subsequent board meeting following any public or judicial listing of a group entity or individual director to see if an immediate disclosure was made. These minutes may reflect a change in status of a Key Management Personnel (KMP) that has not been captured by the company in the interim period.

Related Party Transactions and Conflicts of Interest

A life insurer transacts with promoters, group entities, reinsurers and outsourced service providers that may be connected persons and it manages large investment portfolios in which conflicts can arise. The corporate governance regime and the Companies Act both impose related party transaction controls and both operate parallelly. The auditor tests the full cycle that:

- The insurer maintains a current register of related parties wide enough to capture the connections that actually exist
- Transactions with them are identified before execution
- They are approved as law requires, with interested persons recusing themselves
- They are assessed for arm's length pricing on a basis the insurer can evidence and
- They are disclosed as required in the financial statements and to the regulator.

The audit also extends to the conflict of interest framework more broadly the declarations obtained from directors, key management persons and, where relevant, members of the Investment Committee and the manner in which declared conflicts are managed in practice. The typical weakness is not the absence of a policy but its non-operation:

- A register that is not refreshed
- Transactions identified only at the audit confirmation stage or
- Arm's length assertions unsupported by any contemporaneous analysis.

Closely related is the whistle blower or vigil mechanism, required under both the corporate governance framework and the Companies Act and overseen by the Audit Committee. The auditor confirms not merely that the mechanism exists on paper but also that:

- It provides a confidential route,
- Disclosures are logged and investigated and
- The Audit Committee receives and reviews them

A vigil mechanism that exists in policy but produces no evidence of committee review, is a common and readily evidenced deficiency.

The Inventory of Board Approved Policies

The regulations require a life insurer to maintain a substantial set of policies approved by the board covering, among others, underwriting, investments, outsourcing, anti-fraud, anti-money laundering, grievance redress, expenses of management, stewardship, remuneration and protection of policyholders' interests. These policies are the documented bridge between the regulatory obligation and the conduct of the business. They translate the law into the insurer's own operating instructions.

For the population of required policies, the auditor tests four things in sequence:

- **Existence and Completeness:** Every policy the regulations require is actually held. Here, apart from reviewing the policies presented by the insurer, the auditor also independently establishes which policies the regulations require and tests the insurer's inventory against that list.
- **Approval:** Each was approved by the board, traced to the minute that records the approval, rather than adopted at management level.
- **Currency:** Each has been reviewed within its stated review cycle, since a policy that has lapsed its annual or bi annual review is no longer a reliable statement of the insurer's obligations, particularly given how frequently the underlying master circulars change.
- **Force:** The version on the shelf is the version actually operating in the business, tested by comparing the policy against what is found on the ground.

The anti-fraud policy in this inventory warrants specific attention because the framework around it changed with effect from 1 April 2026. The IRDAI (Insurance Fraud Monitoring Framework) Guidelines, 2025 require a board approved anti-fraud policy reviewed annually, a dedicated and independent Fraud Monitoring Committee and Fraud Monitoring Unit and compressed, binding reporting timelines to law enforcement, IRDAI and the Insurance Information Bureau. As an entity level governance obligation the auditor confirms that:

- The committee and unit exist and are independent,

- The policy is current under the new guidelines rather than the repealed 2013 framework and
- The new reporting timelines are built into the process in this regard, the auditor must sample detected fraud cases from the internal whistle blower/vigil logs or claims investigative files and trace them to the exact timestamp of the IIB upload to verify compliance with the new timelines.

The operational fraud risk testing across sourcing, underwriting, claims, servicing and channel payouts is performed in the relevant process chapters.

Appointment of the Statutory Auditor

The corporate governance regime governs the selection and appointment of the statutory auditor the eligibility of the firm, the rotation requirements, the appointment of joint auditors where mandated and the recommendation of the appointment by the Audit Committee. The internal auditor tests compliance with these requirements as a governance control that:

- The appointee was eligible,
- Rotation was observed,
- The Audit Committee made the recommendation the regulations require and
- The appointment was approved at the correct level.

Building the Compliance Universe: the Risk Ranked Obligations Register

11.4 The obligations register is the audit population for this chapter. It should identify every applicable legal, regulatory, filing, approval, certification, disclosure and conduct obligation, mapped to an accountable owner and risk rating.

The Internal auditor does not rely on the insurer's register without testing it. Completeness is tested independently against IRDAI's live register, master circulars, Gazette notifications, amended statutes and non-IRDAI laws applicable to the insurer.

Testing the Register for Completeness and Currency

Where the insurer maintains an obligations register, the Internal audit proceeds in two directions.

- The auditor first tests **completeness** that nothing required is missing by reconciling the register against independent sources. The auditor traces a sample of obligations from those sources into the register and investigates any that do not appear. A single material omission an applicable master circular absent from the register is reported.
- The auditor then tests **currency** The register must be updated whenever the law moves. Given that the operative detail of the regime sits in master circulars that are amended frequently, the auditor checks that the register records, for each obligation, the specific instrument and version that is current, the date it was last reviewed and the owner responsible for it. Next panel of this chapters examines the change management process that is supposed to keep the register current the two tests are complementary and a finding in one ordinarily points to a weakness in the other.
- Finally the auditor tests **ownership** Every obligation in the register should map to a single accountable owner who can be identified and who acknowledges the obligation as theirs. Obligations with no owner, or with an owner who has left or who disclaims responsibility, are obligations that in practice no one is discharging and therefore most likely to have gaps.

When the Register is Absent or Inadequate: Where the insurer has no obligations register, or one too incomplete to rely on, its absence is itself a reportable finding of the first order the insurer cannot demonstrate that it knows its obligations.

Risk Ranking the Register to Direct Audit Effort

Risk ranking converts the register into a prioritised audit population. Audit depth should follow consequence of breach, frequency of change, manual dependency, regulatory attention and pervasiveness.

The risk score should determine the audit response: detailed testing for high-risk obligations, rotational or lighter testing for moderate risk obligations and documented exclusion for low-risk items.

Below is the list of risk drivers that each obligations should be scored against:

Sr. No.	Risk driver	Why it Raises Compliance Risk	Indicative Compliances that usually Carry High-risk Markers
1	Consequence of Breach	Some breaches now carry not only monetary penalty but disgorgement of wrongful gains under the 2025 amendments, alongside reputational and license consequences	Conduct, mis selling and policyholder protection obligations solvency,
2	Frequency of Change	Obligations governed mainly by a master circular change far more often than those fixed in a regulation or statute, so the window for falling out of compliance is wider	
3	Manual Dependency	Obligations discharged through manual effort or spreadsheets fail more often and less visibly, than those enforced by a configured system control	
4	Regulatory Attention	Areas under active thematic inspection, recent circular, or sector wide regulatory focus carry a higher	Expenses of management the Ind AS transition cyber and data governance

		likelihood of examination and finding	
5	Pervasiveness	An obligation embedded across many processes has a wider failure surface and a larger impact when the control breaks	Section 64VB premium control anti money laundering data protection

Document the reason for testing or excluding each obligation. Any scope limitation or deliberate exclusion of a material obligation should be communicated to the Audit Committee.

Regulatory Change Management

11.5 A major compliance risk is failure to keep pace with frequent amendments to master circulars, statutory amendments, regulatory directions and annual obligation notifications. An insurer may fall into breach even if its process has not changed, because the applicable rule has changed.

The auditor obtains assurance that every relevant change is detected, applicability is assessed, ownership is assigned, affected policies/SOPs/ systems/returns are updated, staff are trained where needed and closure is evidenced.

The Change Management Lifecycle

The lifecycle below sets out the usual stages that any organisation follows for implementing changes in statutes, regulations, master circulars, guidelines, directions and regulatory correspondence.

Horizon scanning and detection

Monitor IRDAI register, circulars, gazette and Council communications

↓

Applicability and impact assessment

Does it bind a life insurer? Which processes, systems, returns, policies are affected?

↓

Assign ownership and plan implementation

Single accountable owner target date interim control where needed

↓

Implement the change

Update SOPs and systems amend the board policy train the affected staff

↓

Evidence and update the register

Record the change and the date of implementation refresh the obligations register

↓

Monitor and close :loop back if incomplete

Confirm sustained compliance reopen where implementation lags

Key Audit Tests

The principal tests are:

- **Completeness of Detection:** Independently compile the circulars, amendments and notifications issued during the audit period from IRDAI's live register and for changes issued in the period, has each one been *detected, logged and routed* through the lifecycle.

- **Quality of Impact Assessment:** For a sample of detected changes, examine whether the insurer correctly determined applicability and identified every affected process, system, return and policy. For example, a change logged but recorded as relevant to one department when it touches three is a sign of control weakness.
- **Implementation Lag Testing:** For a sample of changes, measure the elapsed time from the effective date to evidenced implementation and quantify any period of non-compliance.
- **Circular versus Regulation Reconciliation:** Confirm that the insurer is operating in accordance with the current master circular rather than to the parent regulation alone and that superseded circulars have been withdrawn from use.
- **Forward Calendar:** Confirm that changes with a future effective date phased provisions of the 2025 Act, Ind AS milestones, annual obligation notifications are tracked on a forward calendar with owners, so that the insurer is ready on the date the obligation takes effect rather than scrambling after it.

The Change Register: The evidence for these tests is the insurer's regulatory change register ideally the same record as the obligations register mentioned in previous paragraph, so that detection, assessment, ownership and implementation status sit alongside the obligation each change affects. Where the two are maintained separately, or where the change register is an email trail rather than a structured record, the auditor notes the weakness and tests completeness with greater rigour.

Where the change management process is informal dependent on an individual's diligence rather than an owned and documented procedure the auditor treats this as a control design weakness in its own right, irrespective of whether a specific change happens to have been missed.

The Regulatory Returns and Filings Universe

11.6 Regulatory returns and filings create direct, timestamped evidence of compliance or breach. The auditor tests completeness, accuracy, timeliness, approval, source reconciliation and retention of filing acknowledgements.

The reference point is the IRDAI Master Circular on Submission of Returns dated 14 June 2024, issued under Section 34 of the Insurance Act read with

Section 14 of the IRDA Act, 1999. It was created precisely to consolidate into one place the returns previously scattered across many circulars and it is reviewed annually. It is organised in three parts:

- **Part I** specifies the returns required under the eight consolidated 2024 regulations and their master circulars covering rural and social sector obligations, capital and shareholding, expenses of management and commission, the actuarial, finance and investment functions, corporate governance, products, protection of policyholders' interests and reinsurance.
- **Part II** comprises business statistics returns, collected through the Business Analytics Project portal or by email that track the spread and performance of the business.
- **Part III** repeals the earlier circulars the master circular supersedes and is itself a useful check that the insurer has retired the old filing instructions.

A distinct category within this population is the set of periodic compliance certifications and attestations the insurer signs to IRDAI among them the corporate governance compliance certificate, the annual AML/CFT compliance certificate due within 45 days of the financial year end and the various confirmations of compliance that accompany other filings. Unlike a data return, a certificate is an assertion and its risk is misattestation the internal auditor confirms that:

- Each certificate was signed by the authority the instrument requires,
- It was supported by underlying compliance evidence at the date of signing rather than back filled and
- Any qualification or exception was disclosed in the certificate rather than suppressed.

Building and Testing the Returns Inventory

The Internal auditor independently builds the returns population from the Master Circular on Submission of Returns and reconciles it with the insurer's filing calendar. A return absent from the insurer's own calendar is a high-risk exception, because it will not be filed or tested unless independently identified.

For each return in the inventory, the auditor establishes and then tests against the evidence, four attributes:

- **Ownership:** A single named owner in the first line is accountable for preparing and filing the return.
- **Accuracy:** The figures in the return reconcile to the underlying books, systems and actuarial workings from which they are drawn and the return is internally consistent and consistent with related returns filed for the same period.
- **Timeliness:** The return was filed by the due date for its periodicity. The most reliable evidence of timeliness is the filing acknowledgement or portal timestamp, which the auditor obtains rather than relying on the preparation date declared by the auditee.
- **Approval and sign off:** The return carried the internal review and the governance approval it requires before filing. Several returns must be approved by the audit committee and the board before submission the expenses of management and commission returns being a clear example and the auditor confirms that approval was obtained and minuted, not applied after the event.

The table below illustrates the structure of the population the auditor constructs it is indicative, drawn from the regulation wise organisation of the master circular and is not a substitute for building the current inventory from the circular itself:

Sr. No.	Domain (per the 2024 regulations)	Illustrative Returns	Typical Periodicity	First line Owner
1	Actuarial, finance and investment	Actuarial valuation returns With Profits Committee report Appointed Actuary's annual report ALM returns investment returns	Mixed: actuarial/ valuation returns as prescribed standard investment returns include quarterly filings for all insurers ALM quarterly reporting	Appointed Actuary/ CIO/ CFO

		including investment asset, downgrade, NPA and investment compliance forms	where specifically applicable to D SIIs annual filings where prescribed	
2	Registration and capital structure	Equity shareholding pattern statement	Quarterly	Company Secretary
3	Expenses of management and commission	Commission return expenses of management return	Annual (audit committee and board approved)	CFO
4	Protection of policyholders' interests	Grievance and policyholder protection returns	Periodic	Head of Operations
5	Rural and social sector obligations	Rural and social sector obligation return	Half yearly	Chief Compliance Officer
6	Corporate governance	Corporate governance returns	Periodic/ annual	Company Secretary/ CCO
7	Business statistics (Part II)	Life department statistical returns via the BAP portal	Periodic	Designated MIS owner

Common Deficiencies

Certain weaknesses recur across returns audits and provide a useful focus for fieldwork:

- A required return never set up for filing and therefore absent from the insurer's own calendar detectable only by building the inventory independently from the master circular.
- Returns filed on time but inconsistent with one another, where the same figure reported in two returns for the same period does not agree a sign that returns are compiled in isolation rather than from a single reconciled source.
- Governance approval obtained after filing, or recorded as a formality, for returns that require audit committee or board sign off before submission.
- Reliance on manual compilation in spreadsheets, with no maker checker, for returns drawn from systems that could supply the data directly raising the risk of both error and untimeliness.
- Filing evidence not retained, so that the insurer cannot demonstrate the date on which a return was actually submitted.

The Ind AS Transition

The adoption of Indian Accounting Standards from 1 April 2026, operationalised by Schedule IIA inserted into the Actuarial, Finance and Investment Functions Regulations, 2024, is treated here as a filing, implementation and governance compliance matter. The accounting judgements themselves are tested in the financial closing chapter.

- **Parallel Reporting:** For the first two years, confirm that the insurer furnishes the audited/limited reviewed Ind AS financial statements (Schedule IIA) alongside the existing IGAAP based financial information (Schedule II, limited reviewed) and that both are filed for each period the framework requires. Further, also test the dual ledger reconciliation system. The risk is that adjustments made in the Ind AS engine (like Contractual Service Margin (CSM) or Expected Credit Loss (ECL) under Ind AS 117/109) do not accurately route back or reconcile with the IGAAP figures submitted via the BAP portal. The procedure must check for a board approved operational policy managing the dual profit framework.

- **Forbearance and Progress Reporting:** Where the insurer applied for the one-year forbearance from full Ind AS statutory statements, confirm the application was made within the window that closed 30 April 2026 and confirm that, the quarterly financial information under Ind AS (as required) and the monthly implementation readiness progress reports were submitted on time. Further, also check the monthly implementation readiness progress reports submitted to IRDAI on a sample basis, to ensure the data pipelines are genuinely being built, preventing an emergency scramble as the forbearance expires in 2027.
- **Ind AS 117 Transition Data:** For participating and other applicable business, test the insurer's annual cohort grouping, use of transition relief, completeness of historical data, data lineage, governance approval of key judgements and evidence supporting the transition approach. Avoid recording specific retrospective year thresholds unless tied to a live IRDAI circular or notification applicable on the testing date.
- **Reconciliations that Must Hold:** Confirm that the insurer reconciles actuarial surplus to Ind AS profit and that Section 49 of the Insurance Act continues to govern surplus distribution (Ind AS profit is not distributable surplus) that the tax basis is reconciled to Ind AS profit and that for a listed insurer, the SEBI LODR quarterly review timelines are met on the new basis.

Registration, Capital and Ongoing License Conditions

11.7 An insurer carries on business under a certificate of registration granted by IRDAI and that certificate is not a one-time clearance but a standing license subject to continuing conditions. The grant itself and the events surrounding it, are of limited interest to a recurring internal audit what the auditor examines year after year, are the conditions attached to the license and to the insurer's capital structure, several of which were reshaped by the 2025 amendments to the insurance statutes. Each is tested as a live obligation that must hold throughout the period, not merely at the date the registration was granted.

The governing instruments are the Insurance Act, 1938 as amended in 2025, the IRDAI (Registration, Capital Structure, Transfer of Shares and Amalgamation of Insurers) Regulations, 2024 and its master circular, read with the FEMA Non-Debt Instrument Rules and the Indian Insurance Companies

(Foreign Investment) Rules for the foreign investment conditions. Chapter on Legal and Regulatory Framework sets out these provisions this section addresses how the auditor tests compliance with them.

Capital Adequacy and the Net Owned Fund Requirement

The net owned fund is the foundation of an insurer's financial standing and its maintenance is a continuing statutory condition rather than an entry test met once at registration. The auditor confirms that the insurer holds, throughout the period, the net owned fund the Act requires. The substantive testing of solvency and the required solvency margin is performed in the actuarial chapter here the auditor's focus is the capital condition attached to the license and its continuing satisfaction.

Share Transfers and Changes in Shareholding

Changes in an insurer's shareholding are regulated because they bear on who ultimately controls the insurer. Prior approval of IRDAI is required where a transfer of shares crosses the prescribed threshold, which the 2025 amendments raised from one per cent to five per cent of paid up equity. The auditor:

- Confirms that the insurer applies the current five per cent threshold and that its internal monitoring aggregates related transfers rather than testing each in isolation,
- Traces a sample of share transfers in the period to the approval obtained, or to a documented assessment that approval was not required,
- Review the Ultimate Beneficial Ownership (UBO) registers under the Companies Act and a cross check against the insurer's related party vendor networks to verify whether the transferees are acting in concert and
- Confirms that the equity shareholding pattern statement filed with IRDAI (the quarterly return noted in Section "The Regulatory Return and Filling Universe) is consistent with the share register and with any approvals obtained.

Foreign Investment Conditions

Foreign investment in Indian insurers is permitted up to one hundred per cent of paid-up equity following the 2025 reforms, but the increased ceiling does

not remove the conditions. The auditor tests the Insurance Act, FEMA Non-Debt Instrument Rules, Indian Insurance Companies (Foreign Investment) Rules, IRDAI verification/approval requirements and any conditions applicable on the testing date:

- That the level of foreign investment is within the permitted ceiling and was effected through the automatic route now available up to one hundred per cent, subject to the conditions in the FEMA Non-Debt Instrument Rules and the Indian Insurance Companies (Foreign Investment) Rules,
- That the financial condition attaching to the enhanced one hundred per cent cap is satisfied namely that the insurer invests the entire premium it collects within India,
- That the resident Indian citizen requirement as liberalised by the 2025 amendments is met at least one of the Chairperson, the Managing Director or the Chief Executive Officer being a resident Indian citizen (tested also as a governance condition in Section 11.3).
- That any conditions attached to foreign owned or foreign controlled status board composition, residency of key persons and the like are satisfied on a continuing basis and
- Where the auditee is the Life Insurance Corporation, that the separate twenty per cent foreign investment ceiling applicable to it is observed, rather than the one hundred per cent ceiling that applies to other insurers.

Continuing Registration Conditions and Undertakings

Beyond capital and shareholding, the registration carries conditions and the insurer may have given undertakings to IRDAI at registration or on subsequent approvals for instance on the scope of business, on the use of a particular name, or in connection with a scheme of amalgamation. The Internal auditor establishes the population of such conditions and undertakings from the registration file and subsequent regulatory correspondence and tests that each continues to be observed. Conditions of this kind are easily lost from view precisely because they are not periodic filings an undertaking given years ago, with the individuals who gave it long departed, is exactly the obligation that quietly falls into breach.

The 2025 amendments introduced structural flexibility around transfer or amalgamation of insurance and non-insurance business, subject to IRDAI approved schemes. The Internal auditor confirms that the insurer operates only within the class or classes of business for which it is registered and that any transfer, amalgamation or structural change has been effected with the approvals required by the amended Act and registration regulations.

Audit Evidence: The primary evidence is the registration certificate and file, the share register and transfer approvals, the FEMA filings and the regulatory correspondence recording any conditions or undertakings.

Rural and Social Sector Obligations

11.8 A life insurer is required to underwrite a minimum volume of business among rural populations and the social sector, as a condition of carrying on insurance business and as an instrument of the regulator's financial inclusion mandate. It is governed by the IRDAI (Rural, Social Sector and Motor Third Party Obligations) Regulations, 2024 and the master circular issued under them the Internal auditor must check as per master circular in force for the financial year under review, because the targets are set for defined years and are revised the 2025 master circular, for instance, sets graded targets for the financial years 2025 26 and 2026 27 and supersedes the earlier circular.

The audit objective of Internal Audit to confirm:

- That the insurer has correctly measured its obligation for the year,
- Has genuinely achieved it through business that qualifies and
- Has reported the outcome accurately.

The risk that drives the audit is: because the obligation is mandatory and its non-achievement is a reportable breach, there is a standing incentive to classify business as qualifying when it does not and so to overstate achievement.

Establishing the Obligation for the Year

The Internal auditor first establishes what the insurer was required to achieve, from the master circular applicable to the year, rather than from the insurer's own statement of its target. The obligation is graded and year specific and is expressed in more than one dimension:

- Rural sector a minimum percentage of lives covered within gram panchayats allocated to the insurer, against year specific targets.
- Social sector a minimum percentage of lives, measured as a proportion of the total, lives the insurer covers, again rising year on year, with the social sector defined widely to include cardholders and beneficiaries under specified government schemes.

The internal auditor confirms that the insurer has read the obligation correctly in each dimension, has used the allocation of gram panchayats actually made to it and has applied the percentages prescribed for the specific year rather than carrying forward a prior year figure.

Testing Achievement and the Qualifying Population

The substance of the audit is the classification of business as rural or social sector. The internal auditor re performs or samples the classification, tracing reported lives back to the policy records and to the geographic or scheme based criterion that makes them qualify and tests in particular that:

- lives reported as rural fall within the allocated gram panchayats, by reference to the address and location data on the policy and are not classified rural on a looser or outdated basis,
- lives reported as social sector genuinely meet the scheme membership or beneficiary criterion, with the supporting identification held on file,
- The measurement base is correct in particular that the social sector percentage is taken against the right denominator of total lives covered,
- lives are not double counted across obligations or across policies and that group business is counted on the prescribed basis.

Particular attention is due to any reliance on self-certification. The master circular permits, within limits, the self-certification of social sector lives where government identity proof is not available up to twenty per cent of the social sector obligation under the 2025 circular. Self-certification is the point of least independent evidence and therefore of greatest risk of overstatement the internal auditor tests that the insurer has stayed within the permitted proportion and that even self-certified lives rest on some contemporaneous record rather than a year end adjustment to close a shortfall. For this purpose, a useful test is to do an aging and time series analysis of self-certified policies. If more than 40% of the self-certified social sector population is logged in the final quarter

of the year, the internal auditor must sample these cases with enhanced skepticism, calling for field verification or telephone verification records rather than accepting the system flag blindly.

Data Analytics Procedures: Use policy level data to test rural/social classification against allocated gram panchayat mapping, scheme/beneficiary identifiers, duplicate lives, group policy counting basis, year end surges and self-certified social sector lives approaching or exceeding the permitted threshold.

Reporting and the Obligation Return

Finally the Internal auditor traces the achievement the insurer reports to IRDAI through the rural and social sector obligation return identified in Section "The Regulatory Return and Filling Universe", filed half yearly back to the tested underlying figures and confirms that the return is accurate, complete and filed on time. A discrepancy between the reported achievement and the auditor's re performed figure is reported, as is any shortfall against the obligation that the insurer has not itself disclosed, since an undisclosed shortfall is both a substantive breach and a reporting failure.

Common Deficiencies: Lives classified as rural on an outdated or incorrect mapping to the allocated gram panchayats social sector lives counted without the supporting scheme or beneficiary evidence the social sector percentage measured against the wrong denominator self-certification used beyond the permitted proportion or relied on to close a year end shortfall and achievement reported to IRDAI that cannot be traced to underlying records. Each is evidenced against the policy data and the applicable master circular, not asserted.

Tax Compliance

11.9 In this engagement, the Internal auditor's objective is to check the completeness, accuracy, timeliness and reconciliation of the insurer's tax filings and withholdings. Auditor's objective is to check whether it has been identified, provided for and disclosed appropriately, not whether the insurer's view of the law is correct.

Taxation of Life Insurance Business

The profits of life insurance business are computed on special basis. Section 44 of Income Tax Act 1961 read with the First Schedule outlines, computing the profit of the life business by reference to the actuarial surplus rather than a conventional profit and loss measure the Income Tax Act 2025 carries this special computation regime forward under Section 55 read with Schedule XIV. The internal auditor tests the Act that governs the period under review: the Income Tax Act 1961 for FY 2025-26 and the Income tax Act, 2025 (Section 55 and Schedule XIV the consolidated withholding provisions of Section 393 and FATCA/CRS under Section 508) from FY 2026 27. The audit focus is not the computation itself which is specialised and advised but its integrity as a compliance matter:

- that the computation has been performed on the special basis the Act requires for life insurance and ties to the actuarial surplus determined in the valuation examined in Chapter 4,
- that the return of income and any tax audit or accompanying report, are filed completely and by the due date and
- that contested positions and demands are identified, provided for or disclosed as contingent liabilities and tracked through assessment and appeal.

Withholding Tax

A life insurer is a substantial deductor of tax at source and withholding is largely a systems and process control: the rates, thresholds and exemptions are configured into the policy administration and payment systems and failures are usually configuration failures that repeat across many transactions until corrected. The two withholding streams of most consequence are deduction on commission paid to agents and intermediaries and deduction on payments to policyholders. Under the 2025 Act these obligations sit within the consolidated withholding provisions of Section 393, replacing the separate sections of the Income Tax Act 1961. The auditor:

- Confirms that the systems deduct at the correct rate and apply the correct threshold and exemption logic for each payment type, by re computing the deduction on a sample of commission payments and policyholder payouts,

- Owing to the transition include a specific test of the ERP configuration master table. The auditor must verify that the logic maps specific payment types (like agent commissions vs. policyholder payouts with conditional taxability) to the standardized rules of Section 393 and check the automated validation mechanism for PAN, Aadhaar matching to prevent systemic short deductions.
- Confirms that tax deducted is deposited within the prescribed time and that the periodic withholding statements are filed accurately and on time, with certificates issued to deductees and
- Pays particular attention to deduction on policyholder payouts, where the taxability turns on conditions attaching to the policy and is a frequent source of error when the system logic does not track those conditions correctly.

Goods and Services Tax

Premium income and the input credits an insurer claims, fall within the goods and services tax regime. The auditor check that:

- Output tax is charged and remitted correctly across the insurer's product and premium types,
- Input tax credit is claimed only where eligible and reversed where required and
- The periodic GST returns are reconciled to the books and filed on time. The reconciliation between the GST returns, the financial records and the withholding data is a useful test, because inconsistencies across these filings for the same period are a reliable indicator of a compilation weakness.

Foreign Account Tax Compliance Act (FATCA) and Common Reporting Standard (CRS) Reporting

A life insurer that issues cash value or annuity contracts is a reporting financial institution for the purposes of the inter-governmental FATCA regime and the Common Reporting Standard and carries a distinct set of due diligence and reporting obligations that are easily overlooked because they are embedded in onboarding rather than owned by the tax function. The auditor check the full chain that:

- The insurer has correctly determined its status as a reporting financial institution and which of its products are financial accounts within the regime,
- The prescribed due diligence procedures are applied to identify reportable accounts and that valid self-certifications are obtained from account holders,
- The insurer's system logic for monitoring "changes in circumstances" are working effectively, such as a customer updating their address to a foreign jurisdiction, a change in a controlling person for entity accounts, or an account balance crossing a reporting threshold is identified through system alert for relevant reporting. In such cases, on a sample basis also check whether the reporting was done on a timely basis.
- Reportable accounts are reported through the prescribed annual statement Form 61B under the 1961 Act framework (Section 285BA read with Rules 114F to 114H), with the corresponding form under the 2025 Act (Form 166 under Section 508 read with Rules 238 to 240 from FY 2026 27) completely and by the due date and
- The underlying data is retained so that the basis of inclusion or exclusion of an account can be evidenced.

Unclaimed Amounts of Policyholders

Closely related and specific to life insurers, is the treatment of unclaimed amounts of policyholders. Although not a tax in itself, it is a statutory obligation with a defined lifecycle. The auditor check that:

- The insurer identifies unclaimed amounts correctly,
- Ages them on the prescribed basis,
- Segregates and invests them as required,
- Makes the policyholder information and outreach efforts the regulator mandates and
- Transfers amounts unclaimed beyond the prescribed period to the designated fund.

Other Compliances

11.10 A life insurer is not only a regulated insurer but also a company, an entity in the financial system and a custodian of large volumes of personal data. It is therefore bound by laws administered by authorities other than IRDAI. The auditor check the insurer's tracking of and compliance with, each regime that applies to it. Where the operational substance of an obligation is examined elsewhere, this section addresses only the residual entity level layer and says so.

Companies Act and Corporate Filings

As a company, the insurer carries the obligations of the Companies Act, 2013 statutory registers, board and committee processes, annual filings with the Ministry of Corporate Affairs, related party transaction and corporate social responsibility provisions operating in parallel with the IRDAI corporate governance regime examined in Section "Auditing the Corporate Governance Compliance Framework. The auditor confirms the completeness and timeliness of the MCA filings.

Securities Market Obligations for a Listed Insurer

Where the insurer is listed, the SEBI (Listing Obligations and Disclosure Requirements) Regulations, 2015 apply: periodic financial results within the prescribed timelines, disclosure of material events and price sensitive information, related party disclosures and corporate governance reporting to the exchanges. This only applies to a listed insurer and the internal auditor confirms timeliness and completeness of the disclosures against the listing regulation calendar.

Prevention of Money Laundering Act the Entity Layer

The operational anti money laundering process customer due diligence, monitoring and suspicious and cash transaction reporting is examined in Chapter on "outsourcing functions" covered here is the entity level layer: the insurer's status and registration as a reporting entity under the Prevention of Money Laundering Act, the appointment of the principal officer and the governance of the annual compliance certification. The auditor confirms these are in place and current and cross refers to Chapter 19 for the operational testing.

Data Protection at the Entity Level

The Digital Personal Data Protection Act, 2023 imposes obligations on the insurer as a data fiduciary handling policyholder and prospect data. The obligations are tested as compliance. Where the insurer is, or is likely to be, notified as a Significant Data Fiduciary, the auditor additionally tests enhanced obligations including appointment of Data Protection Officer, data protection impact assessments and periodic independent data audit. The internal auditor also conducts walk through of the digital onboarding journey (apps and portals) to test whether consent is explicit, itemized, withdrawable and multi lingual. He also verifies that data processor contracts in section "Contract Lifecycle and Legal documentation controls" include binding clauses for the immediate erasure of prospect data where a sale is not converted.

Domestic Systemically Important Insurers Conditional Module

This module applies only where the auditee has been designated a Domestic Systemically Important Insurer (D SII) under the latest IRDAI annual D SII notification applicable to the audit period. Among life insurers, LIC is ordinarily the relevant entity, but the auditor should not rely on a static statement and should verify the current notification for the period under review:

- Adherence to the enhanced corporate governance and risk management expectations attached to the designation,
- The identification of the insurer's material risks and the soundness of the framework for managing them at a systemic level,
- The arrangements for systemic risk mitigation and recovery and
- Compliance with the specific reporting and disclosure mandates that apply to a D SII, including any enhanced frequency returns noted in Section 11.6.

Litigation and Legal Case Management

The legal function should maintain a central litigation register covering Ombudsman matters, consumer forum cases, civil/criminal matters, writs, tax litigation, employment disputes, recovery matters and material contractual disputes. The auditor tests:

- Completeness,

- Counsel assignment,
- Next hearing and limitation date tracking,
- Provisioning/contingent liability evaluation,
- Settlement authority and linkage between repeated litigation and root cause remediation in claims, servicing, mis selling or product processes.

Contract Lifecycle and Legal Documentation Controls

The auditor tests whether the insurer maintains a central contract repository and approval workflow for distribution, vendor, outsourcing, technology, medical service provider, data processor, consultant and group insurance arrangements. Testing should cover:

- Use of approved templates,
- Deviation approval,
- Stamp duty/e sign/execution controls,
- Renewal and expiry tracking,
- Test for renewal required due to change in underlying regulations. Here, the auditor checks that contracts impacted by a regulatory shift were formally amended or addended within the legally mandated transition window, rather than waiting for natural contract expiration.
- Related party tagging and
- Mandatory clauses on audit rights, confidentiality, DPDP, cybersecurity, outsourcing, indemnity, termination and transition.

Legal Opinions and Contested Positions

Where management relies on a legal opinion for a product, tax position, regulatory interpretation, claim stance, contractual position or disclosure, the internal auditor verifies that:

- The opinion is current,
- Fact pattern specific,
- Approved at the right level,
- Implemented with all stated conditions and

- Revisited after legal change.

Contrary opinions, unresolved caveats and material contested positions should be escalated to the Audit Committee/Board and evaluated for disclosure or provisioning.

Compliance Data Analytics Use Ccases

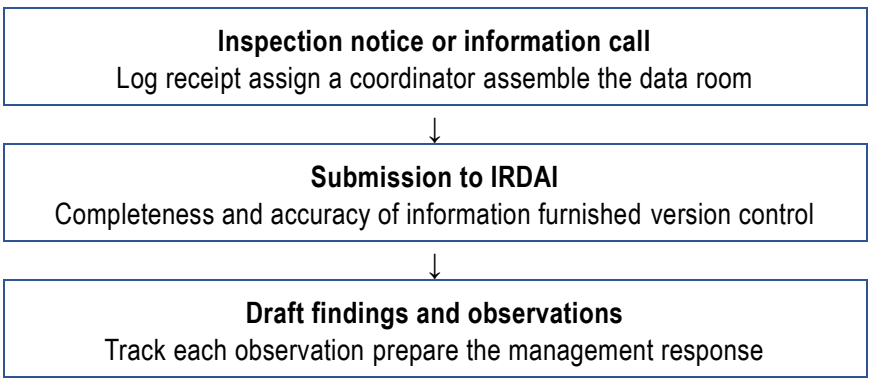
Illustrative analytics include: due date tracker versus filing acknowledgements regulatory return figures versus GL/policy admin/actuarial source data TDS re-computation on commission and policy holder payouts GST liability versus premium register related party vendor payments not tagged as RPT large marketing/ consultancy payments that may be commission or outsourcing ageing of regulatory findings repeat litigation by product/ channel/ branch/ claim type and policy review due dates versus Board approvals.

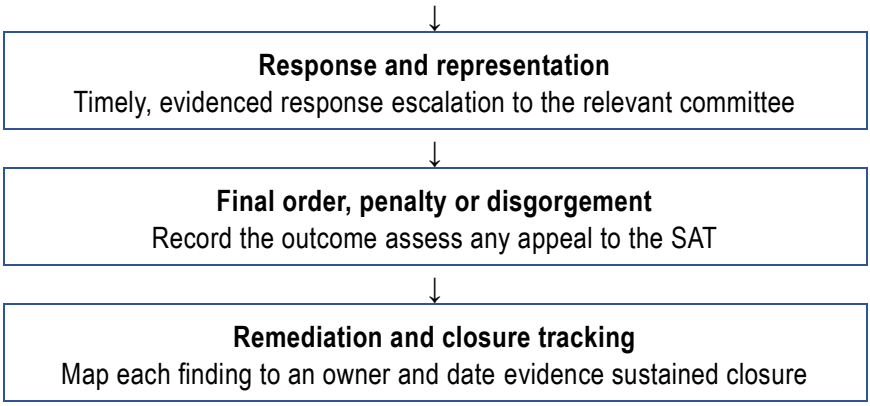
Regulatory, Inspection, Enforcement and Remediation

11.11 The objective of this audit is to obtain assurance that regulatory interactions are controlled from information call or inspection notice through final order and evidenced closure. The scope covers inspection observations, enforcement matters, penalties, appeals, information calls and commitments made by the insurer to IRDAI or other regulators.

The Inspection and Enforcement Lifecycle

A regulatory inspection follows a sequence with hand offs between the insurer and the regulator and is best understood as a flow. Each stage is a point at which the insurer's handling can be controlled or can fail and therefore a point the auditor tests:





Key Audit Tests

- **Completeness of the Regulatory Findings and Commitments Register:** Confirm that every IRDAI inspection observation, information call, show cause matter, enforcement order, penalty, appeal, management commitment and open prior finding is captured in a single tracked register with owner, due date, status and closure evidence.
- **Genuine Closure:** For a sample of findings marked closed, re test that the underlying control now actually operates.
- **Penalties, Disgorgement and Appeals:** Confirm that penalties and any disgorgement of wrongful gains under the 2025 amendments are recorded and accounted for, that the related accounting and disclosure are correct and that the status of any appeal to the Securities Appellate Tribunal is tracked. Further, for disgorgement orders, also perform a retrospective transactional trace over the subsequent three months to confirm that the specific product, channel payout, or mischaracterised expense structure that triggered the order has been entirely decommissioned or amended in the live production system.
- **Repeat Findings:** Identify findings that recur across periods or across locations. A repeat finding is direct evidence that the remediation process does not work, irrespective of the assurances given when the earlier finding was closed.
- **Timeliness and Quality of Submissions:** For information furnished to IRDAI during an inspection, test that it was complete, accurate and

submitted within the time allowed, since a deficient or late submission can itself become a finding.

- **Regulatory Commitment Register:** In addition to inspection findings, test whether commitments made in letters, emails, meetings, approval conditions and management representations to IRDAI or other regulators are captured with owner, due date, evidence and closure status. Commitments are frequently missed because they are not periodic filings.
- **Issue Severity Taxonomy:** For reporting consistency, classify findings as statutory breach, regulatory filing breach, inaccurate return, delayed filing, unsupported certification, policy governance failure, regulatory change not implemented, evidence gap, repeat finding, open regulatory commitment, customer impact issue, or potential penalty/disgorgement exposure.

Red Flags and Illustrative Deficiencies Observed in Practice

11.12 This part of the guide is retained as a practical red flag bank. The auditor should supplement it with the insurer's own regulatory inspection history, prior internal audit findings, litigation trends and repeat exceptions.

Payments Mischaracterised to Stay below the Regulatory Radar

Outsourcing Payments not Reported "Marketing" Spend that was Really Commission

In a remote inspection of an insurer, the regulator found that substantial payments to vendors had crossed the prescribed outsourcing thresholds but were not reported in the outsourcing returns which, the regulator observed, had the effect of keeping them away from regulatory scrutiny. Separately, payments made to related parties and unlicensed entities had been booked as "advertising" and "consumer awareness" expenses when they functioned, in substance, as commission and solicitation payments. The arrangements lacked due diligence, board approval, arm's length pricing and outsourcing disclosure. A consolidated penalty of INR 1 Crore was imposed followed under Section 102 of the Insurance Act.

Audit Takeaway: Test the **substance** of a payment. Reconcile the outsourcing register and returns to the expense ledger and probe large "marketing," "awareness" or "consultancy" heads for payments that are really commission or outsourcing.

Share Transfers Executed without the Required Approval

Stake Transactions Contrary to the Regulator's Directions Approval Obtained on a Misrepresentation

In a case concerning the purchase and sale of an insurer's shares within a promoter group, the regulator found that the transactions were not in compliance with its directions on share transfer and that approval had been obtained on a misrepresentation. The transactions were also found to have produced undue gains for the related corporate agent. Penalties were imposed on both the insurer (INR 3 Crore) and the corporate agent (INR 2 Crore).

Audit takeaway: Share transfer compliance is not only about the percentage threshold. Trace transfers in the period to the approval actually obtained and test that the representations made to the regulator to **secure** that approval were accurate. An approval procured on incomplete or incorrect information is no approval at all and the related party dimension is usually where the real exposure sits.

Inability to Produce Records for An Inspection

Information not Furnished an Unclear Grasp of the Insurer's Own Outsourcing

In another outsourcing matter, the regulator recorded that the insurer had failed to furnish requested information to the inspection team and showed an unclear understanding of its own outsourcing arrangements. The regulator treated this not as a mere administrative lapse but as evidence of significant gaps in internal systems and controls, since it limited the regulator's ability to assess the underlying risk. A penalty of INR 1 Crore was imposed.

Audit Takeaway: How an insurer responds to an inspection is itself a control. If the management cannot readily produce a complete list of its outsourcing arrangements, its returns, or its board approvals, the auditor should treat that

difficulty as a finding in its own right a register that cannot be produced on demand is, for practical purposes, a register that does not work.

A Mandatory Sectoral Obligation Simply Not Met

Minimum Statutory Obligation Missed for the Year

An insurer was penalised for failing to meet a minimum statutory sector obligation for a financial year, under the specific section of the Insurance Act that mandates it. The breach was not one of interpretation but of achievement the required volume of qualifying business was not written and the shortfall stood on the insurer's own numbers.

Audit Takeaway: For the rural and social sector obligations, the auditor's job is to confirm the shortfall before the regulator does. Re perform the achievement against the year's graded target early enough in the cycle that a projected shortfall can still be acted upon and confirm that any shortfall the insurer is heading towards, has been surfaced to the board rather than discovered at year end.

Governance and Policy Weaknesses that Recur

Not every deficiency reaches a penalty order. The following recur in internal reviews and inspection observations and each maps to a test earlier in this chapter:

- **The Board Policy that Lapsed its Review:** An underwriting, investment or outsourcing policy still in force two regulatory amendments after it was last refreshed, so that staff are operating on a document the regulator has already overtaken.
- **Fit and Proper Declarations Frozen at Appointment:** Directors' and KMPs' declarations on file from the date of joining, never refreshed, with no record that the board considered them.
- **Returns that Disagree with one Another:** The same figure reported differently in two returns for the same period, because each was compiled in isolation rather than from a single reconciled source.
- **Findings "Closed" on An Assurance:** A prior inspection or audit finding marked closed on management's confirmation, with no evidence that the control was actually remediated revealed when the same finding recurs the following year (Para 11.11).

- **The Obligation Nobody Owns:** A non-IRDAI obligation an MCA filing, a FATCA report, a DPDP requirement that falls between functions because no single person was made accountable for it (Para 11.4 and 11.10).

Use these illustrations as audit triggers, not as an exhaustive list. The insurer's own inspection history, prior internal audit findings, litigation, complaints and repeat exceptions provide the most reliable guide to where its compliance framework is likely to fail again.

Chapter 12
Relationship and Complaint Handling

Introduction

12.1 Grievance is defined as any communication that expresses dissatisfaction about an action or lack of action, about the standard of service/ deficiency of service of an insurance company and/ or any intermediary or seeks remedial action.

Every insurer must ensure a grievance redressal mechanism is in place for providing excellent customer service which in turn is the most important tool for business growth. The insurer must maintain an in-house Customer Complaints Cell headed by a Grievance Redressal Officer (GRO).

Scope and Objective

12.2 The primary objective of the audit is to evaluate whether the insurer has established an effective customer relationship management and grievance redressal framework in compliance with the IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024, IRDAI Master Circular on Protection of Policyholders' Interests dated 5 September 2024 and IRDAI Master Circular on Operations and Allied Matters of Insurers dated 19 June 2024.

The scope of the review shall cover governance, monitoring and control over:

- Customer Relationship Management Framework
- Customer Service Requests
- Complaint Registration and Classification
- Complaint Investigation Process
- Grievance Redressal Mechanism
- Grievance Redressal Officers (GROs)
- Policyholder Protection Committee
- Internal Ombudsman Framework

- Insurance Ombudsman Cases
- Bima Bharosa Integration and Reporting
- Turnaround Time (TAT) Compliance
- Complaint Closure Controls
- Root Cause Analysis and Corrective Action Tracking
- Customer Feedback and Satisfaction Monitoring
- MIS and Regulatory Reporting
- Outsourced Customer Service Activities
- Digital Service Channels
- Social Media Complaints Monitoring

The process flow is enumerated below:

1	**Complaint Receipt**	Complaint received through Branch, Email, Website, Call Center, social media, Bima Bharosa Portal, Insurance Ombudsman or Intermediary
2	**Complaint Registration**	Unique complaint number generated and acknowledgement sent
3	**Complaint Classification**	Classification into Service Request, Complaint, Regulatory Complaint, Fraud Complaint or Ombudsman Matter
4	**Investigation**	Complaint assigned to responsible department for investigation
5	**Escalation**	Escalation based on ageing, severity and regulatory timelines
6	**Resolution**	Resolution approved and communicated to customer
7	**Internal Ombudsman Review**	Eligible complaints referred to Internal Ombudsman

8	**Bima Bharosa Update**	Complaint status updated on Bima Bharosa Portal
9	**Closure**	Closure after confirmation of action and communication
10	**MIS & Root Cause Analysis**	Trend analysis, reporting and corrective action monitoring

Illustrative Checklist

Risk	Control Objective	Illustrative Audit Procedures
Governance Framework		
• Board approved Grievance Redressal Policy with periodic review • Appointment of GRO • Composition of Policyholder Protection Committee • Process of Redressal to be published on the Website • Complaint Governance MIS	Regulatory Governance	• Obtain Board approved policy • Check for Annual review with Version Control • Verify appointment of GRO along with reporting responsibilities • Review Composition, frequency of meeting and Board reporting • Review if Website is uploaded with the current process • Review periodic Management reporting
Escalation Matrix	Customer Protection	• Review escalation hierarchy

		• Monitoring Controls
Complaint Registration and Classification		
• Registration of Complaint • TAT for acknowledgement of the Complaint • Incorrect classification • Complaints treated as enquires • Duplicate complaints not identified	• Customer Protection • Regulatory Compliance • Customer Protection • Operational efficiency	• Verify all complaints are logged in through IGMS (Integrated Grievance Management System portal) • Verify written acknowledgement has been sent within 3 working days from receipt of the complaint duly signed by the officer along with designation. Acknowledgement shall also mention the redressal procedure and the time taken for resolution • Verify the classification matrix, logic and escalation • Review controls over Duplicate complaints
Complaint Investigation & Resolution		
• Delays in grievance resolution	• Regulatory Compliance	• Review ageing reports and TAT Compliance (Max 2

• Inadequate investigation procedures • Closure without adequate evidence • Customer not informed of outcome • Incorrect resolution provided	• Customer Protection	weeks from receipt of the complaint) • Verify investigation documentation, supporting documents and approvals • Check communication records, sample test resolution quality
Turn Around Time (TAT) Compliance		
Check whether: • Regulatory times lines are being followed • Escalation controls • Manual Override of ageing	Regulatory Compliance	• Review TAT dashboard and exception reports (Max 2 weeks from receipt of the complaint) • Verify escalation triggers • Verify system controls and audit trail
Internal Ombudsman		
• Eligible complaints not referred • Delay in referral process • Recommendation not implemented	Regulatory Compliance	• Verify criteria for referrals, review sample cases • Review compliance to timelines • Verify tracking mechanism and implementation evidence

Insurance Ombudsman		
• Timely implementation of awards by Ombudsman • Delayed response to Ombudsman notices • Repeat Complaints	• Regulatory Compliance • Customer Protection	• Review Ombudsman register and implementation records • Verify response timelines • Review RCA reports and corrective actions
Bhima Bharosa Reporting		
• Complaints not reported • Incorrect Complaint status • Data mismatch between systems	• Regulatory Compliance • Data Integrity	• Review process for reconciliation between complaint database with Bhima portal • Verify portal updates and exception reports • Re perform reconciliation process
Customer Service Requests		
• Delay in servicing requests • Changes not processed correctly • Unauthorized servicing requests • Customer communication gaps	• Customer satisfaction • Operational accuracy • Fraud Prevention • Customer protection	• Verify TAT reports • Verify service request for Policy changes • Verify maker checker controls • Verify customer notifications

Digital Service Channels		
• Process of capturing Complaints received from digital media • Monitoring Social media complaints • Adequacy of Audit trail	• Regulatory Compliance • Customer Protection	• Review reconciliation process for complaints received from all channels • Review monitoring dashboard • Verify retention and logging controls
Other Areas		
• Maintenance of Complaint repository • Root Cause analysis • Ineffective corrective action tracking	• Regulatory Compliance • Governance	• Review Complaint register • Review RCA methodology • Review if RCA is submitted to IRDA quarterely • Verify closure of action items

Audit Analytics/ CAATs

Sr. No	Area	Audit Analytics
1	Complaint Repository	100% scan of complaint population
2	Complaint Ageing	Age bucket analysis
3	TAT Compliance	Exception reporting
4	Repeat Complaints	Duplicate complaint analytics
5	Ombudsman Cases	Trend Analysis

6	Customer Service Requests	Turnaround Analytics
7	Complaint Closure	Closure without response Analysis
8	Product wise Complaints	Heat Map analysis
9	Branch wise Complaints	Density Analysis
10	Agent wise Complaints	Mis selling indicators
11	Bima Bharosa Reconciliation	Data Matching
12	Root Cause Analysis	Text Analysis
13	Complaint Escalation	Escalation Trend analytics
14	Digital Complaints	Channel wise analytics
15	Fraud related Complaints	Exception reporting

Commonly Observed Irregularities/ Violations

A. Regulatory Non-Compliance

- Complaints not registered immediately upon receipt.
- Failure to comply with prescribed grievance timelines.
- Non reporting of complaints to Bima Bharosa.
- Internal Ombudsman referrals not made.
- Delay in implementation of Ombudsman awards.
- Non-compliance with IRDAI grievance reporting requirements.
- Inadequate disclosure of grievance redressal channels.

B. Governance and Control Deficiencies

- Grievance policy not reviewed periodically.
- GRO not appointed or responsibilities not defined.
- Weak escalation matrix.
- Inadequate complaint monitoring.
- Lack of Board oversight.

- Poor management reporting.

C. Operational Deficiencies

- Incorrect complaint classification.
- Incomplete investigation records.
- Closure without supporting evidence.
- Delayed customer communication.
- Duplicate complaints not identified.
- Missing audit trail.

D. Customer Protection Related Deficiencies

- Repeated complaints relating to same issue.
- Poor service request turnaround time.
- Inadequate root cause analysis.
- Failure to provide fair resolution.
- Customer dissatisfaction not monitored.

E. Technology and Reporting Deficiencies

- Inaccurate MIS reporting.
- Weak Bima Bharosa reconciliation controls.
- Incomplete complaint audit trail.
- Data integrity issues between systems.
- Inadequate digital complaint monitoring.

F. Audit Red Flags

- Material backlog of unresolved complaints.
- Significant Ombudsman awards against insurer.
- Repeated IRDAI observations.
- High concentration of mis selling complaints.
- Complaints closed without evidence of resolution.
- Repeated complaints against specific intermediaries.

- Significant ageing beyond regulatory timelines.
- Systemic customer service failures.

Regulatory References

Reference	URL
IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024	IRDAI Consolidated Gazette Notified Regulations (IRDAI)
IRDAI (Protection of Policyholders' Interests and Allied Matters of Insurers) Regulations, 2024*	IRDAI Regulations & Guidelines Repository
IRDAI Master Circular on Operations and Allied Matters of Insurers, 2024 (19 June 2024) – Ref. No. IRDAI/PPGR/CIR/MISC/97/06/2024	IRDAI Circulars Repository (IRDAI)
IRDAI Master Circular on Protection of Policyholders' Interests, 2024 (05 September 2024) – Ref. No. IRDAI/PP&GR/CIR/MISC/117/9/2024	IRDAI Circulars Repository (IRDAI)
Bima Bharosa Portal	Bima Bharosa Portal
Insurance Ombudsman (Council for Insurance Ombudsmen)	Insurance Ombudsman Portal

Chapter 13
Agency Licensing Function

Introduction

13.1 Agency licensing in life insurance refers to the formal regulatory process by which an individual or entity is authorised by the Insurance Regulatory and Development Authority of India (IRDAI) to solicit and procure insurance business on behalf of a specific life insurer. A licensed agent serves as the primary interface between the insurer and the prospective policyholder, performing needs-based selling, proposal facilitation, premium collection assistance and post-sale servicing.

The significance of a robust licensing framework cannot be overstated:

- **Consumer Protection:** Only licensed, trained agents can legally solicit business, protecting consumers from unqualified intermediaries.
- **Regulatory Compliance:** IRDAI mandates that insurers maintain accurate records of all agents on the IRDAI portal and that only agents with valid, in force license s conduct business.
- **Financial Integrity:** Licensing controls prevent commission leakages, fraudulent policy issuance by unlicensed persons and AML risks from unverified intermediaries.
- **Reputation Risk Management:** Mis selling by unlicensed or improperly supervised agents exposes insurers to regulatory sanctions, customer complaints and reputational damage.
- **Distribution Channel Governance:** Agency licensing forms the foundation of the insurer's distribution governance framework, underpinning compliance with IRDAI inspection norms.

Role of Agents in Insurance Distribution

Insurance agents in India operate under a principal agent relationship with the insurer. Their core responsibilities encompass:

- Soliciting and procuring new insurance proposals in accordance with the insurer's approved products.

- Providing accurate, fair and complete product information to prospective customers.
- Assisting customers with proposal form completion, documentation and KYC compliance.
- Collecting first year and renewal premiums (where permitted) and depositing them with the insurer.
- Rendering post sale services including policy servicing, claims assistance and grievance redressal.
- Maintaining records of customer interactions and proposals submitted.

The agent's role has evolved significantly in the digital era. Agents now use digital platforms, mobile applications and e proposal systems to submit applications and customers interact through video KYC for identity verification. The Point of Sales Person (POSP) model further simplifies the sales process, allowing simple, standardised insurance products to be sold with a shorter training requirement.

Regulatory Significance of Licensing

IRDAI regulates the insurance agency function primarily through the IRDAI (Licensing of Insurance Agents) Regulations, 2000, read with subsequent circulars and guidelines. Key regulatory requirements include the following:

Regulatory Requirement	Applicable Provision	Internal Audit Focus
Minimum educational qualification	Reg. 4: Class 10 pass (or Class 12 in some states)	Verification of certificates on file
Mandatory pre license training (100 hours)	Reg. 7/ Schedule I: Training by ATI	Training attendance and completion records
IRDAI prescribed examination	Reg. 8: Written/online exam	Exam pass certificate on IRDAI portal
Single insurer restriction	Sec. 42 of Insurance Act, 1938	Duplicate agent code/ multi insurer check

License renewal every 3 years	Reg. 13: CPE hours required	Expiry tracking and renewal audit
Code of Conduct compliance	Reg. 17/ Schedule IV	Complaint analysis and field verification
POSP specific training (15 hours)	IRDAI POSP Guidelines 2016/2019	POSP training log verification

Governance Expectations

The IRDAI and the Insurance Institute of India (III) have progressively raised governance expectations for insurer agent relationships. Board of life insurers are expected to:

- Approve a Board level Agency Distribution Policy covering recruitment, licensing, monitoring and termination.
- Constitute an Agency Management Committee responsible for agent lifecycle governance.
- Implement technology driven licensing management systems with audit trails.
- Establish a grievance and mis selling redressal mechanism linked to agent performance.
- Mandate IRDAI portal synchronisation for all agent records and status updates.

Agency Lifecycle: Recruitment to Termination

The agency lifecycle in a life insurance company typically comprises of the following stages:

Stage	Key Activities	Internal Control Points
1. Recruitment	Identification, sourcing, reference checks	Eligibility verification, background check
2. Application & KYC	Form submission, PAN/Aadhaar, photos	Document completeness, KYC validation
3. Training	100 hour pre license training (ATI)	Attendance register, ATI certification

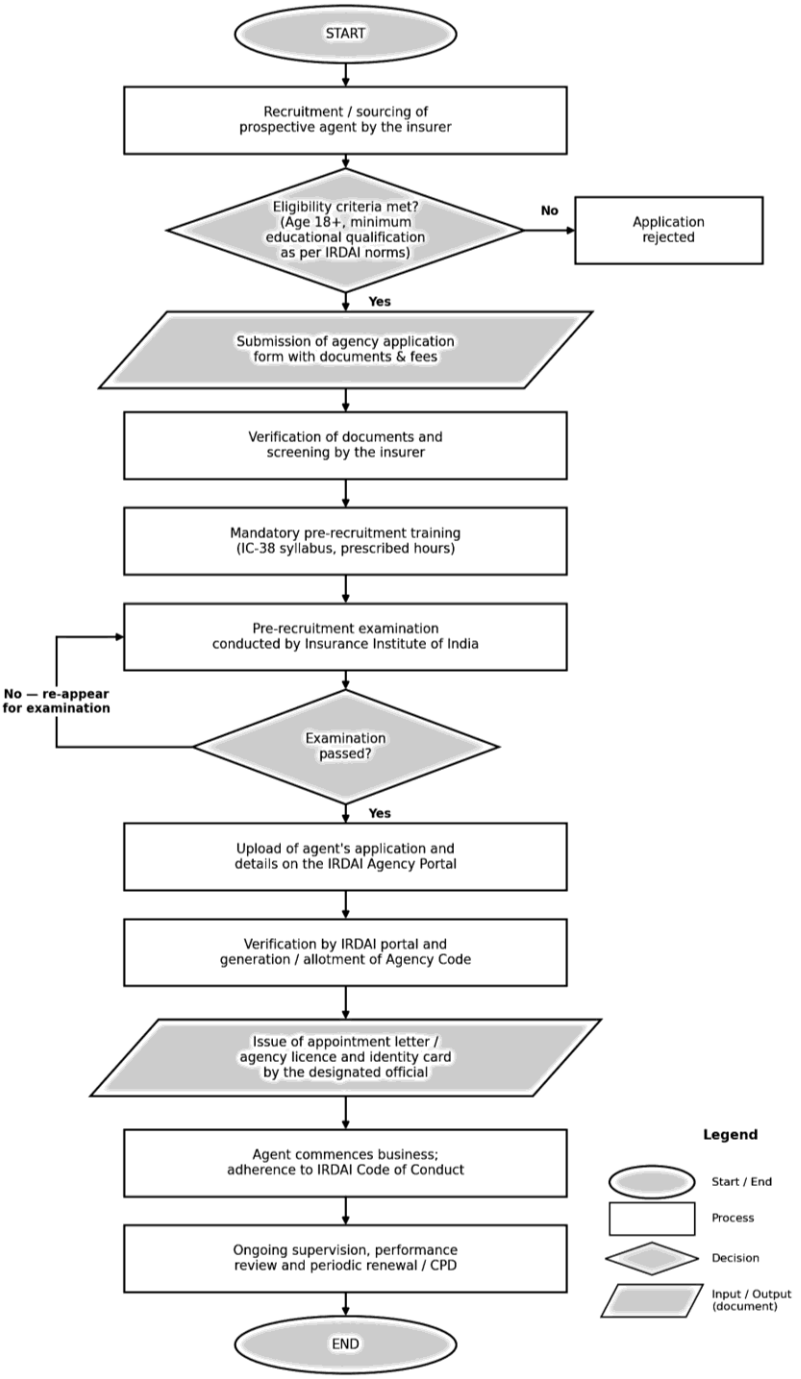
4. Examination	IRDAI online examination registration & result	Exam pass certificate, IRDAI portal upload
5. Licensing	IRDAI portal upload, URN assignment, license download	Portal upload, license print & dispatch
6. Activation	Agent code creation in agency management system	Maker checker, dual control
7. Operations	Policy solicitation, commission processing, renewal	Commission validation, persistency monitoring
8. Renewal	CPE hours, renewal application to IRDAI, fee	Expiry alerts, CPE compliance
9. Termination	Resignation/lapse/cancellation, IRDAI portal update	Code deactivation, commission settlement

Importance of Internal Audit in Agency Management

Internal audit of the agency licensing function serves as an independent assurance mechanism over the entire agency lifecycle. Its importance encompasses:

- **Regulatory Assurance:** Confirming adherence to IRDAI regulations, circulars and guidelines, thereby reducing regulatory risk during inspections.
- **Fraud Prevention:** Detecting and deterring fake agent creation, identity theft, commission diversion and ghost agent frauds.
- **Conduct Risk Monitoring:** Identifying mis selling indicators, complaint patterns and policy churning at the branch and agent level.
- **Operational Efficiency:** Assessing the adequacy and effectiveness of controls in the onboarding, renewal and termination processes.
- **Governance Enhancement:** Providing the Board and Audit Committee with independent assurance over distribution channel governance.
- **Digital Risk Coverage:** Evaluating technology controls, cybersecurity measures and data privacy compliance in the digital licensing ecosystem.

Flow Chart


START
Recruitment / sourcing of prospective agent by the insurer
Eligibility criteria met? (Age 18+, minimum educational qualification as per IRDAI norms)
No
Application rejected
Yes
Submission of agency application form with documents & fees
Verification of documents and screening by the insurer
Mandatory pre-recruitment training (IC-38 syllabus, prescribed hours)
Pre-recruitment examination conducted by Insurance Institute of India
No — re-appear for examination
Examination passed?
Yes
Upload of agent's application and details on the IRDAI Agency Portal
Verification by IRDAI portal and generation / allotment of Agency Code
Issue of appointment letter / agency licence and identity card by the designated official
Agent commences business; adherence to IRDAI Code of Conduct
Ongoing supervision, performance review and periodic renewal / CPD
END
Legend
Start / End
Process
Decision
Input / Output (document)

Regulatory Framework

Overview of Key Insurance Regulatory and Development Authority of India (IRDAI) Regulations

13.2 The regulatory framework governing insurance agency licensing in India is multi layered, comprising of primary legislation, IRDAI regulations and circulars/guidelines issued from time to time. A summary of the principal regulatory instruments is set out as follows:

Sr. No.	Instrument	Key Provisions	Internal Audit Relevance
1	Insurance Act, 1938 (as amended by IRDA Act, 1999)	Sec. 42 — Licensing of agents prohibition on unlicensed solicitation	Verify agent license validity before commission payment
2	IRDAI (Licensing of Insurance Agents) Regulations, 2000	Eligibility, training, examination, code of conduct, renewal	Core compliance checklist for agent onboarding
3	IRDAI (Insurance Brokers) Regulations, 2018	Corporate agents, brokers, web aggregators	Corporate agent compliance audit
4	IRDAI POSP Guidelines, 2016 & 2019	POSP eligibility (18+ yrs, Class 10), 15 hr training, prescribed products	POSP onboarding and product restriction audit
5	IRDAI (Insurance Web Aggregators) Regulations, 2017	Digital comparison platforms and their compliance obligations	Web aggregator integration controls
6	PMLA, 2002 & RBI/IRDAI AML Guidelines	KYC, CDD, suspicious transaction reporting, record keeping	KYC documentation, STR filing, FIU reporting

7	IRDAI Circular on AML/KYC (Master Circular)	Customer identification, beneficial ownership, PEP screening	KYC file revi7ew, PEP register
8	DPDP Act, 2023	Data fiduciary obligations, consent, purpose limitation, data breach reporting	Agent data privacy compliance
9	IT Act, 2000 & Amendments	Electronic records, digital signatures, cybercrime	Digital licensing system audit
10	IRDAI Cybersecurity Guidelines, 2017/2023	ISMF, CISO designation, cyber audit	Agency system cybersecurity controls
11	Bima Sugam Framework (forthcoming)	Digital insurance marketplace, unified platform for sales and servicing	Integration readiness audit

Point of Sales Person (POSP) Framework — Detailed Analysis

The Point of Sales Person (POSP) framework introduced by IRDAI was designed to expand insurance penetration by enabling a simplified, technology assisted sales channel. Key features of the POSP framework include the following:

- **Eligibility:** Minimum age 18 years, Class 10 pass certificate required (relaxed from regular agent's Class 12 requirement in specified geographies).
- **Training:** 15 hours of training (reduced from 100 hours for regular agents), covering product knowledge, KYC norms and sales ethics.

- **Product Restrictions:** POSPs can only sell pre-approved "simple" insurance products standardised term plans, health products and basic endowment plans as prescribed by IRDAI.
- **Appointment:** POSPs must be appointed through and supervised by a licensed insurer, insurance broker, or corporate agent.
- **Commission:** POSPs earn fixed commissions prescribed by IRDAI no differential commission is permitted.
- **Digital Integration:** Most POSP onboarding and sales activity is facilitated through digital platforms and mobile applications.

Internal audit focus for POSP: Verify that only approved POSP products are being sold by POSPs, training records meet the 15 hour minimum, POSPs are not soliciting products outside their authorised scope and commission payments comply with prescribed rates.

AML/KYC Obligations

Insurance companies are "reporting entities" under the Prevention of Money Laundering Act, 2002 (PMLA). In the context of agency licensing, AML/KYC obligations are two dimensional: compliance at the customer level (policyholders) and at the intermediary level (agents). Internal audit should assess compliance with both dimensions.

Agent Level KYC (Intermediary Due Diligence)

- PAN card verification through NSDL/UTIITSL APIs.
- Aadhaar verification through UIDAI authorised KYC process (offline Aadhaar XML or DigiLocker).
- Photograph and signature capture in digital systems.
- Address verification (utility bills, bank statements, or Aadhaar).
- Bank account validation for commission remittance (penny drop or API based IFSC/account validation).
- PEP (Politically Exposed Person) screening against Government databases and commercial watchlists.
- Negative list/ debarred agent list check (IRDAI debarment list and internal blacklist).

Anti Mis Selling Guidelines

IRDAI has issued specific guidelines on product suitability and anti mis selling. Internal audit should test:

- **Needs Analysis Documentation:** whether agents have assessed customer income, liabilities and insurance needs before recommending a product.
- **Product Disclosure:** whether the policy document, benefit illustration and Key Information Sheet were provided to the customer.
- **Premium Affordability:** whether the annual premium is proportionate to declared income.
- **Policy Replacement:** whether any existing policy was surrendered or made paid up to fund a new policy without documented customer consent.
- **Free Look Period Utilisation:** tracking free look cancellations by agent/branch as a mis selling proxy.

Code of Conduct for Agents

Schedule IV to the IRDAI (Licensing of Insurance Agents) Regulations, 2000 prescribes a mandatory Code of Conduct for insurance agents. Key obligations include:

- Identifying oneself as an insurance agent and presenting the license before conducting any insurance transaction.
- Disclosing the full name and address of the insurer on whose behalf solicitation is being made.
- Refraining from inducing customers through rebating or misrepresentation.
- Not splitting a premium amount that must be paid in one instalment.
- Not having any illegal transactions or dealings in cash above the permissible limits.
- Immediately reporting to the insurer any material fact known to the agent about the proposer's health, occupation, or lifestyle.

Data Privacy Requirements

The Digital Personal Data Protection Act, 2023 (DPDP Act) imposes significant obligations on life insurers as "Data Fiduciaries." In the context of agency licensing, this includes:

- **Purpose Limitation:** Agent's personal data (Aadhaar, PAN, bank account) collected during onboarding may only be used for licensing and commission purposes it cannot be repurposed without explicit consent.
- **Data Minimisation:** Only data necessary for the specific purpose of licensing should be collected.
- **Consent Management:** Digital consent records must be maintained for data collection and processing.
- **Data Retention:** Agent records must be retained as per prescribed periods and purged/anonymised thereafter.
- **Data Breach Reporting:** Breaches affecting agent data must be reported to the Data Protection Board of India within the prescribed timelines.

Bima Sugam and the Digital Insurance Ecosystem

Bima Sugam, IRDAI's proposed unified digital insurance marketplace, represents a transformational shift in the distribution landscape. When fully operational, Bima Sugam will:

- Create a one stop digital platform for insurance purchase, servicing and claims.
- Enable real time connectivity between insurers, intermediaries and customers.
- Provide a digital repository of all insurance policies linked to Aadhaar/PAN.
- Standardise KYC and agent verification processes across the industry.
- Facilitate portability of customer records and policy details.

Internal Audit Implications: The integration of insurer systems with Bima Sugam will require audit of data migration controls, API security, access management and real time reconciliation processes.

How Internal Audit Ensures Regulatory Compliance

Internal audit ensures regulatory compliance in the agency licensing function through a multi-pronged approach as described below:

Sr. No.	Audit Procedure	Regulatory Compliance Assured
1	Physical and digital verification of agent license documents	IRDAI Licensing Regulations, Sec. 42 of the Insurance Act, 1938
2	IRDAI portal reconciliation	Portal upload requirements, URN assignment
3	PAN/Aadhaar verification through APIs	KYC Master Circular, PMLA obligations
4	Examination certificate verification	Training and exam requirements under Regulations
5	Commission payment validation against license status	Anti unlicensed solicitation provisions
6	AML/KYC file review	PMLA, IRDAI AML Master Circular
7	Complaint trend analysis	IRDAI Grievance Redressal guidelines
8	Data privacy compliance testing	DPDP Act, 2023 IT Act obligations

Agency Recruitment and Licensing Audit

Agent Onboarding Process

13.3 The following process describes the end-to-end agent onboarding workflow typically followed by life insurance companies:

Stage 1: Application Receipt & Pre screening

- Prospective agent submits Proposal History Form (PHF) with supporting documents (educational certificate, PAN, Aadhaar, photograph, cancelled cheque).

- Branch Agency Manager (BAM)/ Agency Development Manager (ADM) reviews documents for completeness.
- Incomplete applications are returned for completion.

Stage 2: Training

- Eligible applicant is registered with an approved Training Institute (ATI) for the mandatory 100 hours pre license training (15 hours for POSP).
- Training attendance register is maintained by ATI and forwarded to the insurer.
- Internal training may supplement ATI training for product knowledge.

Stage 3: Examination

- Candidate is registered for IRDAI online examination through the examination body (currently Insurance Institute of India (III) or NISM for some categories).
- Examination result is downloaded from IRDAI portal and updated in the agency management system.

Stage 4: Licensing

- PHF details, training certificate and examination pass certificate are uploaded to IRDAI portal.
- IRDAI validates data and assigns a Unique Registration Number (URN).
- License is downloaded from IRDAI portal, printed and dispatched to the agent.

Stage 5: Activation

- Agent code is created in the insurer's core agency management system.
- Maker Checker approval is obtained for agent code activation.
- Bank account details are entered for commission remittance.
- Agent is provided with login credentials for digital sales platform/ mobile app.

Verification of Eligibility Criteria

Internal audit should verify the following eligibility criteria for each agent sampled:

Sr. No.	Eligibility Parameter	Document Required	Verification Method	Audit Test
1	Age (minimum 18 years)	Date of Birth in Aadhaar/ PAN	Cross check DoB in UIDAI records	Select sample, verify DoB against Aadhaar
2	Educational qualification (Class 10 pass)	School leaving certificate/ marksheet	Original inspection or digital verification	Verify certificate authenticity check board records for high-risk cases
3	Not previously debarred by IRDAI	IRDAI debarment list search	IRDAI portal/ internal debarment check	Check debarment register for all new agents
4	Not appointed by another insurer	Declaration in PHF	IRDAI portal cross insurer check	Portal verification for sample agents
5	PAN card	Original PAN card/ e PAN	NSDL API verification	PAN seeding status in IRDAI portal
6	Valid bank account	Cancelled cheque/ bank statement	Penny drop/ IFSC API verification	Verify commission bank account matches license holder

Background Verification

A key audit area is whether the insurer has conducted adequate background verification of agent applicants. Best practice and internal policy typically requires:

- **Criminal Record Check:** Police verification or engagement of third-party background verification (BGV) agency.

- **Previous Employer/Insurer Check:** Verification that the applicant was not terminated from a prior insurance company for misconduct.
- **Reference Verification:** Corroboration of at least two professional references provided in the PHF.
- **Social Media Screening:** In digital first onboarding environments, review of publicly available social media profiles for red flags.
- **Audit Observation Template:** Internal audit should document whether background verification was completed before code activation, whether the results were documented and reviewed and whether any adverse findings were escalated.

Duplicate Agent Code Detection

A significant risk in the agency management system is the creation of duplicate agent codes either for the same individual under different insurer codes or through system data entry errors. Internal audit should perform:

- **PAN Based Deduplication:** Query the agency management system to identify multiple agent codes linked to the same PAN number.
- **Aadhaar Based Deduplication:** Where Aadhaar is seeded in the system, perform cross check for duplicate Aadhaar numbers.
- **Name + DoB Matching:** Fuzzy matching of name and date of birth combinations to detect near duplicate records.
- **IRDAI Portal Cross Check:** Verify that the agent's license on the IRDAI portal shows only one insurer appointment.
- **Commission Payment Check:** Identify cases where commission has been paid to multiple codes for the same PAN.

IRDAI Portal Validations and Licensing Approval Controls

The IRDAI portal is the authoritative system of record for insurance agent licensing. Internal audit procedures for IRDAI portal validation include:

- Verify that all agents active in the agency management system have a valid, unexpired URN on the IRDAI portal.
- Confirm that the status of each agent on the IRDAI portal matches the status in the agency management system (active, lapsed, terminated, suspended).

- Verify that commission has not been paid to agents whose license s were lapsed or cancelled at the time of commission processing.
- Check that portal uploads were completed within prescribed timelines after examination pass confirmation.
- Verify that agents who failed the examination have not been activated in the system pending re-examination.

Segregation of Duties Matrix

Sr. No.	Function	Performed By	Approved/Checked By	Control Objective
1	PHF receipt & document check	Branch licensing officer	Branch Agency Manager	Completeness of documentation
2	IRDAI portal upload	HO licensing team	Senior licensing officer (checker)	Accurate and timely upload
3	Agent code creation	IT/System admin (maker)	Branch Manager/ IT manager (checker)	Prevent unauthorised code creation
4	Commission rate set up	Actuarial/finance team	Chief Actuary sign off	Compliance with prescribed rates
5	Bank account entry	Agency operations team	Finance/ dual authorisation	Prevent commission diversion
6	Agent code deactivation	Agency operations	Compliance/ Legal sign off	Timely deactivation on termination

Agency Licensing Audit Checklist

The following checklist covers the core audit procedures for agency recruitment and licensing:

Sr. No.	Audit Procedure	Expected Evidence	Risk if Not Complied
1	Verify PHF completeness for sample of new agents	Signed PHF, supporting documents	Incomplete onboarding, regulatory non-compliance
2	Verify educational qualification documents	Original certificate/ digital verification	Ineligible persons licensed
3	Confirm PAN verification through NSDL API	PAN verification log/ screenshot	Identity fraud, fake agents
4	Confirm Aadhaar e KYC/ OTP verification	e KYC log with timestamp	Identity mismatch, regulatory violation
5	Verify training completion certificate from ATI	ATI attendance register/ certificate	Untrained agents soliciting business
6	Verify IRDAI examination pass certificate	Exam pass certificate on IRDAI portal	Unlicensed solicitation
7	Reconcile agent records with IRDAI portal	Portal printout/ API extract	Portal mismatch, regulatory risk
8	Perform PAN based deduplication test	System query results	Duplicate codes, commission fraud
9	Verify maker checker for code activation	System audit trail	Unauthorised code creation
10	Verify IRDAI debarment list check performed	Debarment check log	Debarred agent onboarded

11	Verify background check conducted	BGV report/ reference check log	High risk agent not identified
12	Confirm bank account validation performed	Penny drop log/ API response	Commission to incorrect/fraudulent account
13	Verify no commission paid during lapsed period	System commission report vs license expiry dates	IRDAI violation, financial loss
14	Confirm photo ID matches agent in system	Photograph comparison/ system record	Identity substitution fraud

Common Audit Observations and Red Flags

Common Observations

- PHF documents incomplete at time of code activation several supporting documents collected post activation.
- Examination pass certificate not on IRDAI portal at time of commission processing.
- Agent codes active in system for agents whose IRDAI license s had expired.
- Duplicate PAN numbers found across active agent codes.
- Training certificates issued by non-approved training institutes.
- IRDAI portal upload delayed beyond prescribed timelines.

Red Flags

- Multiple agents sharing the same address, mobile number, or bank account.
- Agent codes with zero policy count but active commission payouts.
- Rapid activation of large number of agents by a single ADM within a short period.
- Agents with unusually high policy count but very low persistency ratios.

- Educational certificates issued from institutions with unknown or unverifiable track records.
- PAN names inconsistent with Aadhaar names possible identity manipulation.

Digital Licensing and Technology Risks

Modern Digital Onboarding Practices

13.4 The shift from paper based to digital agent onboarding has been accelerated by regulatory support, the COVID 19 pandemic and technology investments by insurers. Modern digital onboarding processes include:

e KYC and Aadhaar Authentication

- **Aadhaar OTP Based e-KYC:** Agent provides Aadhaar number OTP is sent to registered mobile number UIDAI API returns demographic data (name, DoB, address) for pre filling of digital forms.
- **Offline Aadhaar XML:** Agent downloads digitally signed XML from UIDAI portal this is used for KYC without sharing biometric data online.
- **Digi Locker Integration:** Agents share digitally signed documents (educational certificates, driving license) directly from government repositories.
- **Video KYC:** Regulated by RBI for financial services and adopted by insurers — a live video interaction with a KYC officer who verifies identity documents and captures facial biometrics.

API Integrations

- **PAN verification API (NSDL/UTIITSL):** Real time name matching between PHF and PAN database.
- **Bank Account Validation API (NPCI/ fintech services):** Penny drop or bank account verification to confirm account number, IFSC and account holder name.
- **IRDAI Portal API:** Some insurers have API based integration with the IRDAI licensing portal for real time license status verification and upload.
- **CERSAI/CIBIL Integration:** For checks against financial crime databases.

AI Based Onboarding Tools

- **Optical Character Recognition (OCR):** Automated extraction of data from documents (Aadhaar, PAN, certificates) to reduce manual data entry errors.
- **Face Match Technology:** Comparison of live selfie with photograph on identity documents using AI/ML algorithms.
- **Document Authenticity Verification:** AI tools that detect document tampering, pixel inconsistencies, or metadata anomalies indicative of forgery.
- **Risk Scoring Engines:** ML models that assess the risk profile of incoming agent applications based on behavioural and geographic data patterns.

Digital Technology Risk Assessment

Sr. No.	Technology/ Process	Associated Risk	Potential Impact	Audit Procedure
1	Aadhaar OTP e KYC	OTP interception, SIM swap fraud	Fraudulent agent onboarding	Verify OTP logs, check mobile number ownership
2	Video KYC	Deepfake video submission, impersonation	Identity fraud at onboarding	Review deepfake detection controls check vendor capabilities
3	OCR data extraction	OCR errors, data entry bypass	Incorrect agent data in system	Sample comparison of OCR output vs original documents
4	Face match API	AI generated face substitution,	Wrong person onboarded	Review match score thresholds

		low threshold match acceptance		check rejection rates
5	Document AI verification	Sophisticated forgery bypassing AI checks	Fake educational/id entity documents accepted	Spot check manual verification for high-risk applicants
6	IRDAI portal API	API key exposure, unauthorised access	Data manipulation in portal	Review API key management, access logs
7	Digital signature on certificates	Forged digital signatures, expired certificates	Invalid training/exam certificates	Verify DSC chain of trust for digital certificates
8	Cloud hosted onboarding platform	Data breach, multi tenant data leakage	Agent personal data exposure	Review cloud security controls, data segregation

Identity Fraud and Deepfake Risks

The proliferation of AI generated content and deepfake technology poses an emerging and rapidly evolving risk to digital agent onboarding. Specific threats include:

- **Synthetic Identities:** Fraudsters create entirely fictitious identities combining real and fabricated information legitimate PAN numbers paired with AI generated photographs and forged supporting documents.
- **Deepfake Video KYC:** AI generated video footage of a real person used to bypass live video KYC checks, particularly where deepfake detection tools are not deployed.
- **Document Forgery:** Advanced AI tools can now generate convincing facsimiles of identity documents with authentic looking security features.

- **SIM Swap Fraud:** Fraudsters obtain a SIM card swap from telecom operators to intercept OTPs sent to the agent's registered mobile number.
- **Internal Audit Recommendation:** Assess whether the insurer has deployed deepfake detection tools in its video KYC process, whether liveness detection (3D liveness or challenge response) is used, whether document verification includes metadata analysis and whether the onboarding vendor's technology is audited annually.

System Override and Cybersecurity Risks

- **Privilege Escalation:** Users with standard access credentials gaining administrative privileges to override system controls e.g., activating agent codes without maker checker approval.
- **Bypass of Mandatory Fields:** Technical workarounds allowing agent codes to be created without mandatory KYC fields being populated.
- **Backdating of Records:** System manipulation to alter the effective date of agent license s to cover periods of unlicensed activity.
- **Data Export Vulnerabilities:** Unauthorised export of agent master data from the agency management system for commercial exploitation or identity fraud.
- **API Injection Attacks:** Malicious inputs through API integrations that bypass validation controls.

Agency Operations Audit

Agent Code Management

13.5 Agent code management encompasses the end-to-end maintenance of agent records in the insurer's agency management system. Key controls and audit focus areas:

Activation and Deactivation Controls

- **Activation:** Agent code should only be activated after IRDAI URN is received, training and examination are complete and all KYC documents are verified. System should enforce these as mandatory pre conditions.
- **Deactivation:** Agent codes must be deactivated promptly on license lapse (non-renewal), voluntary resignation, IRDAI cancellation, or

disciplinary termination. Delayed deactivation risks commission payments to unlicensed agents.

- **Reactivation:** Reactivation of previously deactivated codes must be subject to the same controls as new activation, including fresh IRDAI portal verification.

Commission Payment Validation

- Commission should only be processed for agents with active, unexpired license s at the policy issue date.
- Commission rates should be validated against IRDAI prescribed schedules and insurer board approved structures.
- Trail commission/ persistency linked commission should be verified for policy continuity claims paid on lapsed or surrendered policies should not attract trail commission.
- Bonus commissions, override commissions and incentive payments to Development Managers must be validated against documented performance criteria.
- Commission payments should be made only to the bank account registered against the agent's license not to third party accounts.

Renewal Monitoring

- Every IRDAI agent license must be renewed every three years, subject to completion of Continuing Professional Education (CPE) hours.
- The agency management system should generate automated alerts at 6 months, 3 months and 1 month before license expiry.
- Audit should verify that a sufficient number of agents completed CPE requirements in time for renewal.
- Audit should identify agents whose license s lapsed but whose codes were not promptly deactivated.

Branch Level Compliance Audit

Branch level audits of agency operations should cover:

Sr. No.	Area	Audit Procedure	Key Control	Red Flag
1	Agent recruitment quality	Review new agent joinings vs targets assess documentation completeness	BAM sign off on all new joinings	Bulk recruitment without adequate documentation
2	Agent activity monitoring	Review active vs inactive agent ratio identify zero activity codes	Monthly activity report reviewed by BM	Large number of zero activity codes with commission payments
3	Commission payment accuracy	Reconcile commission paid vs policies issued per agent	System calculated commission with actuary validation	Manual commission credits outside system
4	Persistent lapsed policies	Analyse persistency ratio by agent — flag agents with <50% persistency	Persistency incentive structure	Agents with high new business but very low persistency
5	Customer complaints	Extract complaint registers for branch — analyse by agent	Complaint acknowledgment and resolution tracking	Multiple complaints against one agent — churning, mis selling
6	Surrenders and lapses	Identify policy replacements within 6 months of issuance	Product suitability review	Agent linked surge in surrenders

Unauthorised Selling Practices

Unauthorised selling practices represent both a regulatory risk and a consumer protection risk. Internal audit should test for:

- **Solicitation by Unlicensed Persons:** Policies sourced by individuals not registered as agents or POSPs on the IRDAI portal.
- **Multi Insurer Selling:** Agents simultaneously appointed by two or more life insurers in violation of the single insurer restriction under the Insurance Act, 1938.
- **Product Mis Categorisation by POSPs:** POSPs selling complex products (ULIPs, annuities) outside their approved product scope.
- **Selling by Suspended Agents:** Agents who have been placed under administrative suspension but whose codes have not been deactivated.
- **Third Party Code Usage:** Cases where a licensed agent's code is used by an unlicensed person to solicit business.
- **Cash Premium Collection outside Prescribed Limits:** Collection of cash premiums in excess of IRDAI permitted limits, or collection in personal accounts.

Mis Selling and Conduct Risk

13.6 Mis selling in life insurance refers to the marketing or sale of insurance products through misrepresentation, concealment of material facts, inappropriate product recommendations, or exploitation of customer vulnerability. It represents one of the highest impact conduct risks in the insurance distribution ecosystem.

Categories of mis selling include:

- **Product Misrepresentation:** Describing a life insurance product as a "savings scheme," "fixed deposit," or "tax saving investment" without disclosing the insurance component or surrender charges.
- **Premium Misquotation:** Misrepresenting the premium amount, premium payment period, or benefit amounts.
- **Need Mismatch Selling:** Selling products inappropriate to the customer's income, age, or financial needs e.g., selling a 30 year premium payment policy to a 60 year old.

- **Churning:** Inducing customers to surrender existing policies to fund new policies, generating fresh commissions for the agent while imposing surrender charges on the customer.
- **Forced Selling:** Conditioning a loan, salary, or service on the purchase of an insurance product without the customer's genuine free consent.
- **Forgery of Proposal Forms:** Signing customer names on proposal forms without actual customer consent, or altering declared income or health information.
- **Unauthorised Premium Collection:** Collecting premiums in personal accounts, issuing unofficial receipts, or misappropriating collected premiums.
- **Vulnerable Customer Exploitation:** Targeting elderly, illiterate, or financially unsophisticated customers with complex products.

Fraud Indicators and Red Flag System

Sr. No.	Red Flag	Metric/Indicator	Detection Method	Escalation
1	Ghost agent (code exists no real individual)	Zero policy count commission to unknown account	Field verification beneficiary account audit	Compliance + Fraud cell
2	Policy churning by agent	>20% of agent portfolio surrendered/replaced in 12 months	Policy replacement analysis	Branch head + compliance
3	Forced selling indicator	Multiple policies from same employer/group with identical dates	Employer linked policy analysis	Compliance investigation
4	Forged proposals	Customer complaints of non-receipt of policy mismatch in signature	Customer validation call Grievance Redressal	Legal + fraud cell + IRDAI

5	Unauthorised cash collection	Premium received in personal account no official receipt	Bank reconciliation customer complaints	Police report + IRDAI
6	Premium misappropriation	Policy issued no premium reflected in insurer system	Policy premium reconciliation	Legal action + IRDAI report
7	Unlicensed solicitation	Policies in agent code with expired license	License vs policy date audit	Commission reversal + IRDAI
8	Commission fraud	Commission paid to account other than registered bank	Commission payout reconciliation	Finance + compliance + police

Data Analytics Approaches for Mis selling Detection

Modern internal audit functions use data analytics to detect mis selling patterns at scale. Key analytics approaches include:

Policy Replacement/ Churning Analysis

- Query the policy database for all surrenders/paid up conversions within 12 months of issuance.
- Overlay with agent code to identify agents with disproportionately high replacement rates.
- Cross reference with new policy issuances from the same agent in the same period to confirm churning pattern.

Free Look Cancellation Analysis

- Agents with free look cancellation rates exceeding the branch average by more than 2 standard deviations are flagged for investigation.
- Product level analysis to identify specific products with unusually high free look cancellations (potentially indicates misrepresentation of product features).

Premium to Income Ratio Analysis

- Analyse annual premium amounts against declared customer income flag policies where annual premium exceeds 25% of declared annual income.

- Multiple policies for the same customer through the same agent in a short period.

Complaint Mining and Sentiment Analysis

- Use text analytics on customer complaints to identify recurring themes "misled," "not informed," "wrong product" linked to specific agents or branches.
- Social media monitoring for insurance mis selling complaints naming specific agents or branches.

Illustrative Case Studies

Case Study 1: Policy Churning Scheme

An internal audit analytics review identified an agent in a metropolitan branch with 47 policy surrenders in a 12 month period compared to a branch average of 3. Further investigation revealed the agent had simultaneously sourced 52 new policies from the same customers. The surrender new policy combination generated approximately ₹8.5 lakh in fresh first year commissions for the agent, while customers incurred surrender charges totalling ₹12 lakh. IRDAI was notified the agent's license was cancelled and all first year commissions were recovered from the agent.

Case Study 2: Ghost Agent Fraud

During a branch audit, internal audit identified 15 agent codes that had collectively earned commissions of ₹3.2 lakh but had zero policies in the system sourced directly by them. Field verification revealed that the agents in question were fictitious their KYC documents (PAN and Aadhaar) belonged to real individuals who had no knowledge of their insurance agent registration. The Branch Agency Manager, in collusion with an IT administrator, had created these codes to divert commissions from the "pooled" overriding commissions of the branch. A forensic investigation was initiated police complaint filed under the IT Act.

AML, Compliance and KYC Audit

13.7 Life insurance companies are required to maintain comprehensive KYC records for both policyholders and intermediaries (agents). Internal audit of KYC compliance in the agency licensing function should cover:

Sr. No.	KYC Element	Regulatory Requirement	Internal Audit Test	Common Gap
1	PAN verification	IRDAI KYC Circular mandatory PAN seeding	Verify API based PAN validation log	PAN not verified mismatch with agent name
2	Aadhaar verification	IRDAI/ PMLA requirements for identity verification	Confirm e KYC/OTP log or offline XML	Physical copy accepted without digital verification
3	Photograph	PHF requirement IRDAI portal upload	Compare portal photograph with physical document	Old/ low quality photograph no liveness check
4	Address proof	Address verification as per KYC norms	Verify current address against utility bill/Aadhaar	Aadhaar address not current no re verification on change
5	Bank account	IRDAI commission to own account only	Penny drop verification log account name match	Commission to third party account no account name match
6	Renewal KYC update	Re KYC at license renewal (3 year cycle)	Verify renewal KYC records	No re KYC at renewal outdated records

PMLA Compliance — Agent Level Obligations

Under the Prevention of Money Laundering Act, 2002, insurance companies must exercise customer due diligence (CDD) at the intermediary level. This means:

- **Enhanced Due Diligence (EDD):** for high-risk agents: Agents with unusually high premium volumes, cash heavy portfolios, or agents sourcing policies from PEPs or high-risk geographies must be subject to EDD.
- **Suspicious Transaction Reporting (STR):** Internal audit should test whether the insurer has procedures for identifying and reporting STRs related to insurance premium payments that may involve money laundering.
- **Record Keeping:** PMLA requires that KYC records and transaction records be maintained for 5 years from the date of transaction. Audit should verify record completeness and accessibility.
- **FIU IND Reporting:** Verify that the insurer is registered with FIU IND and filing required reports Cash Transaction Reports (CTR), STRs and Non-Profit Organisation Transaction Reports (NTR).

PEP and Sanctions Screening

Politically Exposed Persons (PEPs) and individuals on international sanctions lists represent elevated AML/CFT risks. In the context of agent licensing:

- **Screening Process:** All new agent applicants should be screened against IRDAI's debarment list, internal negative lists, OFAC (US Treasury) SDN list, UN Consolidated Sanctions List and domestic PEP databases.
- **Ongoing Monitoring:** Screening should not be a one time event agents should be re screened at license renewal and whenever there is a material change in their profile.
- **Enhanced Monitoring for PEP Agents:** Agents who are themselves PEPs, or close associates of PEPs, should be subject to senior management approval before appointment and ongoing enhanced monitoring.

- **Audit Procedure:** Internal audit should verify that screening was performed for a sample of agents, that the screening tool used has adequate list coverage and that matches were investigated and documented.

High Risk Agent Identification

Internal audit should test for the insurer's framework to identify high-risk agents. Key risk parameters include:

- **Geographic Risk:** Agents operating in geographies identified as high-risk for terrorism financing, money laundering, or fraud.
- **Cash Premium Concentration:** Agents with a disproportionately high share of premium receipts in cash.
- **Policy Concentration:** Agents where a small number of policies account for a very large share of premium.
- **Customer Demographics:** Agents whose portfolios are heavily skewed towards NRI customers, HNI customers, or politically sensitive customers.
- **Premium Irregularity:** Policies with very large single premiums sourced by relatively new or low volume agents.

Risk Based Internal Audit Approach

Risk Assessment Methodology

13.8 A risk based internal audit approach allocates audit resources to areas of highest risk, ensuring that critical control failures are identified before they result in material loss or regulatory sanction. For the agency licensing function, the risk assessment framework considers:

Risk Dimension	Risk Factors Assessed	Scoring Approach
Inherent Risk: Regulatory	Number of active agents, license expiry backlog, recent IRDAI inspection findings	High/Medium/Low (1 5 scale)

Inherent Risk: Financial	Commission volumes, persistency linked commission exposure, trail commission payable	Proportional to financial exposure
Inherent Risk: Fraud	Ghost agent indicators, complaint volume, churning rates, high-risk branch flags	Weighted scoring model
Inherent Risk: Operational	Onboarding volumes, manual override frequency, pending renewals, IT change frequency	Volume and complexity adjusted
Control Effectiveness	Maker checker compliance, audit trail completeness, exception resolution rate, prior audit findings	Control maturity assessment (1 5)
Residual Risk	Inherent risk discounted by control effectiveness	Inherent risk/ Control score

High Risk Branch Identification

Internal audit uses a data driven branch risk profiling model to prioritise branch audits. Key parameters in the branch risk scorecard include:

- Number of active agent codes vs IRDAI portal verified codes (discrepancy).
- Commission paid to agents with lapsed license s in the past 12 months.
- Agents with persistency ratio below 50%.
- Free look cancellation rate vs branch average.
- Customer complaint volume per 1000 policies.

- Number of agents with zero policy activity but active codes.
- Proportion of policies sourced by top 10 agents (concentration risk).
- Branch performance vs target extreme over or under performance may indicate manipulation.
- Recent personnel changes new BAM/ ADM with limited supervision.

Continuous Monitoring and Exception Reporting

Best in class internal audit functions in insurance companies have moved beyond periodic audit cycles to continuous monitoring. For the agency licensing function, continuous monitoring dashboards should track:

- **Daily:** Commission payments processed exceptions for lapsed license s or non-verified accounts.
- **Weekly:** New agent activations vs IRDAI portal confirmation free look cancellations policy surrender alerts.
- **Monthly:** Persistency report by agent and branch complaint register analysis IRDAI portal reconciliation.
- **Quarterly:** High risk branch risk score update ghost agent field verification completion PEP re screening.
- **Annually:** Full scope branch audits for high-risk branches IT penetration test of AMS vendor security review.

Sample Risk Rating Model

Sr. No.	Parameter	Weight	Score (1 5)	Weighted Score	Risk Level
1	IRDAI portal discrepancy (% agents unmatched)	20%	4	0.80	High
2	Commission to lapsed agents (₹ value)	20%	3	0.60	Medium High
3	Complaint frequency (per 1000 policies)	15%	3	0.45	Medium

4	Persistency ratio (% below 50%)	15%	4	0.60	High
5	Free look cancellation rate	10%	2	0.20	Low Mediu m
6	Ghost agent indicators (zero activity codes)	10%	5	0.50	High
7	Prior audit findings (unresolved)	10%	4	0.40	High
8	TOTAL RISK SCORE	100%	—	3.55/ 5.00	HIGH RISK

Branches scoring above 3.0 should be prioritised for immediate full scope audit. Branches scoring 2.0–3.0 should be subject to targeted audit. Branches below 2.0 may be included in the standard cyclical audit programme.

Emerging Challenges and Current Scenario

Digital Only Insurance Distribution

13.9 The rapid growth of digital only distribution channels through apps, web aggregators and Insurtech platforms has created new risks that traditional agency audit frameworks were not designed to address. Key challenges include:

- **Verification Gap:** In fully digital onboarding, the physical presence verification that provides an additional layer of fraud prevention is absent.
- **Scalability of Fraud:** Digital channels enable fraudsters to attempt large scale fake agent registrations at a fraction of the cost and effort required in physical channels.
- **Customer Interface Risks:** In app based selling, the customer's interaction with the insurer is mediated entirely through technology misrepresentation is harder to detect and easier to deny.
- **Regulatory Grey Areas:** The regulatory framework was designed for physical, face to face solicitation digital only distribution creates ambiguities around jurisdiction, customer consent and solicitation.

AI Generated Fake Identities

The emergence of generative AI has created a new category of fraud risk: AI generated synthetic identities that can convincingly pass traditional document verification checks. Internal audit must ensure:

- The insurer's onboarding platform incorporates AI based document authenticity verification that checks for signs of digital manipulation.
- Liveness detection in video KYC includes 3D depth analysis or challenge response mechanisms that cannot be defeated by 2D deepfake videos.
- The insurer participates in industry level intelligence sharing on known synthetic identity patterns and fraud typologies.
- The fraud detection model is regularly retrained on emerging synthetic identity techniques.

Third Party Onboarding Vendors

Many large life insurers have outsourced part or all of the agent onboarding process to third party fintech/Insurtech vendors. This creates:

- **Vendor Dependency Risk:** If the vendor's platform has a security vulnerability, all agents onboarded through that vendor are potentially compromised.
- **Data Sovereignty Risk:** Agent personal data is held on the vendor's servers the insurer may not have full visibility or control over data security practices.
- **SLA and Accountability Gaps:** Vendor contracts may not adequately specify accountability for KYC verification accuracy, fraud losses, or data preach liabilities.
- **Regulatory Exposure:** IRDAI holds the insurer accountable for compliance failures, even if the failure originates with the outsourced vendor.

Audit recommendation: Internal audit should perform an annual security and compliance review of all material third party onboarding vendors, including on-site visits, penetration test review and contract adequacy assessment.

Social Engineering and Cyber Fraud

- Phishing attacks targeting agency licensing staff to obtain system credentials.
- Pretexting: Fraudsters impersonating IRDAI officials or senior management to coerce licensing staff into bypassing controls.
- SIM swap attacks on agent mobile numbers to intercept OTPs for account takeover.
- Ransomware attacks on agency management systems, with fraudsters threatening to release agent personal data.
- BEC (Business Email Compromise): Spear phishing emails targeting finance teams to redirect commission payments.

ESG and Ethical Selling Expectations

Environmental, Social and Governance (ESG) expectations are increasingly influencing how insurers manage their distribution practices:

- **Social Responsibility in Selling:** Avoiding exploitation of vulnerable customers elderly, rural, financially illiterate through inappropriate product recommendations.
- **Inclusive Insurance:** IRDAI's push for greater insurance penetration in underserved segments requires agents with genuine geographic and linguistic capabilities, not just code registrations in remote geographies.
- **Climate Risk Disclosure:** As ESG linked insurance products grow, agents must be adequately trained to represent these products accurately.
- **Governance Transparency:** ESG reporting frameworks may require insurers to disclose agent mis selling rates, complaint volumes and conduct governance metrics.

Reputation Risk from Social Media

Social media has emerged as a powerful amplifier of insurance mis selling complaints. A single viral post about an agent's misconduct can generate significant reputational damage before the insurer's internal processes have even detected the issue. Internal audit should assess:

- Whether the insurer has a social media monitoring function that captures insurance related complaints mentioning the company or its agents.
- Whether social media complaints are fed into the grievance management system and linked to agent performance data.
- Whether the insurer has a rapid response protocol for social media reputation incidents.

How Internal Audit Should Evolve

In response to these emerging challenges, the agency licensing internal audit function must evolve from:

Traditional Approach	Evolved Approach
Periodic, sample based file review	Continuous monitoring with automated exception alerts
Manual compliance checklist	Data analytics driven audit with ML based anomaly detection
Physical document inspection	Digital verification through API based authentication
Post event fraud detection	Predictive fraud scoring using behavioural and transaction patterns
Siloed licensing audit	Integrated audit covering licensing + operations + IT + conduct risk
Annual branch visits	Risk scored, dynamic branch audit calendar with continuous remote monitoring
Audit report to management	Real time dashboard reporting to Board Audit Committee

Conclusion

13.10. The agency licensing function in life insurance companies occupies a critical position at the intersection of regulatory compliance, consumer protection, financial integrity and distribution governance. As the industry transitions from paper based, branch centric operations to digital, API

integrated and AI assisted processes, the risk landscape has expanded significantly creating new fraud typologies, regulatory challenges and governance expectations that internal audit must be equipped to address.

The modernised internal audit approach for the agency licensing function is characterised by three fundamental shifts: from compliance verification to risk assurance, from periodic sampling to continuous monitoring and from manual procedures to technology enabled analytics. These shifts require internal audit functions to invest in data analytics capabilities, RegTech integrations and audit staff competencies in areas including cybersecurity, digital forensics and AI tools.

Simultaneously, the foundational elements of agency licensing audit regulatory compliance verification, KYC completeness, commission payment integrity, mis selling detection and fraud prevention remain as important as ever. The evolving digital ecosystem has not diminished the importance of these controls it has simply required that they be reimplemented in new technological contexts.

For professional examination candidates and practising auditors alike, a deep understanding of the agency licensing audit universe spanning regulatory frameworks, digital risks, conduct risk, fraud management and governance is essential for effective engagement with one of the insurance industry's most critical and dynamic operational functions.

Glossary of Key Terms

Term	Definition
ADM	Agency Development Manager: insurer's field staff responsible for recruiting, training and supervising agents.
AML	Anti Money Laundering: regulatory framework to prevent use of financial systems for money laundering.
AMS	Agency Management System: core IT system managing agent lifecycle, licensing, commissions.
ATI	Approved Training Institute: institutes approved by IRDAI to deliver pre license training.
BAM	Branch Agency Manager: manages agency operations and compliance at branch level.

BGV	Background Verification: process of verifying agent applicant's criminal, employment and reference history.
Bima Sugam	IRDAI's proposed unified digital insurance marketplace for all insurance transactions.
CDD	Customer Due Diligence: process of verifying identity and assessing risk profile.
CPE	Continuing Professional Education: mandatory ongoing training for license renewal.
CTR	Cash Transaction Report: PMLA mandated report of cash transactions above ₹10 lakh.
DPDP Act	Digital Personal Data Protection Act, 2023: India's principal data privacy legislation.
e KYC	Electronic Know Your Customer: digital identity verification using Aadhaar or equivalent.
EDD	Enhanced Due Diligence: heightened KYC/AML scrutiny for high-risk individuals.
FIU IND	Financial Intelligence Unit: India government body receiving and analysing financial intelligence.
IAM	Identity and Access Management: framework for managing digital identities and access privileges.
IRDAI	Insurance Regulatory and Development Authority of India: insurance sector regulator.
ISMF	Information Security Management Framework: IRDAI mandated cybersecurity governance framework.
MAP	Management Action Plan: agreed actions to remediate audit findings.
NTR	Non-Profit Organisation Transaction Report: PMLA mandated report on suspicious NPO transactions.
PEP	Politically Exposed Person: individual in a prominent public function with elevated AML risk.

PHF	Proposal History Form: IRDAI prescribed form for agent license application.
PMLA	Prevention of Money Laundering Act, 2002: India's primary AML legislation.
POSP	Point of Sales Person: simplified insurance distributor category introduced by IRDAI.
RegTech	Regulatory Technology: technology solutions for automating regulatory compliance.
STR	Suspicious Transaction Report: PMLA mandated report of transactions indicating money laundering.
URN	Unique Registration Number: IRDAI assigned identifier for each licensed insurance agent.

Internal Audit Checkpoints

13.11 The checkpoint matrix below is intended to be executable by a Chartered Accountant led internal audit team. It combines legal requirements, operational controls and current enforcement themes.

Sr. No.	Area of Verification	Expected Control/ Regulatory Requirement	Audit Procedure	Documents/ Evidence to be Verified	Source/ Regulatory Reference
1	Governance over agency matters	Annual board approved policy on agency matters annual review and filing with the Authority by 31 March	Obtain policy, verify board approval date, compare current year policy with prior year, check evidence of filing and	Board minutes, approved policy, filing acknowledgement, revision tracker	IRDAI (Appointment of Insurance Agents) Regulations, 2016, Annexure I.

			implementation		
2	Governance over commission	Written board approved policy for payment of commission periodic review annual board approved commission return within 45 days after year end, post Audit Committee review	Verify existence of policy, approval workflow, product/channel matrices, annual return filing timeline and Board/Audit Committee review	Commission policy, Audit Committee minutes, Board minutes, annual return filed with IRDAI.	Insurance Act, 1938, section 40 IRDAI (EOM including Commission) Regulations, 2024, regulations 4 and 14 repeal of 2023 commission regulations.
3	Individual agent application	Form I A complete PAN, age, address, examination proof and other required documents on file	Sample open and recently appointed agents perform document completeness review verify date stamps and acknowledgement controls	Agency application, PAN copy, age proof, address proof, exam certificate, agency file register	IRDAI (Appointment of Insurance Agents) Regulations, 2016, regulation 4 and Form I A
4	Eligibility and disqualification	Applicant should not suffer from disqualificatio	Re perform statutory disqualification checklist	Applicant declarations, background check notes	Insurance Act, 1938, section 42(3) IRDAI

		n under section 42(3)	on selected samples inspect declarations and due diligence notes	where maintained, approval memo	(Appointment of Insurance Agents) Regulations, 2016, regulation 7
5	Examination and certification	Passed agency examination pass certificate valid for first time appointment	Match appointment date to certificate date test expired certificates verify product line examination relevance	Examination result, pass certificate, candidate number, examination body evidence	IRDAI (Appointment of Insurance Agents) Regulations, 2016, regulation 6
6	Approval and code generation	Appointment letter within regulatory timeline agency code allotted identity card issued	Compare document receipt date, approval date, appointment date, code creation date and first business date	Appointment letter, dispatch evidence, identity card record, system user/master log	IRDAI (Appointment of Insurance Agents) Regulations, 2016, regulations 4(5) and 4(6)
7	Sales conduct for individual agents	Agent must identify self, disclose insurer, explain proposal	Review training material, proposal pack controls,	Proposal forms, confidential reports where applicable,	IRDAI (Appointment of Insurance Agents) Regulations,

		disclosures, obtain required documents and avoid prohibited practices	customer communication samples and complaints test for mis selling indicators	training records, complaint files, call scripts	2016, regulation 8 Insurance Act, 1938, section 42A
8	Corporate agent onboarding	Valid CoR, valid tie up framework, relevant board approved policy, valid PO/SP evidence before business activation	For selected corporate agents, verify existence/validity of CoR, tie up agreement, PO details, SP certificate list and implementation in insurer systems	CoR copy, tie up agreement, insurer approval note, SP/PO evidence, portal download/acknowledgement	IRDAI corporate agent requirements page corporate agent FAQs
9	Specified Person controls	Only validly certified persons should solicit/procure insurance business for the CA	Match proposals to SP identifiers test whether branches with proposals had active SP cover review branch clustering	SP master, certificate numbers, proposal source logs, branch mapping, portal reports	IRDAI order noting disclosure of SP details and certificate numbers under regulation 22(5) orders on unlicensed solicitation

			and exception logic		
10	Corporate agent renewal and expiry	No business after CoR expiry renewal pendency does not by itself extend validity	Identify any policy issuance/quote/proposal acceptance during CoR expiry windows	CoR validity register, renewal tracker, proposal logs, issuance reports	IRDAI enforcement order, Flipkart Internet Pvt. Ltd., 7 April 2025
11	Forced selling/ tied sale	Customers should not be compelled to buy insurance with primary product	Review bancassurance/corporate agent scripts, welcome calls, product bundling controls, complaints and refund cases	Product brochures, branch circulars, complaint analytics, cancellation/ free look cases	IRDAI order referring to regulation 21(2) of Corporate Agent Regulations, 2015
12	Cessation, surrender, suspension and cancellation	Timely cessation certificate immediate stop on sourcing recovery of identity card/forms portal updates and	Sample resignations / cancellations inspect whether channel was blocked across all systems and whether	Form I C, resignation letter, speaking order, blacklist/portal confirmation, system deactivation logs	IRDAI (Appointment of Insurance Agents) Regulations, 2016, regulations 10 to 16 and Form I C

		blacklist updates where applicable	documents were recovered		
13	Master data controls	One source of truth for active/inactive codes maker checker and audit trail on changes	Obtain full agent/channel master dump test duplicate PAN/mobile/bank details inspect change logs and authorizations	Channel master dump, maker checker logs, user access matrix, change tickets	Appointment, cessation and commission control framework
14	Commission payment processing	Payment only to duly authorised channel and in line with board policy and product approvals	Recompute sample commissions from system logic test suspended/inactive agents, reversed policies, free look/cancelled cases and blocked products	Commission run reports, GL entries, payable ageing, policy source file, reversal journals	Insurance Act, 1938, section 40 IRDAI (EOM including Commission) Regulations, 2024
15	Complaint and grievance monitoring	Complaints involving agents/corporate agents	Analyse complaint trends by channel,	Complaint register, Bima Bharosa	IRDAI grievance redressal/ Bima

		must be tracked and addressed through insurer system and IRDAI grievance framework	branch and product check whether root causes reach sales governance forum	extracts if available, RCA reports, corrective action tracker	Bharosa framework
16	Financial reporting and year end control	Agency related balances and commission must reconcile with books and annual returns	Reconcile channel wise commission system output with GL, outstanding payables, reversals and annual commission return	GL, sub ledger, return filed with IRDAI, reconciliations, board approved return	Insurance Act, 1938, section 11(1A) IRDAI (Preparation of Financial Statements and Auditor Report of Insurance Companies) Regulations, 2002 IRDAI (EOM including Commission) Regulations, 2024, regulation 14

List of Important Acts, Regulations, Circulars, Guidelines and Other References

Source	Issuing authority	Date/ year	Relevant section/ regulation/ paragraph	Relevance to this chapter
Insurance Act, 1938	Government of India	1938, as amended	Sections 40, 41, 42, 42A, 42D, 11(1A)	https://irdai.gov.in/document detail?documentId=366196
IRDAI (Appointment of Insurance Agents) Regulations, 2016	IRDAI	15 April 2016 effective 1 April 2016	Regulations 4, 5, 6, 7, 8, 10 16 Annexure I Forms I A, I B and I C	https://irdai.gov.in/document detail?documentId=605121
IRDAI (Registration of Corporate Agents) Regulations, 2015	IRDAI	15 September 2015 effective 1 April 2016 per IRDAI FAQs	Regulation 14, regulation 21(2), regulation 22(5), regulation 26, Schedule III corporate agent registration and open architecture framework	https://irdai.gov.in/document detail?documentId=379633
IRDAI (Expenses of	IRDAI	24 January 2024	Regulations 4, 13, 14, 24	https://irdai.gov.in/document

Management, including Commission, of Insurers) Regulations, 2024		effective 1 April 2024		detail?documentId=4359902
Master Circular on Expenses of Management, including Commission, of Insurers, 2024	IRDAI	15 May 2024	Circular listing and implementation support to 2024 EOM framework	https://irdai.gov.in/document detail?documentId=4886329
IRDAI (Protection of Policyholder Interests, operations and allied matters of insurers) Regulations, 2024	IRDAI	1 April 2024	Current policyholder protection and operations framework	आईआरडीएआई (पालिसीधारकों के हितों का संरक्षण, बीमाकर्ताओं के परिचालन और संबद्ध कार्य) विनियम, 2024 IRDAI (Protection of Policyholder's Interests, operations and allied matters of insurers) Regulations, 2024.pdf
Master Circular on Protection of	IRDAI	5 September 2024	Consolidated current circular framework	https://irdai.gov.in/document

Policyholders Interests, 2024			under the 2024 regulations	detail?documentId=5625747
IRDAI (Preparation of Financial Statements and Auditor Report of Insurance Companies) Regulations, 2002, as amended	IRDAI	2002 amended 2021	Read with section 11(1A) of the Insurance Act	https://irdai.gov.in/document detail?documentId=603541

Chapter 14
Commission

Introduction

14.1 Commission represents one of the most significant acquisition costs incurred by life insurers and plays a critical role in driving insurance distribution across agency, bancassurance, broker, corporate agent, digital and other intermediary channels. Given its direct impact on insurer profitability, policyholder interests, intermediary conduct and regulatory compliance, commission management requires a robust governance framework supported by effective systems, controls and monitoring mechanisms.

The regulatory landscape governing commission payments has undergone a significant transformation with the introduction of the IRDAI (Expenses of Management, including Commission, of Insurers) Regulations, 2024. The revised framework shifts the focus from product wise commission ceilings to an enterprise wide Expenses of Management (EOM) governance model, placing greater accountability on the Board of Directors and Senior Management for ensuring sustainable expense management, appropriate distribution practices and regulatory compliance. Accordingly, internal audit is expected to assess not only the accuracy of commission computation and payment but also the effectiveness of governance, technology controls, regulatory reporting, fraud prevention measures and adherence to the insurer's Board approved Commission and EOM Policies.

Scope and Objective

14.2 Commission constitutes one of the most significant components of acquisition cost for a life insurer and directly influences distribution strategy, product profitability, intermediary behaviour and overall business growth. Given the extensive reliance on agency, bancassurance, broker, corporate agent, digital and other intermediary channels, insurers are required to establish robust controls to ensure that commission payments are accurate, authorized, compliant with regulatory requirements and aligned with approved business objectives.

The primary objective of the internal audit of commission is to evaluate the adequacy and effectiveness of the governance framework, systems,

processes and internal controls governing commission administration. The audit seeks to provide assurance that commission is calculated, approved, accounted for and paid only to eligible intermediaries in accordance with applicable laws, regulations, Board approved policies and contractual arrangements. The audit should also verify that commission expenses are appropriately classified, recorded and disclosed in the books of account and regulatory returns.

Specifically, the internal audit should assess whether:

- Commission is paid only to licensed and eligible intermediaries authorised to solicit and procure insurance business.
- Commission rates, incentive structures and payout mechanisms are approved by the Board and are consistently applied across products and distribution channels.
- Commission computations are accurate, complete and supported by valid underlying transactions and premium collections.
- Adequate controls exist to prevent duplicate, erroneous, excessive or fraudulent payments.
- Appropriate claw back and recovery mechanisms are implemented for cancelled, lapsed, surrendered or otherwise ineligible policies.
- Outstanding commission payable and commission recoverable balances are accurately determined, appropriately provisioned and periodically reviewed.
- Tax deductions, statutory levies and other regulatory obligations relating to commission payments are correctly complied with.
- Commission related accounting entries are properly recorded under the respective products, business segments and financial reporting heads.
- Adequate management information systems (MIS), reconciliations and monitoring mechanisms are in place to facilitate oversight and decision making.

The introduction of the IRDAI (Expenses of Management, including Commission, of Insurers) Regulations, 2024 has fundamentally transformed the regulatory framework governing commission expenditure. The earlier regime primarily focused on product specific commission ceilings and

transactional compliance. Under the revised framework, regulatory emphasis has shifted towards enterprise wide governance, prudent expense management and Board accountability for the overall Expenses of Management (EOM) of the insurer.

Commission expenditure now forms an integral part of the EOM framework and is required to be monitored in conjunction with all other operating and acquisition expenses. Consequently, the scope of internal audit extends beyond verification of commission calculations and includes an assessment of governance arrangements, monitoring processes, regulatory reporting mechanisms and management oversight over commission expenditure.

Regulatory Framework

14.3 The revised regulatory framework places significant emphasis on:

Governance and Oversight

- Board approved Commission and EOM Policies.
- Clearly defined governance structures and accountability mechanisms.
- Periodic review of commission strategies and distribution economics.
- Oversight by the Board, Audit Committee and Senior Management.

Expenses of Management (EOM) Compliance

- Monitoring of overall EOM limits prescribed under the Regulations.
- Assessment of commission expenditure within the broader EOM framework.
- Identification and escalation of emerging EOM risks and breaches.
- Implementation of corrective action plans where required.

Sustainability of Acquisition Costs

- Alignment of commission structures with long term profitability objectives.
- Monitoring of persistency, renewal performance and product economics.
- Prevention of aggressive or unsustainable commission practices.
- Evaluation of business quality indicators and intermediary performance.

Regulatory Reporting and Disclosures

- Accuracy and completeness of EOM related regulatory submissions.

- Adequacy of management information systems supporting regulatory reporting.
- Consistency between financial records, regulatory returns and Board reporting.
- Timely submission of reports and compliance certifications.

Technology and Data Integrity

- Reliability of commission engines and automated payout systems.
- Integrity of intermediary master data, licensing information and bank details.
- Effectiveness of system controls, maker checker mechanisms and access controls.
- Adequacy of audit trails supporting commission processing activities.

Accordingly, the internal audit function is expected to move beyond traditional transaction testing and adopt a risk-based approach encompassing governance effectiveness, operational efficiency, regulatory compliance, financial reporting accuracy, technology controls, fraud risk management and enterprise-wide monitoring of commission expenditure within the EOM framework.

Key Regulatory Shift under EOM Regulations, 2024 is as under:

Sr. No.	Earlier Framework	Current Framework
1	Product wise commission caps	Enterprise level EOM governance
2	Operational focus	Board driven governance
3	Product monitoring	Enterprise wide monitoring
4	Commission centric compliance	Total expense management
5	Limited reporting	Enhanced regulatory reporting

Internal audit is now expected to move beyond transaction verification and evaluate:

- Governance effectiveness
- Accuracy of commission computation

- EOM compliance
- Data integrity
- Technology controls
- Fraud prevention mechanisms
- Regulatory reporting processes

The Key Systems Involved in commission processing are:

Sr. No.	System	Purpose
1	Agency Management System	Agent onboarding and hierarchy
2	Policy Administration System	Policy issuance and servicing
3	Premium Accounting System	Premium realization
4	Commission Engine	Commission computation
5	Finance/ ERP	Accounting and payouts
6	Compliance Systems	TDS, GST and licensing validation
7	EOM Monitoring Framework	Regulatory monitoring and reporting

Illustrative Internal Audit Checklist

14.4 Illustrative Internal Audit Checklist covering key risks, control objectives, audit procedures and applicable regulations, guideline, notifications and circulars for audit of commission are as follows:

Risk	Control Objective	Illustrative Audit Procedures
Governance Framework		
Board Approved Policy along with Periodic Review	Regulatory	• Obtain Board approved policy • Check for Annual review with Version Control

Delegation Matrix along with exception approvals	Ensure approved payouts	• Defined authority levels • Exception approvals
• Rates are not in line with commission structure as prescribed in the Board • Policy documents and/ or appointment letter issued to agents.	Ensure approved payouts	• Obtain the Board Policy • Check that the commission paid to agents is as per the rates approved by the Board • Commission rates to be checked with appointment letter issued to different types of agents.
Commission Process Flow		
• Agent onboarding Licensing and PAN validation, Agent code generation • The commission for procurement of business has been paid to non-licensed insurance agents.	Regulatory	• Check if the system allows enrollment of agents without valid license. Only valid license holders should be allowed to procure business. • Also in payment file, valid license numbers should be checked • A list of agents associated with the insurer to be obtained along with the policies converted during the same period • Match both the lists to identify deviations • Identify the process of activation/ deactivation of agents in the system and ensure adequate controls are in place

		• Check the names of officials having access rights for creation of masters for agents • Check whether list of agents associated with the insurer does not include active agents transferred to other life insurance companies.
Commission payout is made without obtaining the PAN number of Agents	Regulatory	• Obtain the list of agents with PAN details from the system • Check whether the PAN details are matched with the official site • Where the PAN details are missing, check whether any commission is paid to such agent. Also check if paid, TDS is deducted at a higher rate.
Duplicate/ erroneous PAN details & bank account updated in the system	Preventing duplicate payouts	• Obtain the PAN details of Agents from the system • Check for the duplicate entries in the list • Ensure that PAN consist of 10 digits • Ensure that there are no same bank account/PAN for different agents • Check the PAN details with the details on NSDL website.

Commission not processed for all the premiums booked for that period	Accurate Payments Preventing fraud risk	Two Scenarios: Where Premium System and Commission system is, • Closely Integrated: One time checking of flow of information between both the systems including the reconciliation mechanism and existence of maker checker controls for these systems • Manual data Synchronization: All the premium records to be matched with the books of account. Reconciliation to be in place for upload and download. Ensure that there is no manual intervention of data repair during this process. • In case of manual calculation of commission, verify whether employees processing commission payouts can change the master rates in the excel sheets • Check whether fields in master rates are protected cell • Check the authority to change the master rates and formulas in excel sheets and name of agent

		for calculation of commission.
Commission is paid on non-converted /cancelled policies	Prevent Excess Payouts	• Check the system and process followed for ensuring that only converted policies move to the commission processing system • Also reconcile the premium figure with the books of account.
Upon promotion of LAS to SM, the LA IO is not terminated and commission is still paid to the agent	Prevent excess Payout	• Obtain a list of employees of the insurer and list of agents along with PAN details • Match the PAN details to identify active LA IO's in the system • Check whether commission is paid to such agent post promotion to SM.
For all resigned LA, the renewal commission is paid to the agent who has not 5 completed years of service with the insurer.	Prevent Excess Payout	• Obtain a list of resigned agents along with date of joining and resignation • Check the same with commission pay out file to ensure that commission is paid only for renewal commission for terminated agent serving 5 years with the insurer.
Commission is paid to the agents who were	Prevent Excess Payout	• Obtain a list of agents terminated on account of fraud and policies

terminated on account of fraud.		converted during the period for the agents terminated • Check whether any policy is issued under the name of agent post termination • In case policy is issued, check whether the commission is paid on the policy to the terminated agent.
• Commission is paid to an agent other than the one who has procured the business	Accurate Payments	• Take a report on Change of Agents. Anything other than fixing any data entry error is not permitted
• Business login is permitted during the lapsation of the agent's license	Ensure approved payouts	• Select agents whose license has lapsed for the same period on random basis • Obtain the data of the policies issued during the period and check whether the policies are logged in the system post lapsation of license. • Also check the premium system set up in this regard.
Delays in settlement of commission to agents	Adherence to timelines	• Check the internal TAT set for payment of commission • Check whether the commission is paid within the TAT defined.

Commission is not accurately claw backed for all cancelled policies.	Accurate recoveries	• Check the policies cancelled during the audit period • Check the commission claw backed on such policies with the commission paid at the time to conversion to ensure that the same is accurately claw backed by the system • Check the completeness for period under audit
If policy is cancelled post free look period, proportionate commission is not claw backed from LA.	Accurate recoveries	• Obtain the list of policies cancelled during the free look period • Check with the commission processing system that the commission originally booked at the time of policy issuance has been accurately and timely reversed by the system.
Non-adherence to TDS provisions under the Income Tax Act, 2025.	Tax Compliance	• Check the adherence to TDS provision laid down under the Income Tax Act with regard to commission. • Also check necessary approval from IT to deduct nil/lower tax.
Non-adherence to GST related requirements	Tax Compliance	• Check GST laws relating to the insurer with regard to applicability, set off,

		payment and filing of GST returns.
Operational Controls		
Delay/inaccurate updation of rates in the system	Ensure approved payouts	• Obtain a log from the commission processing system for the data of updation of commission rates for new product launched • In case of delay, check whether any commission is paid during the said period
Commission released for the period between termination and reinstatement	Excess Payouts	• Check Management decision on this and its adherence.
Financial Controls		
Inaccurate recording/ provisioning of commission entries in the books of account.	True and Fair	• Match the commission pay out details sent to the accounts team with the details recorded in the system • Check the amount withheld due to FLC or any other reason and whether they have been properly provided for if the corresponding premium has been accounted for.
Long outstanding balance in commission payable account in the books of account of the insurer	Prevent fraud risk	• Obtain the details of commission payable along with ageing and justification for long outstanding

		• Check the policy of the insurer with regard to the write back of commission payable and ensure adherence to the same.
Long outstanding commission recoverable from the agents	Prevent fraud risk	• Obtain ageing analysis for commission recoverable account from the accounts team along with justification for long outstanding • Check whether any agent appearing in this list is an active agent and commission is paid without set off of commission recoverable • Check the internal policy of the insurer with regard to the write off of commission recoverable and ensure adherence to the same.
Verify Regulatory Filings	Regulatory	• Obtain the reports submitted to IRDA

Specific Product Wise Audit Checking

Sr. No.	ULIP Products	Protection Products	Group Insurance Products	Annuity and Pension Products	Bancassurance Channel	Digital and Online Channels
1	Premium redirection cases	High upfront	Corporate agent payouts	Single premium	Revenue sharing	API based payout

		commissions		structures	arrangements	processing
2	Persistency linked payouts	Mis selling indicators	Group renewals	Deferred annuity treatment	Open architecture compliance	Fraudulent lead generation risk
3	Trail commission arrangements	Early mortality claims	Premium adjustments	Vesting related controls	Large value transactions	Automated payout controls
4	Fund switch related claw backs	High cancellation ratios	Experience refund implications		Channel profitability monitoring	Aggregator commission arrangements

Data Analytics Enabled Audit

Sr. No.	Analytics	Audit Objective
1	Duplicate PAN analysis	Detect linked agents
2	Common bank account analysis	Detect suspicious payouts
3	High commission ratio analysis	Identify outliers
4	Manual override analysis	Detect unauthorized interventions
5	Dormant agent payout analysis	Detect abnormal payouts
6	Commission Payable account	Large Reversals
7	License expiry analysis	Identify invalid payouts
8	Cancellation trend analysis	Detect mis selling indicators

Red Flags

14.5 The following Red Flags may indicate potential control weaknesses regulatory non-compliance operational deficiencies and should be considered for focused audit review:

- Multiple agents linked to same bank account
- Excessive manual overrides
- Commission spikes near reporting periods
- Payments to inactive agents
- Delayed claw back reversals
- Repeated post facto approvals
- Long pending recoverable

Common Audit Observations

14.6 The following are some commonly observed irregularities and instances of non-compliance in commission that may warrant specific attention during internal audit:

- Delayed update of commission rate masters
- Manual overrides without approvals
- Duplicate intermediary records
- Weak recoverable monitoring
- Incorrect TDS deductions
- Unreconciled commission payable balances

Key Regulatory References

Sr. No.	Regulation/ Circular/ Reference	URL
1	Insurance Act, 1938	https://www.indiacode.nic.in
2	IRDAI (Expenses of Management, including Commission, of Insurers) Regulations, 2024	https://irdai.gov.in/document detail?documentId=5066628

3	IRDAI (Appointment of Insurance Agents) Regulations, 2023 (as amended from time to time)	https://irdai.gov.in/regulations guidelines
4	IRDAI Regulations and Guidelines applicable to Insurance Intermediaries, Corporate Agents and Brokers	https://irdai.gov.in/regulations guidelines
5	Income tax Act, 1961 – TDS provisions relating to Insurance Commission (including Section 194D)	https://incometaxindia.gov.in
6	Central Goods and Services Tax Act, 2017 and related GST Rules	https://cbic gst.gov.in
7	Board approved Expenses of Management (EOM) Policy	Internal Policy Document
8	Board approved Commission Policy	Internal Policy Document
9	IRDAI Regulatory Returns and Reporting Framework relating to EOM and Commission Reporting	https://irdai.gov.in
10	IRDAI Circulars, Master Circulars, Guidelines, Clarifications and FAQs issued from time to time	https://irdai.gov.in/regulations guidelines

Chapter 15
Rewards and Recognition

Introduction

15.1 Reward and Recognition (R&R) refers to the structured set of monetary and non-monetary incentives, acknowledgements and benefits provided by an organisation to motivate and retain employees, agents and distribution partners. In the context of life insurance, R&R is a critical business lever that directly influences sales volume, persistency of the policy book, customer satisfaction and overall organisational performance.

In life insurance companies, R&R operates across two distinct but interconnected populations:

- **Employees:** Branch managers, sales managers, operations staff and support functions who are rewarded through salary increments, bonuses, performance awards and recognition programmes.
- **Insurance Agents & Distribution Partners:** Individual agents, corporate agents, brokers and bank partners who earn commissions, overrides, contest rewards and foreign travel incentives based on business produced.

Role of Incentives in Life Insurance Business Growth

Incentives in life insurance serve as powerful tools to align the behaviour of salespeople and agents with organisational objectives. The right incentive structure drives acquisition of new policies, renewal of existing ones and cross selling of additional products. However, poorly designed or inadequately controlled incentive schemes can lead to mis-selling, policy churning and reputational damage.

Sr. No.	Positive Outcomes of Well Designed R&R	Risks of Poorly Controlled R&R
1	Increased new business premium	Incentive driven mis-selling
2	Improved agent productivity	Policy churning for fresh commissions

3	Higher persistency ratios	Ghost policy issuance
4	Better customer satisfaction	Fake customer onboarding
5	Reduced lapse rates	Aggressive selling to vulnerable customers
6	Enhanced brand reputation	Regulatory penalties and fines
7	Channel loyalty and retention	Financial misstatement of incentive expenses

Types of Rewards and Recognition

Sr. No.	Category	Type	Examples
1	Monetary – Employee	Fixed Pay Enhancement	Annual increment, promotion linked pay
2	Monetary – Employee	Variable Pay	Performance bonus, ESOP, PLI
3	Monetary – Agent	Commission	First year, renewal, single premium commissions
4	Monetary – Agent	Override Commission	Hierarchy level additional commission
5	Non-monetary	Recognition Programmes	Star performer, Achievers' Club
6	Non-monetary	Awards	Trophies, certificates, digital badges
7	Campaign Based	Contest Rewards	Gifts, gadgets, cash prizes

8	Campaign Based	Incentive travel	Domestic and foreign trips/conferences
9	Digital	Digital reward Platforms	E vouchers, points based systems
10	Digital	Gamification	Leaderboards, milestone badges, mobile apps
11	Long-term	Retention bonuses	Deferred incentives tied to persistency
12	Long-term	Superannuation/ Gratuity	Employee benefit programmes

Impact of R&R on Sales Behaviour and Compliance Culture

The design of the incentive structure fundamentally shapes the sales culture of a life insurance organisation. When incentives are exclusively focused on new business acquisition without adequately rewarding renewal collections, customer satisfaction, or complaint resolution, they create conditions for systemic mis-selling and customer harm.

Key Governance Principle
• Incentive structures should balance new business acquisition with persistency, customer suitability and complaint outcomes. • High pressure incentive schemes with no clawback mechanisms are a leading indicator of conduct risk. • Internal audit must assess whether the incentive design itself creates adverse behavioural incentives. • IRDAI's guidelines on protection of policyholders and mis-selling directly govern how incentive schemes can be structured.

Role of Internal Audit in R&R Monitoring

Internal audit plays a pivotal role in providing independent assurance over the governance, fairness, accuracy and compliance of the R&R function. The scope of internal audit in this domain has expanded significantly over the last decade, moving beyond simple voucher verification to encompass:

- Assessment of incentive policy design and alignment with regulatory requirements.
- Validation of incentive computation accuracy and data integrity.
- Fraud risk assessment across all reward channels.
- Review of IT controls over automated incentive engines.
- Conduct risk and ethical sales behaviour assessment.
- Continuous monitoring through data analytics and exception reporting.

Regulatory and Governance Framework

IRDAI Guidelines Impacting Incentive Structures

15.2 The Insurance Regulatory and Development Authority of India (IRDAI) has issued comprehensive guidelines that directly and indirectly govern how insurance companies design, implement and control their R&R programs. Key regulatory instruments include:

Sr. No.	Regulation/ Circular	Key Provision	R&R Implication	Audit Focus
1	IRDAI (Payment of Commission) Regulations	Caps on commission payable to agents/brokers	Ensures commission does not exceed prescribed limits	Commission computation audit
2	IRDAI (Protection of Policyholders' Interests)	Mandates suitability, disclosure and fair treatment	Incentive structures must not compromise advice quality	Mis selling linkage audit
3	IRDAI (Insurance Web Aggregators) Regulations	Regulates digital distribution incentives	Digital campaign controls	Digital R&R audit

4	IRDAI (Corporate Governance) Guidelines	Board responsibility for compensation policies	Board approval of incentive schemes mandatory	Policy approval audit
5	IRDAI Circular on Expenses of Management	Controls total expense ratios	Total R&R expenses within EOM limits	Expense monitoring audit
6	IRDAI (Micro Insurance) Regulations	Special incentive provisions for micro insurance	Separate tracking needed for micro insurance rewards	Channel wise expense audit

Corporate Governance Expectations

Life insurance companies are expected to maintain robust corporate governance frameworks that encompass the design, approval, implementation and monitoring of R&R policies. The Board of Directors and its Audit/Compensation Committee bear ultimate responsibility for ensuring that incentive structures are:

- Aligned with long term shareholder value and policyholder interests.
- Free from conflicts of interest and related party manipulation.
- Compliant with applicable regulations and the company's Code of Conduct.
- Subjected to regular review and independent audit.

AML and Anti-Fraud Implications

Premium funding fraud where agents or intermediaries arrange loans or advances to fund insurance premiums solely to earn first year commissions constitutes a significant AML risk. Such arrangements may be used to layer funds through the insurance system and create fictitious policy records. Internal audit must specifically test for indicators of premium funding, such as

early surrender patterns, identical premium amounts across multiple policies and unusual premium payment methods.

Tax and Accounting Implications of Rewards

Tax/ Accounting Issue	Audit Consideration
TDS on agent commissions (Section 194D)	Verify TDS deduction and deposit compliance
TDS on foreign trip benefits (Section 194R)	Perquisite value calculation accuracy
GST on reward fulfilment services	Input credit eligibility and compliance
Expense provision accuracy	Review provisioning methodology and completeness
Related party transactions in R&R	Conflict of interest and arm's length pricing
ESOP accounting (Ind AS 102)	Fair value measurement and amortisation

ESG and Ethical Selling Considerations

Increasingly, environmental, social and governance (ESG) frameworks require insurance companies to demonstrate that their sales incentive structures promote ethical behaviour, fair customer treatment and long term sustainability. Internal audit should assess whether incentive structures are aligned with the company's published ESG commitments and whether aggressive selling practices expose the company to reputational or regulatory risk.

Key Regulatory Audit Objectives
• Verify that commission and incentive payments are within IRDAI prescribed limits. • Confirm that the Board/Compensation Committee has approved all incentive schemes. • Assess whether incentive structures create perverse incentives that could lead to mis selling.

- Review AML controls in relation to premium funding and fake policy risks.
- Validate TDS/GST compliance on all reward payments.
- Assess alignment of R&R practices with ESG and corporate governance commitments.

Rewards Policy and Approval Audit

15.3 Every reward and recognition initiative must originate from an approved policy framework. The absence of a documented policy, or failure to follow approval processes, exposes the organisation to financial risk, regulatory non-compliance and the potential for fraudulent manipulations. The internal audit function must systematically verify the integrity of the policy approval lifecycle.

Audit Checklist – Reward Policy & Approval

Sr. No.	Audit Area	Audit Procedure	Expected Control	Red Flag
1	Policy Documentation	Review current R&R policy document and version history	Approved, dated policy document	No documented policy/ undated document
2	Board/ Committee Approval	Verify Board minutes for approval of incentive schemes	Board/Compensation Committee resolution	Scheme launched without Board approval
3	Campaign Authorization	Review campaign launch approvals	Signed campaign brief with authority sign off	Campaigns launched by local management without HO approval
4	Delegation of Authority	Test actual payments	Defined DOA matrix covering all	Payments made outside

		against DOA matrix	reward categories	approved authority levels
5	Eligibility Criteria	Validate recipient eligibility against policy rules	Documented eligibility criteria applied consistently	Eligibility criteria applied differently across branches
6	Policy Communication	Verify communication of scheme to participants	Documented communication / acknowledgement	Scheme communicated verbally without documentation
7	Exception Approvals	Review all exceptions granted during the audit period	Exceptions approved by next level authority with rationale	Exceptions approved by same authority who initiated
8	Budget Controls	Compare actual R&R spend against approved budget	Budget allocation with periodic utilisation review	Overspend without re approval

Control Matrix – Rewards Policy Governance

Sr. No.	Risk	Control	Test Procedure
1	Unapproved incentive schemes	Mandatory Board/Committee approval before launch	Verify Board minutes against scheme launch dates
2	Budget overspend	Monthly budget vs. actual reporting to CFO	Reconcile actual spend against approved budget

3	Inconsistent eligibility application	Automated eligibility check in incentive engine	Test sample of recipients against eligibility rules
4	Conflict of interest in approvals	Maker checker in all approval workflows	Verify no self approvals in exception register
5	Policy not communicated	Mandatory e acknowledgement from participants	Review system acknowledgement records
6	Unauthorised scheme modifications	Change management process for policy amendments	Compare live scheme with last Board approved version

Sales Incentive Audit

15.4 Sales incentive structures in life insurance companies are multi-layered, combining base commissions, persistency linked bonuses, contest rewards and hierarchy level override commissions. The complexity of these structures creates significant risk of computation error, manipulation and fraud. A thorough sales incentive audit must cover the entire cycle from target-setting through computation, payment and reversal.

Sales Target Calculation Audit

Sales targets form the foundation of incentive eligibility. Target manipulation whether by inflating base targets to limit payouts or deflating targets to guarantee excessive rewards is a significant governance risk. Internal audit should:

- Verify that targets are set using approved methodology (e.g., previous year actuals + growth factor).
- Test whether targets were communicated to participants before the campaign period began.
- Identify instances where targets were revised mid campaign without proper approval.

- Check whether targets for preferred agents/employees were set lower than comparable peers.

Incentive Computation Accuracy Testing

Sr. No.	Component	Computation Risk	Audit Test	Sample Size
1	First Year Premium (FYP)	Inclusion of rejected/lapsed policies	Reconcile eligible FYP with policy issuance register	25 top agents + 25 random
2	Renewal Premium	Double counting of renewal credits	Trace renewal credits to actual collections	50 policies per branch
3	Persistency Rate	Manipulation of lapse recording	Independently compute persistency from MIS	All agents above threshold
4	Contest Threshold	Lowering of qualifying threshold post hoc	Compare live scheme with original approved scheme	All contests in period
5	Override Commission	Incorrect hierarchy mapping	Verify org structure against incentive engine setup	All managers receiving overrides
6	Clawback/ Reversal	Failure to reverse on policy lapse/ cancellation	Test clawback triggers against actual policy status	All policies within 90 day lapse window

Persistency Linked Rewards Audit

Persistency linked rewards represent one of the most important controls against short term, commission driven mis-selling. When designed and administered correctly, they align agent interests with policyholder retention. However, they also create a risk of persistency manipulation including premium funding, lapse recording delays and false renewal crediting.

Persistency Audit Red Flags
• Unusually high persistency ratios for specific agents compared to branch/channel average. • Multiple policy renewals received on the same date from the same bank account. • Agent persistency improves significantly in months immediately preceding incentive measurement date. • Policies renewed by third parties (not the original policyholder). • Persistency rates reset to zero for policies shortly after incentive payment is made. • Agents with high persistency ratings but high complaint volumes.

Leaderboard and Contest Manipulation Risks

Digital leaderboards and real time contest tracking create both motivational benefits and manipulation risks. Agents or sales managers with access to sales data entry systems may attempt to manipulate rankings by:

- Backdating policy issuance to meet contest deadlines.
- Splitting large single premium policies into multiple policies to gain multiple contest credits.
- Issuing policies for non-existent or non-consenting customers.
- Colluding with operations staff to bypass issuance controls.

Digital Reward Systems and Technology Risks

15.5 The shift to digital reward platforms has transformed how life insurance companies manage, track and disburse incentives. Modern incentive ecosystems typically comprise of automated incentive engine, CRM integration for sales tracking, a mobile based reward portal for agents and

employees, digital points/voucher system for non-cash rewards and real time dashboard for management reporting.

Technology Risks in Digital Incentive Systems

Sr. No.	Risk Category	Specific Risk	Preventive Control	Detective Control
1	Data Integrity	Sales data manipulated before reaching incentive engine	Digital signature/ hash of source data	Periodic reconciliation of source vs. incentive data
2	Unauthorized Override	Manual overrides to incentive calculations by administrators	Maker checker on all override functions	Audit trail review of all manual overrides
3	Fake Sales Entries	Fictitious policies entered to trigger incentive payouts	Policy issuance controls with customer verification	Outlier analysis on premium/policy ratio
4	Duplicate Rewards	Same sales event credited twice	Unique transaction ID controls	Duplicate detection analytics
5	Access Control	Excessive user privileges in incentive system	Role based access control (RBAC)	Quarterly user access review
6	API Vulnerabilities	Manipulation of API data between CRM and incentive engine	API authentication and payload validation	API transaction logging and anomaly detection

7	Cybersecurity	Unauthorised access to reward disbursement system	MFA, encryption, network segmentation	SIEM alerts, penetration testing
8	Change Management	Unauthorised changes to incentive calculation rules	Change control board approval	Comparison of live vs. approved rules

IT Audit Procedures for Digital Rewards Platforms

- Extract and review the complete audit trail of all manual overrides performed in the incentive engine during the audit period.
- Perform an independent re-computation of top 50 incentive payouts and reconcile with system output.
- Review the User Access Matrix for the incentive system and identify segregation of duties violations (e.g., same user can enter sales data and approve incentive payouts).
- Test API logs between CRM and incentive engine for data integrity: compare source policy data with data received by the incentive engine.
- Review change management logs for all modifications to incentive calculation rules during the audit period and verify Board/management approval.
- Assess the vulnerability management programme for the incentive platform (patch management, penetration testing).
- Review data retention and backup controls for incentive transaction data.

Emerging Digital Risk: AI Generated Sales Patterns

- Advanced fraud actors are using AI tools to generate synthetic sales patterns that appear legitimate to rule based detection systems.
- AI assisted fraud may involve coordinated creation of fake customer profiles, policy applications and premium payment records.

- Internal audit should assess whether the company's fraud detection tools are capable of identifying AI generated fraudulent patterns.
- Collaboration with the technology team and external cybersecurity experts is recommended for advanced threat assessment.

Fraud Risks in Reward and Recognition Function

15.6 The R&R function is one of the highest fraud risk areas in life insurance operations. The financial magnitude of incentive pools, the large number of participants across geographically dispersed channels and the complexity of calculation systems create multiple opportunities for fraud. Internal audit must maintain a comprehensive fraud risk register specific to the R&R domain.

Fraud Risk Register – R&R Function

Sr. No.	Fraud Scheme	Description	Red Flag Indicators	Analytics Detection
1	Fake Policy Issuance	Policies issued for non-existent or non-consenting customers to earn first year commissions	No contact possible at customer address/phone same address for multiple policies	Address clustering phone number duplication analysis
2	Policy Churning	Existing policies surrendered and replaced with new policies to earn fresh commissions	High lapse rate followed by new policy issuance for same customer	Customer level policy lifecycle analysis
3	Ghost Policies	Policies created in system without actual customer	Policies with no genuine premium inflow single premium paid and	Premium to surrender ratio analysis

		knowledge or premium receipt	immediately surrendered	
4	Premium Funding Fraud	Agent/intermediary funds premiums via loans to earn commissions policies lapse post incentive	Common funding account for multiple policyholders early lapse post contest period	Bank account clustering lapse timing analysis
5	Agent Collusion	Groups of agents coordinate to meet contest thresholds, sharing rewards	Multiple agents achieving exactly threshold levels cross referral patterns	Network analysis of agent relationships
6	Fake Customer Onboarding	Customer details fabricated or misused to create incentive qualifying policies	Duplicate PAN/Aadhaar across multiple policies customer complaints of unwanted policies	ID deduplication complaint correlation analysis
7	Leaderboard Manipulation	Sales data backdated or inflated to win contests	Policy issuance dates cluster at contest deadlines high rejection rate post contest	Temporal pattern analysis of policy dates
8	Foreign Travel Abuse	Agents or employees falsely claim	Travel entitlements claimed	Entitlement computation audit against

		eligibility for incentive trips	without meeting achievement criteria	actual performance
9	Vendor Collusion	Reward vendors overbill or provide inferior goods/services	Invoices without supporting delivery evidence related party vendors	Invoice analytics vendor price benchmarking
10	Campaign Misuse	Incentive campaigns used as cover for kickbacks or related party benefits	Campaign beneficiaries linked to senior management above market vendor rates	Beneficiary relationship mapping price variance analysis

Illustrative Case Study – Premium Funding Fraud

Case Study: Premium Funding via Microfinance Network

Background: A branch manager at a mid-sized private life insurer was consistently ranking in the top 3 nationally for new business generation for three consecutive quarters, earning foreign trip incentives and a large performance bonus.

How the fraud worked: The manager had arranged with a local microfinance cooperative to advance small loans to semi urban and rural customers specifically to fund single premium life insurance policies. The branch manager earned full first year commissions. The cooperative received a kickback. Over 90% of these policies were surrendered within 6 months.

Detection: Data analytics flagged the branch for an unusually high new business to surrender ratio. The audit team identified a concentration of policies with premium payments from accounts linked to a single cooperative. PAN based deduplication revealed several instances of customers appearing in multiple policy records.

Outcome: The branch manager was terminated, the incentives were clawed back, regulatory reporting was made and the case was referred to law enforcement. The company introduced automated analytics to monitor premium funding patterns on an ongoing basis.

Conduct Risk and Mis-Selling Linkages

15.7 Conduct risk in the context of R&R refers to the risk that incentive structures motivate insurance salespeople to prioritise their financial interests over the genuine needs and best interests of customers. This manifests as mis-selling the sale of inappropriate insurance products to customers through misleading representations, incomplete disclosures, or exploitation of information asymmetry.

Mis-selling Indicator	Link to Incentive Structure
High complaints to sales ratio for specific agents	Incentive structure rewards volume without quality filters
Policy replacement patterns	New business incentives exceed renewal rewards
Sales to elderly/financially illiterate customers	No suitability assessment requirement in incentive criteria
ULIP mis represented as FD/savings product	Product specific high incentives create product push
Short term endowment sold as long term wealth plan	Incentive contest focused on specific product category
Free look cancellation rate above 5%	High pressure selling to meet contest deadlines

Internal Audit Assessment of Ethical Sales Behaviour

Internal audit should incorporate conduct risk assessment into the R&R audit scope. This involves:

- Analysing complaint data by agent and product to identify systematic mis selling patterns.
- Reviewing free look cancellation rates and correlating with incentive campaign periods.

- Testing whether suitability assessment documentation is genuinely completed or merely pro forma.
- Interviewing a sample of recently onboarded customers (cold-calling) to verify that the product sold matched the representation made.
- Reviewing mystery shopping and quality check reports in relation to top incentive earners.
- Assessing whether the performance management system incorporates customer satisfaction and quality metrics alongside sales volume in determining eligibility for rewards.

Best Practice – Conduct Linked Incentive Design
• Include Net Promoter Score (NPS) and complaint resolution metrics as qualifying criteria for R&R programs. • Introduce clawback provisions for incentives earned on policies that generate mis selling complaints. • Require quality assessment scores to meet a minimum threshold before an agent qualifies for premium rewards. • Design contest schemes with a persistency lookback: agents qualify only if their prior period persistency exceeds a defined minimum.

Rewards Expense and Financial Controls Audit

15.8 Reward and recognition expenses represent a significant line item in the Expenses of Management (EOM) of a life insurance company. Accurate accounting, timely provisioning and proper classification are essential for regulatory reporting under IRDAI norms and financial statement accuracy under Ind AS. Internal audit must ensure that all R&R related costs are correctly identified, booked and reported.

Audit Procedures – Financial Controls

Sr. No.	Financial Control Area	Audit Procedure	Common Finding
1	Expense Provisioning	Verify end of period accruals for unpaid incentives against scheme terms	Under provisioning to manage P&L

2	Expense Classification	Test whether cash incentives vs. travel vs. gifts are correctly classified	Travel costs classified as training expenses
3	Budget vs. Actual	Obtain budget allocation and compare with actual spend by category	Overspend in non-budgeted categories
4	TDS Compliance (Section 194D)	Verify tax deducted on agent commissions and deposited within due dates	TDS not deducted on additional incentive payments
5	TDS on Perquisites (Section 194R)	Verify TDS on foreign trips, gifts, gadgets above INR 20,000	Section 194R applicability not assessed for trip rewards
6	GST on Vendor Services	Review GST invoices from reward fulfillment vendors verify ITC eligibility	ITC claimed on restricted expenses
7	Foreign Travel Controls	Verify travel costs against approved scheme entitlements check actual participation	Non eligible participants included in travel
8	Gift Inventory	Physical verification of gift stock vs. purchase register	Pilferage of gift inventory fake distribution
9	Reimbursement Validation	Test reimbursement claims against supporting documents	Duplicate/inflated claims by field staff

Reconciliation Format – R&R Expense Reconciliation

Reconciliation Item	Amount (INR Lakhs)/ Status
Total R&R budget approved by Board	To be filled
Less: Utilised in Q1 (verified)	To be filled
Less: Utilised in Q2 (verified)	To be filled
Less: Utilised in Q3 (verified)	To be filled
Less: Utilised in Q4 (verified)	To be filled
Balance unspent (to be reversed/lapsed)	To be filled
Provision raised at year end for pending payouts	To be filled
Difference requiring explanation	To be filled
TDS on total incentive payments	To be filled
TDS deposited (verified from Form 26AS)	To be filled
Short deduction/ Late deposit (if any)	To be filled

Vendor and Third-Party Risk Audit

15.9 The delivery of rewards and recognition programs involves multiple third-party vendors including event management companies, travel agencies, gift procurement firms, reward fulfilment platforms and digital voucher providers. Each vendor relationship introduces risks of overcharging, quality misrepresentation, conflict of interest and fraudulent billing. Internal audit must conduct structured vendor risk assessments as part of the R&R audit.

Sr. No.	Vendor Type	Service Provided	Key Risk	Audit Test
1	Event Management	Award ceremonies, recognition events	Inflated event costs fake attendance	Verify quotes check attendee records

2	Travel Agencies	Foreign/domestic incentive trips	Overbilling on airfare/hotel fake travellers	Compare rates vs. market verify boarding passes
3	Gift Suppliers	Gadgets, hampers, merchandise	Below spec goods inflated invoicing	Physical verification market price comparison
4	Digital Voucher Platforms	E vouchers, reward points systems	Unissued vouchers charged duplicate redemption	System reconciliation of issued vs. redeemed
5	Reward Fulfilment Agencies	End to end R&R programme management	Subcontracting without disclosure markup on sub vendors	Review contracts for sub vendor provisions

Vendor Onboarding and Conflict of Interest Controls

- All vendors must be onboarded through the approved procurement process with minimum three comparative quotations for engagements above the prescribed threshold.
- Vendor registration must include a declaration of relationship with company employees, directors, or their relatives.
- Annual renewal of conflict of interest declarations should be obtained from all active vendors.
- Payment terms, service level agreements and penalty clauses for non-delivery must be documented in formal contracts.
- Vendor performance should be reviewed at least annually and tied to contract renewal decisions.

Data Analytics and Continuous Monitoring

15.10 Data analytics has fundamentally transformed the internal audit of R&R functions. Rather than relying on periodic sample based testing, modern audit teams leverage automated analytics tools to continuously monitor the entire population of incentive transactions, identify outliers and detect fraud patterns in near real time. This shift represents a move from post-hoc detection to proactive prevention.

Key Analytics Use Cases

Sr. No.	Analytics Use Case	Data Required	Insight Generated
1	Persistency Outlier Detection	Agent wise persistency ratios renewal payment data	Agents with statistically anomalous persistency
2	Policy Clustering Analysis	Policy address, phone, email, bank account data	Fake/related customer networks
3	Incentive Computation Validation	Sales data + incentive rules + payment records	Over/underpayment exceptions
4	Contest Timing Analysis	Policy issuance dates vs. contest deadlines	Suspicious end of period spikes
5	Lapse After Contest Analysis	Policy lapse dates vs. contest award dates	Policies lapsing immediately after incentive payment
6	Duplicate Payment Detection	Agent code, policy number, payment date	Same event credited multiple times
7	Branch Performance Comparison	Branch wise incentive payout vs. premium	Disproportionate incentive ratios by branch

8	Vendor Invoice Analytics	Invoice dates, amounts, service descriptions	Round number billing sequential invoice numbers
9	High Earner Profiling	Top 5% incentive earners over 3 years	Consistent dominance requiring qualitative review
10	Free Look Correlation	Free look cancellations vs. campaign periods	Systematic mis selling during campaigns

Continuous Monitoring Dashboard – Key MIS Reports

Sr. No.	Report Name	Monitoring Objective
1	Monthly Incentive Payout vs. Budget Report	Tracks actual R&R spend against approved budget by category and channel
2	Agent Persistency League Table	Ranks agents by persistency ratio flags outliers above/below 2 standard deviations
3	Contest Participation & Award Report	Lists all contest beneficiaries with achievement verification
4	Manual Override Log	Summarises all manual adjustments to incentive calculations with approvals
5	Clawback & Reversal Report	Tracks all incentive reversals and ensures timely recovery
6	Vendor Payment Aging Report	Monitors timeliness of vendor payments and outstanding commitments
7	Exception Report – Policy Incentive Mismatches	Flags policies in incentive claims that do not appear in policy register

8	Free Look and Complaint Correlation Report	Links incentive earners with complaint and free look data

Internal Financial Controls (IFC) and IT Controls

15.11 Under Section 143(3)(i) of the Companies Act, 2013, listed companies are required to maintain adequate Internal Financial Controls (IFC) over financial reporting. Life insurance companies must ensure that IFCs are designed and operating effectively across all processes that affect financial reporting including the R&R function, which directly impacts employee expenses, agent acquisition costs and management expense ratios.

Key IFC Controls for R&R

Sr. No.	Control Area	Control Description	Control Type	Test Frequency
1	Incentive Calculation	Automated incentive engine with locked calculation rules	Automated/ Preventive	Quarterly
2	Maker Checker	Dual authorization for all incentive payments above threshold	Manual/ Preventive	Monthly
3	Budget Control	System blocks processing beyond approved budget	Automated/ Preventive	Continuous
4	Clawback Trigger	Automatic flag for clawback on policy lapse within defined period	Automated/ Detective	Monthly
5	User Access Review	Quarterly review of all users with access to incentive system	Manual/ Detective	Quarterly

6	Segregation of Duties	Sales recording separated from incentive approval	Organisational/ Preventive	Continuous
7	Audit Trail	All transactions logged with user ID, timestamp and IP	Automated/ Detective	Continuous
8	Change Control	All incentive rule changes require IT Change Management approval	Manual + System/ Preventive	Per change
9	Reconciliation	Monthly reconciliation of incentive payout with General Ledger	Manual/ Detective	Monthly
10	Backup & Recovery	Daily backup of incentive transaction database	Automated/ Corrective	Daily

IT General Controls Assessment

- **Logical Access Controls:** Review user provisioning and de provisioning processes verify that separated employees' access is revoked within 24 hours.
- **Change Management:** Verify that all changes to incentive calculation algorithms are approved by IT Change Advisory Board (CAB) and tested in UAT before production deployment.
- **Incident Management:** Review IT incidents related to the incentive system in the past 12 months assess whether any incident created financial impact or data loss.
- **Data Backup:** Verify backup frequency, offsite storage and recovery time objective (RTO) for the incentive platform.

- **Patch Management:** Assess whether the incentive platform's underlying infrastructure is patched against known vulnerabilities.
- **Penetration Testing:** Confirm that annual penetration testing covers the incentive management system and that identified vulnerabilities are remediated.

Risk Based Internal Audit Approach

15.12 A risk based internal audit (RBIA) approach requires the audit team to first identify, assess and prioritise risks in the R&R function before designing audit procedures. This ensures that audit resources are directed toward the highest risk areas and that the audit plan remains dynamic and responsive to changes in the operating environment.

Risk Scoring Matrix for R&R Audit Planning

Sr. No.	Audit Area	Inherent Risk	Control Effectiveness	Residual Risk/ Audit Priority
1	Sales incentive computation	High	Medium	High – Annual full audit
2	Persistency linked rewards	High	Low	Critical – Semi annual audit
3	Foreign trip administration	High	Low	High – Annual audit with surprise element
4	Digital incentive platform controls	High	Medium	High – Annual IT audit
5	Reward policy approvals	Medium	High	Low – Biennial audit
6	Vendor management	Medium	Medium	Medium – Annual audit
7	TDS/GST compliance	Medium	Medium	Medium – Annual compliance audit

8	Contest design and administration	High	Low	High – Audit each major contest
9	Clawback/reversal controls	High	Low	High – Annual audit
10	Data analytics monitoring	Low	High	Low – Continuous monitoring

Continuous Auditing Approach

The transition to continuous auditing in the R&R domain involves embedding audit analytics routines into the organisation's data environment so that exception reports are generated automatically and made available to the audit team on a regular (monthly/quarterly) basis. This supplements periodic full scope audits with an ongoing monitoring capability that provides real time assurance.

- **Phase 1 – Foundation:** Define key risk indicators (KRIs) for R&R function establish access to source data.
- **Phase 2 – Automation:** Build SQL/Python/Power BI analytics routines for priority KRIs.
- **Phase 3 – Integration:** Integrate analytics output with audit management system for automated exception tracking.
- **Phase 4 – Optimisation:** Refine analytics based on actual fraud patterns detected incorporate machine learning models.

Emerging Challenges and Current Scenario

Digital Only Sales Campaigns

15.13 The rapid growth of direct-to-consumer digital channels including insurer websites, mobile applications, insurance aggregators and social media platforms has created a new category of R&R challenges. Digital sales campaigns often operate with minimal human oversight, creating conditions for automated fraud at scale. Incentives linked to digital lead generation or online policy issuance are particularly susceptible to gaming through fake leads, bot generated applications and identity theft.

Emerging Risk Landscape

Emerging Risk Area	Internal Audit Response Required
AI generated fake sales patterns	Deploy AI based anomaly detection in audit analytics toolkit
Social media based selling risks	Review compliance monitoring for social media sales communications
Remote workforce monitoring gaps	Audit effectiveness of virtual supervision and output based controls
Hybrid distribution model conflicts	Review incentive conflicts between direct, bancassurance and broker channels
ESG and ethical incentive expectations	Assess alignment of R&R design with published ESG commitments
Data privacy concerns (DPDPA 2023)	Review data handling in incentive platforms for compliance with DPDPA
Reputation risks from aggressive selling	Monitor social media sentiment and complaint trends by channel
Regulatory scrutiny on incentive structures	Proactive review of all schemes against latest IRDAI circulars
Cross selling pressure risks	Assess whether cross sell incentives compromise product suitability
Cryptocurrency/ alternative reward instruments	Assess legality and traceability of non-traditional reward mediums

Regulatory Developments

- IRDAI's Bima Sugam platform and digital distribution framework implications for incentive structures in the digital ecosystem.

- IRDAI's focus on expenses of management (EOM) rationalisation — potential impact on total R&R budget allocation.
- DPDPA 2023 (Digital Personal Data Protection Act) — implications for customer data used in incentive analytics.
- SEBI/MCA regulations on related party transactions — applicable where R&R vendors are related parties.
- International developments in responsible sales incentive design (FCA Consumer Duty, MAS Fair Dealing guidelines).

Future of Internal Audit in Rewards and Recognition

AI Enabled Incentive Auditing

15.14 The next generation of R&R audit will be powered by artificial intelligence and machine learning. AI enabled audit tools will be capable of processing the entire population of incentive transactions continuously, identifying anomalous patterns that rule-based systems cannot detect and generating risk scored exception lists for human auditor review. Key applications include:

- Natural Language Processing (NLP) for automated review of customer complaint narratives to identify mis selling patterns linked to incentive campaigns.
- Graph analytics for mapping agent customer policy networks to identify collusion clusters.
- Predictive models for early identification of agents likely to engage in fraudulent behaviour based on behavioural indicators.
- Computer vision for verification of travel and event documentation (boarding passes, hotel receipts) uploaded to expense management systems.

Future Audit Capabilities Roadmap

Sr. No.	Capability	Current State	Future State	Technology Enabler
1	Incentive computation testing	Sample based periodic testing	100% population, real time	RPA + Data Integration
2	Fraud detection	Rule based exception reports	AI/ML anomaly detection	Machine Learning
3	Persistency monitoring	Monthly manual review	Real time alerts + predictive scoring	Predictive Analytics
4	Vendor risk assessment	Annual review	Continuous monitoring + AI invoice analysis	AI + OCR
5	Mis selling detection	Complaint based, reactive	Proactive NLP analysis of sales communications	NLP/ Conversational AI
6	Audit trail analysis	Periodic IT audit	Continuous log analytics with SIEM integration	SIEM + AI
7	Blockchain reward tracking	Not implemented	Immutable record of reward issuance and redemption	Distributed Ledger
8	Behavioural analytics	Not implemented	Predict high-risk agent behaviour before fraud occurs	Behavioural AI

Illustrative Internal Audit Checklist

A.1 Pre Audit Planning Checklist

- Obtain and review the current Board approved R&R policy.
- Obtain the list of all incentive campaigns run during the audit period.
- Download the complete incentive payout register for the audit period.
- Obtain the Delegation of Authority (DOA) matrix.
- Obtain the vendor master list for R&R related vendors.
- Review prior audit reports and status of open MAPs.
- Obtain access to the incentive management system for data extraction.
- Review the latest IRDAI circulars and guidelines relevant to incentives.

A.2 Fieldwork Checklist

- Verify Board/Committee approval for each major incentive scheme.
- Independently recompute incentives for a sample of top earners.
- Perform data analytics on the full incentive payout population.
- Test clawback triggers for a sample of lapsed policies.
- Verify TDS deduction and deposit for agent commissions and trip rewards.
- Conduct physical verification of gift inventory.
- Review all manual overrides in the incentive system with supporting approvals.
- Interview a sample of contest winners to corroborate achievement.
- Verify vendor invoices against contracts and delivery evidence.
- Assess access controls in the incentive management system.
- Review free look cancellation and complaint data by agent.
- Conduct customer confirmation calls for a sample of policies by top incentive earners.

15.15 An illustrative Internal Audit Checklist covering key risks, control objectives, audit procedure and applicable regulatory requirement to the rewards and recognition is as follows:

Sr. No.	Audit Observation	Risk Rating	Observation	Risk	Recommendation
1	Reward Qualification Based on Cancelled Policies	High	Advisors qualified for rewards based on policies subsequently cancelled during the free look period. Reward points were not reversed.	Incorrect reward payouts, financial loss and promotion of short-term sales behaviour.	Integrate reward engine with policy cancellation records and automatically reverse points before reward settlement.
2	Splitting of Business to Achieve Recognition Thresholds	High	Policies were distributed among family members of the same customer to meet minimum policy count criteria.	Manipulation of reward eligibility and misrepresentation of performance.	Implement customer level analytics to identify related party and clustered policy issuances.
3	Reward Distribution Without Verification of	High	Rewards were issued to advisors whose licenses	Regulatory non-compliance and recognition of	Validate advisor licensing status before

	Licensing Status		had expired during the qualification period.	unauthorized sales activities.	reward approval.
4	Foreign Travel Reward Provided to Non Eligible Employees	Medium	Employees who joined after campaign commencement were included in foreign travel rewards.	Financial leakage and employee grievances.	Integrate HRMS validation before approving rewards.
5	Duplicate Reward Issuance	Medium	Advisors received duplicate gift vouchers due to multiple reward file uploads.	Excess expenditure and potential fraud.	Implement duplicate checks and unique reward identifiers.
6	Recognition Granted Despite Customer Complaint Cases	High	Advisors with pending mis selling complaints received recognition awards.	Reputational damage and conduct risk.	Include complaint ratios and grievance status in reward eligibility criteria.
7	Reward Scheme Budget Exceeded	High	Approved campaign budgets exceeded without	Budgetary control failure and governance issues.	Enforce budget limits through system controls and

	Without Approval		documented management approval.		approval workflows.
8	Manual Override of Reward Eligibility	Critical	Users manually altered reward qualification data without supporting approvals.	Fraud, favoritism and inaccurate reward allocation.	Implement maker checker controls and maintain system audit trails.
9	Reward Points Awarded on Uncollected Premiums	High	Reward points were granted based on policy issuance rather than premium realization.	Recognition of unrealized business and inflated performance.	Link reward calculations to actual premium collections.
10	Conflict of Interest in Award Selection Committee	High	Committee members evaluated candidates from their own reporting hierarchy.	Bias and governance concerns.	Obtain conflict of interest declarations and independent reviews.
11	Reward Points Not Reversed for Policy Reinstatement	High	Advisors repeatedly revived lapsed policies to earn additional	Artificial inflation of business performance.	Monitor lapse revival trends and exclude manipulated transactions.

	Manipulation		reward points.		
12	Non Monetary Rewards Not Subjected to Tax Compliance Review	High	Foreign trips and gifts were distributed without tax compliance assessment.	Tax penalties and regulatory exposure.	Finance and Tax teams should review all high value rewards before issuance.
13	Branch Level Manipulation of Recognition Scores	Critical	Branch managers manually altered performance scores used for recognition.	Fraudulent recognition and governance failure.	Source performance data directly from core systems and restrict manual edits.
14	Awards Granted Despite AML/KYC Violations	Critical	Advisors with AML/KYC related policy issues received recognition awards.	Regulatory, compliance and reputational risk.	Obtain AML and Compliance clearance before finalizing award recipients.
15	Inadequate Monitoring of MDRT/COT/TOT Sponsorship Programs	High	Sponsorship approvals were granted without validating qualifying business figures.	Financial loss and reputational risk.	Independently verify qualification metrics before sponsorship approval.

16	Rewards Paid on Policies Sourced Through Unlicensed POSP/Referral Arrangements	Critical	Reward points were granted on policies sourced through unauthorized referral networks.	IRDAI compliance violations and conduct risk.	Periodically review lead sources and validate intermediary authorization.
17	Persistency Criteria Relaxed Without Approval	High	Campaign eligibility criteria were modified after launch to accommodate additional winners.	Governance failure and favoritism allegations.	Changes to campaign criteria should require Compensation Committee approval.
18	Reward Qualification Through Backdated Policy Issuance	Critical	Policies were backdated near campaign closing dates to meet reward targets.	Manipulation of sales figures and reward outcomes.	Monitor policy issuance timestamps and investigate unusual backdating patterns.
19	Reward Campaign Rules Not Communicated Uniformly	Medium	Different branches interpreted campaign eligibility criteria differently.	Employee disputes and inconsistent reward allocation.	Publish standardized campaign guidelines and FAQs.

20	Recognition Awards Issued to Employees Under Disciplinary Proceedings	High	Employees facing disciplinary investigations received annual recognition awards.	Reputational risk and weak ethical culture.	Include disciplinary status checks before final award approval.
21	Excessive Concentration of Awards in Specific Branches	High	A disproportionate number of rewards were won by a few branches year after year.	Potential collusion or manipulation of performance metrics.	Conduct periodic analytics on branch wise reward distribution trends.
22	Reward Procurement Not Through Approved Vendor Panel	High	Gifts and trophies were purchased from non-empanelled vendors.	Procurement policy violations and overpricing risk.	Restrict procurement to approved vendors and conduct competitive bidding.
23	Delayed Recovery of Clawback Amounts from Reward Recipients	High	Clawback provisions were triggered but recoveries were not initiated timely.	Financial loss and control weaknesses.	Automate clawback recoveries and periodic monitoring.

24	Inadequate Segregation of Duties in Reward Administration	Critical	The same employee calculated, approved and processed reward payments.	Increased fraud and error risk.	Segregate calculation, approval and payment functions.
25	Reward Scheme Operated Without Documented SOP	High	No formal Standard Operating Procedure existed for reward administration.	Inconsistent implementation and control gaps.	Develop and approve comprehensive SOPs covering all reward processes.

Key Regulatory Reference

Source	Issuing Authority	Date/ Year	Relevant Section/ Regulation/ Paragraph	
Insurance Act, 1938	Parliament of India	1938, as amended	Sections 40, 41 and 42	https://irdai.gov.in/documentdetail?documentId=366196
Insurance Regulatory and Development Authority Act, 1999	Parliament of India	1999	Sections 14 and 26	https://irdai.gov.in/documentdetail?documentId=366291
IRDAI (Payment of Commission)	IRDAI	26 March 2023,	Regulations 3 to 6	https://irdai.gov.in/document

Regulations, 2023		effective 1 April 2023		detail?documentId=3230806
IRDAI (Expenses of Management, including Commission, of Insurers) Regulations, 2024	IRDAI	24 January 2024, effective 1 April 2024	Regulations 2 to 5, 6 to 11, 23	https://irdai.gov.in/document detail?documentId=4359902
Master Circular on Expenses of Management, including Commission, of Insurers, 2024, Ref. IRDAI/F&I/CIR/79/5/2024	IRDAI	15 May 2024	Chapter I to Chapter IV auditor certificates and returns	https://irdai.gov.in/document detail?documentId=4886329
IRDAI (Protection of Policyholder's Interests, Operations and Allied Matters of Insurers) Regulations, 2024	IRDAI	20 March 2024, effective 1 April 2024 or publication date, whichever later	Objective clause definitions of complaint, distribution channel and mis selling outsourcing provisions	https://irdai.gov.in/web/guest/document detail?documentId=4590885
Master Circular on Corporate Governance for Insurers, 2024	IRDAI	22 May 2024	Governance framework internal audit PPGR&CM Committee	https://irdai.gov.in/document detail?documentId=4916164

			NRC provisions where relevant	
IRDAI (Appointment of Insurance Agents) Regulations, 2016	IRDAI	15 April 2016, effective 1 April 2016	Regulations 7, 8, 13 and 14	https://irdai.gov.in/documentdetail?documentId=605121
Compendium of Standards on Internal Audit	ICAI	October 2022	SIA 310, SIA 320, SIA 330, SIA 370, SIA 390, SIA 520 and SIA 530	https://internalaudit.icai.org/wp-content/uploads/2026/03/Compendium of Standards on Internal Audit October 2022.pdf
Publications page of the Internal Audit Standards Board listing Standards on Internal Audit	ICAI	Current official listing	Standards on Internal Audit catalogue	https://internalaudit.icai.org/publications/

Chapter 16
Advertisements

Introduction

16.1 The insurance industry increasingly relies on advertisements and promotional communications across traditional, digital and social media platforms to create awareness, educate prospective policyholders and support business growth. Given the complexity of insurance products and the information asymmetry between insurers and customers, advertisements play a critical role in influencing customer decisions. Consequently, insurers are required to ensure that all advertisements, marketing communications and promotional materials are fair, clear, accurate, transparent and not misleading, while adequately disclosing material risks, exclusions and limitations associated with insurance products.

The regulatory framework governing insurance advertisements has undergone significant strengthening through the IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 and related Master Circulars. The emphasis has shifted from mere compliance with advertisement content requirements to establishing a robust governance framework encompassing approval mechanisms, digital marketing oversight, intermediary advertisements, social media communications, influencer engagements, record maintenance and customer protection measures. Internal audit therefore plays an important role in evaluating the effectiveness of advertisement governance, regulatory compliance, operational controls and monitoring mechanisms to ensure that promotional activities protect policyholder interests and safeguard the insurer from regulatory, reputational and conduct risks.

Scope and Objective

16.2 The primary objective of the audit is to check that Advertisements are fair, clear and not misleading, Regulatory disclosures prescribed by IRDAI are incorporated, Advertisement governance framework complies with IRDAI requirements, Product features, benefits, exclusions and risks are appropriately represented, Advertisement approval controls are operating effectively, Advertisement expenditure is properly authorized and monitored,

Advertisement records and evidences are maintained and customer interests are adequately protected.

16.3 The audit review shall cover governance, approval, dissemination, monitoring and record maintenance relating to:

- Product advertisements
- Institutional advertisements
- Digital marketing campaigns
- Social media advertisements
- Influencer and partner led advertisements
- Website content relating to products
- Brochures and sales literature
- Video advertisements
- Outdoor advertisements
- SMS, WhatsApp and email campaigns
- Advertisements issued through intermediaries

16.4 The process flow is enumerated below:

1	**Advertisement Planning**	Marketing requirement identified approval of annual plan
2	**Proposal and Budget Approval**	Approval by competent authority.
3	**Drafting, Product Representation and Risk Disclosure**	• Standard advertisement which is validated by the Product team. • Advertisement should carry the mandatory disclosure
4	**Rating/Ranking/Award**	Supporting evidence for rating awarded by independent agency
5	**Expenditure**	• Procurement process • Comparative quotes

		• Invoices • Campaign performance evaluation
6	**Fraudulent calls and Misleading Promotions**	• Campaigns • Website disclosures • Communication controls

Illustrative Internal Audit Checklist

16.5 An Illustrative Internal Audit Checklist concerning risks, control objectives, audit procedures, relating to advertisements are as follows:

Risk	Control Objective	Illustrative Audit Procedures
Governance Framework		
Board Approved Policy along with Periodic Review.	Regulatory	• Obtain Board approved policy • Check for Annual review with Version Control
• Advertisement Committee constituted • Compliance Officer designated • Approval matrix defined	Regulatory	• Verify Charter and composition as per Chapter 1 point1 of Protection of Policyholders' Interests, Operations and Allied Matters of Insurers Regulations 2024 • Verify appointment and responsibilities • Defined authority levels • Exception approvals

Product Advertisement Review		
• Advertisement Planning • Budget Approval • Advertisement Drafting • Product Representation Benefits accurately represented, exclusions disclosed • Risk Disclosure No misleading illustrations, exaggerated claims • Product name matches approved products, UIN disclosed • Denigration of Competitors • Standards prescribed by Advertising Standards Council of India (ASCI) have been followed	• Annual marketing plan, budget approval • Standard advertisement review checklist • Policy holder Protection • Regulatory Compliance	• Verify approved marketing plan • Verify approvals and delegation matrix • Verify within standard advertisement review checklist exits • Compare representations, exclusions with policy terms • Verify disclosures to check if mandatory disclosures are included. • Review advertisement language • Compare with approved UIN
Linked Insurance Product (ULIP and Variable Annuities)		
• Risk factors disclosed • Compliance to Past performance disclosures • Benchmark disclosure made • Guarantee disclosures accurate	• Regulatory Compliance • Policy holder Protection	• Review Advertisements to Verify mandatory disclosures as per Chapter 1 point 2 of Protection of Policyholders' Interests, Operations and Allied Matters of

		Insurers Regulations 2024 • Verify Compliance sign off • Verify the methodology used for compliance to past performance • Compare accuracy of Guarantee Disclosures with product features
Rating/Ranking/Award Advertisements		
• Rating awarded by independent agency • Source disclosed conspicuously • No Self-created rankings	• Regulatory Compliance • Policy holder Protection	• Review compliance to ratings as per Chapter 1 point 3 of Protection of Policyholders' Interests, Operations and Allied Matters of Insurers • Verify whether independent verification done
Digital & Social Media Advertisement		
• Pre-approval obtained • Website advertisement/social media content/ Influencer communications approved • Advertisement archive maintained	• Regulatory Compliance • Policy holder Protection	• Verify workflow logs to check whether Centralized content approval workflow exists • Check to see if any Unapproved content posted online

		• Review contracts of the influencer and contents for website • Verify retention records
Advertisement through Intermediaries		
• Approval from Insurer • Advertisement aligns with approved features • Modification of Advertisement	• Regulatory Compliance • Policy holder Protection	• Verify whether prior approval from the insurer has been sought • Check the advertisement with approved product features • Check to see that modifications are duly approved
Advertisement Expenditure		
• Process for Vendor Selection • Comparative quotation obtained • Invoice verification and Authorization • Evaluation of Campaign performance •	• Fraud Prevention • Prevent unauthorized payouts/Excess payouts	• Review procurement process • Verify quotations and justification • Verify the payment process, sample verification of invoices • Check ROI/KPI reports
Fraudulent Calls and Misleading Promotions		
• Warning message on Website • Fraud Prevention Communication	• Regulatory Compliance • Fraud Prevention	• Review Website • Review Campaigns

• Compliance to TRAI requirements • Periodic Reconciliation		• Verify Communication controls
Other Areas		
• Advertisement Repository • Release of Advertisement	Regulatory Compliance	• Verify if Advertisement register is maintained Check register • Process of version control mechanism

Audit Analytics/ CAATs

Sr. No.	Area	Audit Analytics
1	Advertisement repository	100% scan of advertisements
2	Product/UIN validation	OCR and text matching
3	Risk disclosure testing	Keyword analytics
4	Digital advertisements	Web crawler review
5	Social media posts	AI based content scan
6	Vendor payments	Duplicate payment analysis
7	Campaign spend	Budget variance analytics
8	Rating claims	Exception reporting
9	Influencer advertisements	Text comparison analytics

Commonly Observed Irregularities

A. Regulatory Non-Compliance

- Advertisements released without obtaining mandatory compliance approval.
- Product advertisements issued without disclosure of approved product name and UIN.

- Mandatory risk warnings for ULIPs, participating products and annuity products not displayed.
- Misleading statements or exaggerated claims regarding benefits, returns or guarantees.
- Use of illustrations inconsistent with approved product features and policy contract.
- Failure to disclose material exclusions, limitations, waiting periods or conditions.
- Comparative advertisements issued without adequate substantiation.
- Use of unsupported ratings, awards or rankings.
- Source of ratings/awards not disclosed prominently.
- Advertisements violating provisions prescribed under the ASCI Code.
- Advertisements issued by intermediaries without prior approval from the insurer.
- Advertisements containing statements capable of creating unrealistic customer expectations.
- Use of outdated advertisements after product modification or withdrawal.
- Digital advertisements differing from approved versions.

B. Governance and Control Deficiencies

- Advertisement policy not approved or periodically reviewed by the Board.
- Advertisement Committee not constituted or not functioning effectively.
- Absence of documented approval matrix.
- Inadequate segregation of duties between Marketing, Product and Compliance functions.
- Non maintenance of advertisement repository and archival records.
- Inadequate version control over advertisements.
- Missing approval trail and supporting documentation.
- Lack of periodic compliance review of advertisements already in circulation.

C. Digital and Social Media Deficiencies

- Social media posts released without centralized approval.
- Influencer communications not reviewed for regulatory compliance.
- Product advertisements hosted on websites without mandatory disclosures.
- Absence of monitoring mechanism for third party digital advertisements.
- Inadequate controls over modifications to website content.
- Failure to maintain audit trail of digital campaigns.
- Non-compliance with cyber security and data privacy requirements in digital marketing campaigns.

D. Customer Protection Related Deficiencies

- Advertisements not fair, clear and transparent.
- Benefits highlighted without corresponding disclosure of risks.
- Selective disclosure of favourable features.
- Failure to adequately communicate investment risks in market linked products.
- Communication likely to mislead vulnerable customers or senior citizens.
- Product suitability considerations not adequately reflected in promotional material.
- Fraud prevention warnings not prominently displayed.

E. Advertisement Expenditure and Procurement Deficiencies

- Advertisement expenditure incurred without approved budget.
- Media agencies appointed without competitive bidding.
- Inadequate documentation supporting vendor selection.
- Duplicate or excess payments to media agencies.
- Unsupported invoices and campaign expenditure.
- Weak monitoring of campaign effectiveness and return on investment.
- Lack of post campaign evaluation and management review.

F. Fraud Risk Indicators

- Misleading promotional campaigns promising assured returns where such returns are not guaranteed.
- Unauthorized use of insurer's logo, brand name or trademarks.
- Fictitious promotional schemes or offers.
- Non-compliance with TRAI requirements for telemarketing communications.
- Failure to display customer awareness messages against fraudulent calls and premium diversion frauds.
- Inadequate monitoring of unauthorized advertisements circulated through agents, intermediaries or social media channels.

Audit Red Flags

The following observations should be treated as High-Risk Audit Findings:

- Advertisements released without compliance approval.
- Misrepresentation of product benefits or guarantees.
- Omission of mandatory risk disclosures.
- Unauthorized advertisements issued by intermediaries.
- Use of unsupported ratings, awards or rankings.
- Advertisement content inconsistent with approved product filing (UIN).
- Repeated regulatory observations by IRDAI or Internal Audit.
- Material customer complaints arising from misleading advertisements.

Key Regulatory References

Reference	URL
IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024	IRDAI Regulations, 2024

Master Circular on Operations and Allied Matters of Insurers (19 June 2024)	IRDAI Master Circular – Operations and Allied Matters of Insurers
Master Circular on Protection of Policyholders' Interests, 2024 (05 September 2024)	IRDAI Master Circular – Protection of Policyholders' Interests, 2024

Chapter 17
Management Expenses

Introduction

17.1 Management expenses in life insurance companies refer to all costs incurred in the administration, operation, distribution and management of insurance business, excluding benefit payments and investment expenses. These expenses are essential for the functioning of the insurer but must be managed prudently to ensure financial viability and regulatory compliance.

In the life insurance business model, premiums collected from policyholders are earmarked for three primary purposes: payment of claims and benefits, building reserves (provisioning) and meeting management expenses. Excessive management expenses can erode policyholder surplus, weaken solvency margins and compromise the long-term viability of the insurer.

Nature and Classification of Management Expenses

Fixed vs Variable Expenses

Type	Description	Examples
Fixed Expenses	Costs that remain constant regardless of business volume	Salaries of permanent staff, rent, software licenses, board fees
Variable Expenses	Costs that vary with business activity levels	Sales incentives, policy issuance costs, agent commissions, processing fees
Semi Variable	Expenses with both fixed and variable components	Utility bills, IT infrastructure (fixed base + usage based cloud costs)

Acquisition vs Operating Expenses

Acquisition Expenses include all costs associated with acquiring new policies agent commissions, medical examination fees, policy issuance costs, sales

staff incentives, underwriting costs and first year marketing expenditure. These are typically amortized over the policy term under IND AS 117/ IFRS 17.

Operating Expenses (also called Renewal Expenses) cover the ongoing costs of maintaining existing policies policyholder service costs, renewal commission, collections costs and related overheads.

Direct vs Indirect Expenses

- Direct Expenses: Costs directly traceable to a specific function, product, or business unit (e.g., medical examination costs for a specific product line).
- Indirect Expenses: Shared or overhead costs allocated to multiple functions or product lines (e.g., corporate office rent, centralized IT infrastructure).

Allocated vs Shared Costs

Many life insurance companies operate multiple product lines (traditional, ULIP, group insurance, health riders) and distribution channels (agency, bancassurance, digital). The allocation of shared costs across these requires a defined and defensible cost allocation methodology, which is a critical area of audit scrutiny.

Key Insight – Cost Allocation Importance

The internal audit of cost allocation methodologies is critical because incorrect or manipulated allocation can misrepresent the profitability of individual product lines, distort the EOM calculation for regulatory reporting and mask excessive spending in high-risk areas. Auditors must evaluate the basis of allocation and ensure consistency, transparency and board approval.

Relationship between Expenses, Profitability and Solvency

The Expense of Management (EOM) ratio is a fundamental performance and regulatory compliance metric. Under IRDAI regulations, life insurers must maintain their expenses within prescribed limits relative to their gross premium income. Breaching these limits triggers regulatory action.

From a profitability standpoint, expense efficiency directly determines the value of new business (VNB) and the embedded value of the company. Higher expenses reduce margins on new policies and reduce the surplus available for

dividend distribution and capital building. From a solvency perspective, excessive expenses can erode the required solvency margin, potentially leading to regulatory intervention.

Expenses Governance Framework

A robust expenses governance framework in a life insurance company typically includes the following:

- Board approved Expense Management Policy covering categories, limits and authorization hierarchies.
- Annual budgeting process with departmental cost center-wise allocations.
- Expense authorization and delegation matrix with approval tiers.
- Monthly monitoring of actual vs. budgeted expenses at the cost center and company level.
- Quarterly Audit Committee reporting on expense trends, variances and compliance.
- EOM computation and compliance certification to the Board and IRDAI.
- Internal audit coverage of all significant expense categories.

Role of Internal Audit in Expenses Monitoring and Control

Internal audit provides an independent and objective assessment of the effectiveness of expense controls. The role of internal audit has expanded significantly from transaction level verification to strategic governance assurance. The modern internal audit function covers:

- Policy and governance framework audit (Is the framework adequate and implemented effectively?).
- Budgetary control audit (Are variances explained, authorized and corrected?).
- Transaction level verification (Are individual expenses genuine, authorized and correctly recorded?).
- Fraud risk assessment (Are there red flags indicating manipulation, collusion, or fictitious expenses?).

- Technology controls review (Are IT systems enforcing expense controls effectively?).
- Regulatory compliance audit (Is the EOM ratio within permissible limits? Are regulatory filings accurate?).
- Data analytics driven anomaly detection (Are unusual patterns being flagged and investigated?).

Regulatory Framework

17.2 The IRDAI (Expenses of Management of Insurers Transacting Life Insurance Business) Regulations, 2024 (the '2024 EOM Regulations') represent a significant modernization of the expense regulatory framework for life insurers. The key features include:

Regulatory Aspect	Key Provisions
Expense Limit Basis	Expenses of management expressed as a percentage of Gross Premium Written (GPW), separately computed for life and health segments
Linked Business (ULIP)	Lower expense limits apply fund management charges and mortality charges regulated separately
Non-Linked/ Traditional	Expense limits tied to weighted combination of First Year Premium (FYP) and Renewal Premium with separate individual/ group limits
Excess EOM Carry Forward	Excess EOM in any year must be adjusted within the next two financial years persistent breach invites regulatory action
Board Accountability	Board must approve expense management policy and EOM management plan annually
Certification Requirements	CEO and CFO to certify EOM compliance in the Annual Report actuary to consider expenses in product pricing
Regulatory Reporting	Monthly/quarterly EOM returns to IRDAI breach to be reported immediately with corrective action plan

Commission Limits	First year commissions, renewal commissions and reward/incentive payments to agents and intermediaries regulated separately
Related Party Expenses	Related Party Transactions (RPTs) subject to IRDAI RPT guidelines arm's length pricing mandatory
Outsourcing Expenses	Expenses under outsourcing arrangements included in EOM IRDAI Outsourcing Guidelines apply

Board Approved Expense Policies

Insurers are required to have a comprehensive, Board approved expense management policy. The key elements the internal auditor should verify category sub limits, the DFA matrix, cost allocation, related party, outsourcing, reimbursement and travel norms, EOM methodology and annual review are set out in the detailed policy audit checklist.

Corporate Governance and Expense Controls

The Companies Act 2013 mandates Internal Financial Controls (IFC) over financial reporting, which specifically includes controls over expense recognition, authorization and reporting. Life insurers listed on stock exchanges are also subject to SEBI's governance requirements. Key governance requirements include:

- Audit Committee oversight of expense management including review of EOM trends.
- Risk Management Committee (RMC) oversight of operational and financial risks arising from expense management.
- Board level disclosure of significant related party transactions involving service providers.
- CEO/CFO certification of internal controls over financial reporting (IFC FR).

IND AS Implications for Expense Accounting

The transition to IND AS 117 (Indian equivalent of IFRS 17, Insurance Contracts) has significant implications for expense accounting and auditing:

- Acquisition cash flows (including commissions and underwriting costs) must be identified separately and amortized appropriately.
- Contractual service margin (CSM) calculations are impacted by the treatment of acquisition costs.
- Overhead allocation methodologies must be documented and consistently applied.
- Internal audit must assess whether expense accounting under IND AS 117 is consistent with the company's adopted methodology and disclosed accounting policies.

AML and Anti-Fraud Expenditure

AML/CFT Compliance: Life insurers are obligated under PMLA 2002 and IRDAI AML/CFT Guidelines to incur and monitor expenditure on AML/CFT compliance infrastructure. The internal audit should verify that AML related expenditures (software, training, compliance staff) are properly budgeted and utilized.

Audit Alert – EOM Breaches

Cases of EOM limit breaches have resulted in IRDAI imposing monetary penalties, mandating corrective action plans and restriciting new product launches. Internal audit must treat EOM compliance as a high priority audit area with continuous monitoring protocols.

Expense Governance and Policy Audit

17.3 The policy audit is the foundation of the management expense audit. The internal auditor should verify that a comprehensive, Board approved expense management policy exists, is current and is effectively implemented across the organization.

Delegation of Financial Authority (DFA) is a critical internal control document that specifies who can authorize what level of expense. Weak or poorly enforced delegation hierarchies are a primary enabler of expense fraud and unauthorized spending.

Key Audit Procedures

- Obtain the current DFA matrix and verify Board/Audit Committee approval date.

- Check whether DFA limits are consistent with the expense management policy.
- Test a sample of transactions to verify adherence to the DFA (approver's authority level vs. transaction amount).
- Identify transactions approved above the approver's authority level (policy deviations).
- Verify that the DFA in the ERP/expense management system matches the approved paper DFA.
- Check for approvals by individuals who have resigned or been transferred (system access management failure).

Budget Preparation and Approval Process

The budgeting process is the primary preventive control for expense management. A robust annual budgeting process with departmental ownership, CFO review and Board approval provides the baseline against which actual expenses are monitored.

Audit Checklist – Budget Process

- Annual budget is prepared department wise/ cost center wise with supporting justifications.
- Prior year actuals are used as the base with volume growth and inflation adjustments.
- New initiatives, technology projects and strategic spends are separately identified and approved.
- Budget is reviewed and challenged by Finance/ CFO before Board approval.
- Approved budget is loaded into the ERP system with cost center wise controls.
- Mid-year budget revisions are formally approved and documented.
- Budget vs. actual variance reports are prepared monthly and reviewed by management and the Audit Committee.

Risk Control Matrix – Expense Governance

Sr. No.	Risk	Control Objective	Control Activity	Audit Test
1	Unauthorized expense incurred	All expenses are authorized per DFA	System enforced approval workflow in ERP manual override requires Finance Head approval	Test 30 transactions for compliance with DFA verify no system overrides without documentation
2	EOM limit breached	Expenses remain within IRDAI prescribed EOM limits	Monthly EOM computation by Finance CFO review Audit Committee reporting on potential breach	Independently compute EOM ratio for the audit period verify disclosure in financials
3	Fictitious or inflated expenses	All expenses are genuine and correctly valued	Three way match in procurement (PO, GRN, Invoice) maker checker in payment processing	Test sample of payments for PO/GRN/Invoice match verify vendor existence and bank details
4	Misclassification of expenses	Expenses are classified in correct GL accounts and reported accurately	Finance review of journal entries periodic GL account analysis actuary review	Analyse unusual GL postings verify large or unusual reclassification entries

			of acquisition cost classification	

Common Audit Observations in Policy Governance

Sr. No.	Observation	Risk Impact	Recommended Action
1	DFA matrix not updated after organizational restructuring	Employees approving expenses beyond their authority	Update DFA within 30 days of structural changes
2	Expense policy not reviewed for over 2 years	Policy outdated relative to current business scale and regulatory changes	Annual mandatory review Audit Committee ratification
3	Cost allocation methodology not documented	Manipulation risk incorrect EOM calculation regulatory non-compliance	Document, validate with actuary, obtain Board approval
4	Exception approval mechanism bypassed in branch offices	Unauthorized expenses incurred at branch level without appropriate oversight	Strengthen branch audit program enforce system controls
5	Travel policy has no foreign travel pre approval requirement	Excessive foreign travel expenditure without business justification review	Amend policy require CEO/Board approval for foreign travel

Budgetary Control and Expense Monitoring Audit

17.4 The budget vs. actual (B vs. A) analysis is the primary analytical technique in management expense auditing. The internal auditor should perform this analysis at multiple levels overall company, department/function, cost center and expense category to identify variances requiring investigation.

Audit Procedures

- Obtain department wise and cost center wise budget vs. actual reports for the audit period.
- Identify all variances exceeding 10% (or a defined materiality threshold) in any expense category.
- Request management explanations for all significant variances.
- Verify that explanations are supported by documented evidence (approved change requests, business case approvals, board resolutions).
- Identify instances where budget exceeded without appropriate approval.
- Assess whether the budgeting process was realistic or whether budgets were deliberately set low to create headroom.

Illustrative Budget vs. Actual Dashboard

Expense Category	Budget (₹ Cr)	Actual (₹ Cr)	Variance (₹ Cr)	Variance %	Risk Flag
Employee Costs	45.00	47.80	+2.80	+6.2%	Low
IT & Technology	12.00	16.50	+4.50	+37.5%	HIGH
Marketing & Branding	8.00	9.20	+1.20	+15.0%	Medium
Travel & Conveyance	3.50	2.80	0.70	20.0%	Low
Training & Development	2.00	1.20	0.80	40.0%	Medium
Outsourcing/ BPO	10.00	13.80	+3.80	+38.0%	HIGH
Office Administration	4.50	4.60	+0.10	+2.2%	Low
Legal & Professional	2.50	4.20	+1.70	+68.0%	HIGH

Total Management Expenses	87.50	100.10	+12.60	+14.4%	HIGH

Trend Analysis and Unusual Expenses Spikes

Trend analysis involves comparing current period expenses with prior periods (monthly, quarterly, or year over year) to identify unusual spikes, sudden increases, or suspicious patterns that may indicate errors, fraud, or governance lapses.

Key Trend Indicators to Monitor

- Month on month changes in expense categories exceeding 20%.
- Year on year expense growth significantly above premium growth or inflation rates.
- Seasonal expenses (e.g., year end vendor payments bunching).
- Expenses that spike in the final quarter (window dressing to utilize budget).
- New expense categories appearing without budget provision.
- Unusual cross branch or cross department expense transfers.

Branch Level Expenses Controls

For life insurance companies with extensive branch networks, branch level expense management presents unique audit challenges. Branches typically have delegated expense authority but are geographically dispersed, making centralized oversight challenging.

Branch Expense Audit Focus Areas

- Petty cash management and reconciliation.
- Local vendor payments and procurement authority.
- Branch rental expense verification (market rate comparison).
- Branch staff overtime and contractual staff costs.
- Communication and utility expenses (verification against actual usage).
- Branch level travel claims and conveyance reimbursements.

Practical Illustration – Budget Gaming Risk

A life insurance company's audit revealed that certain branch managers were deliberately under spending in the first half of the year to create budget surplus, which was then used in Q3/Q4 for unauthorized expenses claimed as 'backlog utilization'. The internal audit introduced quarterly budget re forecasting and a 'use it or lose it' carry forward policy limited to 5% of annual budget.

Employee and Administrative Expenses Audit

17.5 Employee costs typically constitute 35–50% of total management expenses in a life insurance company, making this the single largest expense category subject to audit scrutiny. The complexity arises from the combination of fixed salary costs, variable incentive structures, contractual/gig workforce and multiple benefit components, each with its own governance and fraud risk profile.

Salary and Payroll Audit

Key Audit Procedures

- Verify payroll output against HR maintained headcount records for the audit period.
- Test individual salary computation for a sample of employees across grades and locations.
- Check for ghost employees: compare payroll list with physical verification/biometric attendance records.
- Verify increments and promotions are supported by approved HR forms and are reflected correctly in payroll.
- Check that resigned employees' salaries are stopped from the effective date of resignation.
- Verify PF, ESI, gratuity and other statutory deductions are correctly computed and remitted on time.
- Test that salary advances are properly authorized, recorded and recovered.

Incentive, Bonus and Variable Pay Audit

Variable pay – including performance bonuses, sales incentives and retention bonuses – represents a significant and fraud prone expense area. The internal audit should verify:

- Incentive computation is based on Board/HR approved incentive policy.
- Performance metrics used for incentive computation are verifiable (sales figures, premium collection, policy persistency).
- Incentive payments are approved at the appropriate authority level (HR Head/MD for senior employees).
- Over incentivization risks: very high incentive payouts relative to salary should be specifically reviewed.
- Deferred compensation and ESOP (Employee Stock Option Plan) accounting compliance.

Travel and Conveyance Expense Fraud Risks

Fraud Type	How It Occurs	Detection Method
Fictitious Travel Claims	Employee claims travel that did not occur submits fabricated tickets or bills	Cross reference with attendance records and hotel check in data
Over Valued Claims	Personal travel expenses claimed as business upgrades claimed without approval	Verify ticket prices against market rates check booking date vs. travel date
Duplicate Claims	Same travel expense claimed twice or across multiple claim cycles	Data analytics: fuzzy match on vendor name, date, amount
Splitting to Bypass Limits	Large expense split across multiple dates/people to stay	Analytics: identify patterns of near

	below approval threshold	threshold transactions from same employee
Collusion with Travel Agencies	Preferred travel vendor inflates bills kick back to employee	Rotate travel vendors compare rates with independent quotes

Ghost Employee Risk

Ghost employees are fictitious individuals on the payroll who receive salary payments that are diverted to a fraudster. This risk is particularly acute in companies with high attrition, multiple branch offices, or weak HR Payroll system integration.

Red Flag Indicators

- Employees with no attendance records or biometric data for extended periods.
- Multiple employees with the same address, bank account, or PAN number.
- Employees whose salary is credited to a bank account also used by another employee.
- New joiners appearing on payroll before their joining date in the HR system.
- Employees not appearing in any email, phone directory, or system access logs.

Preventive Controls

- Mandatory biometric attendance integration with payroll system.
- Periodic physical verification/headcount reconciliation (quarterly for large companies).
- HR system and payroll system must be integrated with automated access to HR records as the master.
- Joiners/leavers process must trigger automatic payroll start/stop with maker checker.

Training, Conference and Staff Welfare Expenses

While training and development is a legitimate and important expense, it is also an area where misuse occurs – particularly through undisclosed personal travel combined with conferences, luxury training venues and questionable 'study tours'.

- All training programs above a defined cost threshold should require pre approval from HR Head and CFO.
- Foreign training programs should require MD/CEO approval with post training report submission.
- Conference attendance should be linked to a specific business need (regulatory requirement, technical knowledge).
- Staff welfare expenses (team events, annual gatherings) should have Board approved annual limits.

Procurement and Vendor Expenses Audit

17.6 Weak vendor onboarding is the entry point for most procurement fraud's in life insurance companies. The internal audit must assess the effectiveness of the vendor registration and due diligence process:

- Verify that a documented Vendor Empanelment Policy exists and is current.
- Test vendor onboarding files for completeness: GST registration, PAN, bank account verification, financial statements.
- Check for related party connections: compare promoters/directors of vendor companies with employee/management lists.
- Verify that bank account details are validated through official banking channels (cancelled cheque + bank certificate).
- Assess vendor risk classification: high value or critical vendors should require enhanced due diligence.
- Check debarment checks: vendors on Government blacklists or under legal proceedings should not be onboarded.

Procurement Process Audit

Three Way Match – The Primary Control

Purchase Order (PO)	Goods/Service Receipt (GRN/SRN)	Vendor Invoice
Issued by Finance/SCM after approval per DFA. Specifies: vendor, quantity, price, delivery terms, PO number.	Issued by receiving department confirming goods/services received as per PO specification and quality standards.	Issued by vendor referencing PO number. Amount should match PO any deviation requires Finance review and approval.

If all three match → Payment can proceed. Any mismatch → Requires specific approval and documentation.

Competitive Bidding Process

- All procurements above defined thresholds should follow a competitive bidding process (minimum 3 quotations).
- Waiver of competitive bidding should require Finance Head/ CFO approval with documented justification.
- Bid evaluation should follow documented criteria (technical + commercial) single parameter (lowest price) evaluation is a red flag.
- Conflicts of interest: bid evaluation committee members should declare conflicts conflicted members should be excluded.

Related Party Transactions (RPT) Audit

Related party transactions in the procurement of services are a high-risk area for life insurance companies, particularly for technology services, marketing agencies, outsourcing and facility management.

The internal audit shall:

- Obtain the list of related parties as identified by management under IND AS 24 and IRDAI RPT Guidelines.
- Verify that all RPTs are supported by arm's length pricing analysis (independent valuation or market comparison).

- Check that RPTs exceeding materiality thresholds have Audit Committee and Board approval.
- Verify IRDAI filing requirements for material RPTs.

Fraud Risk Matrix – Procurement

Fraud Type	Red Flag Indicator	Detective Control	Preventive Control
Shell/ Fake Vendor	Vendor has no digital footprint, no website, residential address, single employee	Vendor existence verification: GST portal check, site visit, reference check	Enhanced due diligence for new vendors above threshold independent validation of bank details
Duplicate Payments	Two payments to same vendor for same invoice number or same amount within short period	Data analytics: match on vendor + invoice + amount ERP system block on duplicate invoice numbers	System level duplicate invoice check maker checker in payment processing
Inflated Invoices	Invoice amounts significantly above market rates for similar services	Market price benchmarking for major expense categories independent price audit annually	Competitive bidding rate contracts with approved vendors Finance review of invoice reasonableness
Split Purchase Orders	Multiple POs to same vendor within short period, each just below competitive	Analytics: flag multiple POs to same vendor within 30 days where aggregate	System enforced aggregate PO tracking by vendor Finance approval for

	bidding threshold	exceeds threshold	aggregate amounts
Fictitious Services	Invoice for services (consulting, training, IT support) with no deliverables or documentation	Require service completion certificate (SCC) for all service payments Finance to verify with business user	SCC mandatory before payment processing system prevents payment without SCC reference

Digital Transformation and Technology Expenses Audit

The Growing Significance of Technology Expenses

17.7 Technology expenses have become one of the fastest growing cost categories in life insurance companies, driven by digital transformation imperatives, regulatory technology requirements, cybersecurity investments and cloud migration. Technology expenses typically now constitute 12–20% of total management expenses in leading life insurers.

Key Technology Expense Categories

Category	Description	Key Audit Risks
Cloud Infrastructure	AWS/Azure/GCP hosting costs scalable but can escalate without proper governance	Cost overruns unused reserved instances lack of FinOps discipline
Software Licensing	ERP (SAP/Oracle), CRM, policy admin system, actuarial software	Duplicate licensing over provisioning unlicensed software unmanaged SaaS sprawl
Cybersecurity	Firewalls, SIEM, endpoint protection, penetration testing, SOC	Inadequate investment masking risk overlapping vendor solutions unmonitored spend

Digital Platforms	Mobile app, web portal, digital onboarding, e KYC platform	Project overruns inactive/abandoned platforms vendor lock in
AI & Automation	RPA bots, AI underwriting, chatbots, fraud analytics tools	PoC investments not scaled shadow AI projects unvalidated model risks
Data & Analytics	Data warehouse, BI tools (Tableau/Power BI), data lake infrastructure	Unused analytics investments data governance gaps unquantified ROI
IT Support & AMC	Annual maintenance contracts for hardware and software, IT helpdesk	Inflated AMC rates maintenance paid for decommissioned assets fake IT vendors

IT Project Spend Audit

Technology project expenditures represent some of the highest risk expense areas due to their complexity, long gestation periods and susceptibility to cost overruns and scope creep.

IT Project Audit Checklist

- Verify that all IT projects above defined thresholds have an approved Business Case and project charter.
- Check that project budgets are approved by the IT Steering Committee/CFO and are loaded in the project accounting system.
- Test milestone based payment releases: payments should be released only on achievement of verified milestones.
- Review project change requests (CRs) for scope creep: are CRs within the original business case or do they represent new scope that should have been separately approved?
- Assess project health: projects with repeated delays and cost overruns should be flagged for detailed review.
- Verify post implementation reviews are conducted to assess whether projected benefits have been realized.

SaaS and Cloud Subscription Management

The proliferation of SaaS tools presents a significant governance challenge – business units can independently subscribe to SaaS tools using procurement cards or direct billing, bypassing the standard IT approval process.

- Audit all SaaS subscriptions against an approved software register.
- Identify unauthorized or unregistered SaaS tools (shadow IT audit).
- Verify that subscription renewals are reviewed for continued business need before renewal.
- Check for duplicate SaaS tools serving the same function from different departments.
- Verify that SaaS vendor contracts address data privacy and IRDAI data localization requirements.

Case Study – Cloud Cost Overrun

A mid sized life insurance company's internal audit discovered that cloud infrastructure costs had exceeded budget by 42% in a financial year. Investigation revealed: (1) development and testing environments left running 24/7 instead of being shut down outside business hours, (2) incorrect instance sizing leading to over provisioned resources and (3) no centralized cloud cost management (FinOps) discipline. The audit recommended appointing a Cloud FinOps champion, implementing cost anomaly alerts and right sizing all non-production environments – resulting in estimated annual savings of ₹2.8 crore.

Marketing, Distribution and Advertisement Expenses Audit

Scope and Audit Significance

17.8 Marketing and distribution expenses are significant and complex in life insurance, given the multi-channel distribution model (agency, bancassurance, direct, digital, brokers) and the diverse nature of marketing activities (product campaigns, brand building, digital marketing, sponsorships, lead generation and rewards programs).

Advertisement and Campaign Expenditure Audit

- Verify that all advertisement expenditures have prior approval per DFA (Marketing Head + CFO above threshold).
- Confirm IRDAI compliance: advertisements must be pre-approved by IRDAI through the IBAI/IRDAI portal for regulated products.
- Test media agency billings: compare actual media placements (TV/digital/print) with agency billing records.
- Conduct ROI analysis: relate advertising expenditure to new policy acquisition volumes in the period.
- Verify whether that celebrity endorsement contracts are at arm's length and approved by the Board for material amounts.

Digital Marketing Expense Audit

Digital marketing expenses have grown significantly and include pay per click (PPC) advertising, social media marketing, SEO/SEM costs, content marketing, email campaigns and influencer marketing. The audit should:

- Verify digital marketing agency contracts include performance metrics (cost per lead, conversion rates) as billing criteria.
- Audit click fraud risk: pay per click campaigns are vulnerable to fraudulent clicks inflating costs without genuine leads.
- Check that digital marketing platforms (Google Ads, Meta Ads) are accessed only by authorized personnel.
- Verify alignment between digital marketing spend and business metrics (website traffic, app downloads, digital policy conversions).

Bancassurance and Distribution Channel Expenses

Bancassurance is a major distribution channel for life insurance products in India. The arrangement involves fee/commission payments to the bank partner for access to their customer base. Audit focus areas include:

- Verify bancassurance agreements are Board approved and registered with IRDAI.
- Test commission and fee computations: are payments consistent with contractual terms?

- Verify training reimbursements paid to bank partner: training programs are actually conducted and documented.
- Assess cost per policy in bancassurance channel vs. other channels (cost efficiency analysis).
- Verify anti mis selling compliance costs are correctly classified and reported.

IT Systems and Internal Financial Controls (IFC)

ERP Controls and Expense Management Systems

17.9 Life insurance companies typically use ERP platforms (SAP, Oracle Financials) integrated with HR/Payroll systems, procurement modules and expense management tools. The effectiveness of application controls within these systems is critical to the integrity of management expense data.

Key Application Controls Audit

Control Area	Control Description	Audit Test
Maker Checker	No single user can initiate and approve the same transaction payment requires separate initiation and authorization	Test 50 payment transactions: verify initiation and authorization are by different users flag any single user transactions.
Segregation of Duties (SoD)	Conflicting roles (vendor creation, PO creation, GRN posting, payment authorization) assigned to different individuals	Run SoD conflict analysis using GRC tool or manual role mapping identify and report SoD violations.
System Enforced DFA	ERP workflow routes transactions to approvers based on amount/category per DFA unauthorized approver cannot release payment	Attempt to post a transaction above approver's limit to verify system rejection test approval routing for different amount ranges.

Duplicate Invoice Block	System prevents posting of invoice with same vendor + invoice number + amount combination within defined period	Attempt to post duplicate invoice in test environment verify system rejection message and alert generation.
Audit Trail	All transactions, modifications and approvals are logged with user ID, timestamp and IP address logs are immutable and retained per policy	Extract audit trail for selected transactions verify log integrity check that log purging does not occur within retention period.
Budget Controls	System flags or blocks expenditure that would exceed approved cost center budget (hard or soft blocks per policy)	Test hard block: attempt to post expense exceeding budget verify system response. Test soft block: verify email notification to budget owner and Finance department.
Vendor Master Controls	New vendor creation requires authorized approval changes to bank details require independent verification inactive vendor auto flagging	Test vendor creation process: a vendor can be created and immediately paid without independent verification of bank details.

Data Analytics and Continuous Auditing

The Analytics Driven Expense Audit

17.10 Data analytics has fundamentally transformed the scope and effectiveness of management expense auditing. Instead of testing a sample of 30–50 transactions (representing less than 1% of total expense transactions in a large insurer), analytics enables auditors to test 100% of the population identifying all anomalies, rather than hoping that sample includes them.

Analytics Toolkit for Management Expense Audit

The tests extend coverage across vendors, employees, payroll and budgets:

Analytics Test	What It Detects	Data Inputs Required
Vendor Master Anomaly Test	Shell vendors, recently created vendors, vendors with residential addresses, vendors linked to employees	Vendor master data, employee master data, GST registration database
T&E Anomaly Detection	Unusual reimbursement patterns, weekend/holiday claims, inflated claims	Employee reimbursement data, travel booking system, attendance records
Budget Variance Heatmap	Departments/cost centers with consistent overruns unusual year end spikes	Budget master, actual expense ledger, cost center hierarchy
Vendor Concentration Analysis	Over reliance on single vendors rapid growth of new vendors payments to previously inactive vendors	3–5 years of vendor payment history
Payroll Anomaly Test	Ghost employees, duplicate bank accounts, post resignation payments, unusual increments	Payroll master, HR master, bank account details, attendance records
Ratio & Benchmark Analysis	EOM ratio trends per employee cost benchmarks cost to premium ratios vs. peers	P&L data, headcount data, IRDAI industry data

AI Enabled Anomaly Detection

Advanced AI based anomaly detection systems use machine learning (ML) algorithms to identify unusual expense patterns that traditional rule-based analytics might miss. These systems:

- Build a baseline model of 'normal' expense behavior for each employee, department, vendor and expense category based on historical data.
- Flag real time deviations from the baseline (e.g., an employee whose average monthly T&E claim of ₹8,000 suddenly spikes to ₹65,000).
- Use natural language processing (NLP) to analyze expense descriptions and identify vague or suspicious descriptions (e.g., 'miscellaneous services', 'consulting fees – confidential').
- Continuously improve detection accuracy as new fraud patterns are identified.

Continuous Auditing Framework

Continuous auditing involves the automated, ongoing execution of audit procedures on a real time or near real time basis, rather than periodic (annual or quarterly) audits. For management expenses, a continuous auditing framework should include:

- **Daily:** Duplicate payment check run on previous day's payments high value transaction (above defined threshold) review.
- **Weekly:** New vendor payment monitoring T&E reimbursement exception report budget variance flash report.
- **Monthly:** Full suite of expense analytics EOM computation and trend analysis cost center variance heatmap.
- **Quarterly:** Vendor master data cleansing and verification payroll headcount reconciliation SoD access review.

Best Practice – Expense Analytics Dashboard

Leading insurers have implemented real time expense analytics dashboards accessible to internal audit, Finance and Audit Committee. The dashboard displays: EOM ratio trend (monthly), top 10 expense variances by cost center, fraud alert count and status, new vendor payment tracking

and top 10 expense categories vs. budget. This transforms internal audit from a periodic reviewer to a continuous monitoring function.

Risk Based Internal Audit Approach

Risk Assessment Methodology

17.11 A risk based internal audit (RBIA) approach prioritizes audit resources on areas of highest risk exposure. For management expenses, the risk assessment should consider:

Inherent Risk: Nature of the expense category (e.g., cash based expenses, discretionary expenses, related party payments).

Control Risk: Effectiveness of existing controls (strong controls reduce residual risk weak controls elevate it).

Detection Risk: Probability that existing monitoring mechanisms would detect errors or fraud.

Residual Risk: Inherent risk adjusted for control effectiveness.

Risk Scoring Matrix for Expense Categories

Expense Category	Inherent Risk	Control Effectiveness	Fraud Risk	Residual Risk	Audit Priority
Vendor Payments (IT)	High	Medium	High	High	1 – Immediate
Employee Reimbursements	Medium	Medium	High	High	1 – Immediate
Marketing Agency Fees	High	Low	High	Very High	1 – Immediate
Payroll & Incentives	High	Medium	Medium	High	2 – Near term
Outsourcing/ BPO	High	Medium	Medium	High	2 – Near term

Branch Office Expenses	Medium	Low	High	High	2 – Near term
Training & Development	Medium	Medium	Medium	Medium	3 – Periodic
Statutory & Legal Costs	Low	High	Low	Low	4 – Routine
Office Administration	Low	High	Low	Low	4 – Routine

Audit Universe and Dynamic Audit Planning

The audit universe for management expense audit in a life insurance company should cover:

Corporate Office: all major expense categories

Branch Offices: top 20% of branches by expense volume (risk-based selection)

Key Vendors: top 10 vendors by payment value annually

Shared Services/ Outsourcing Partners: periodic reviews of outsourced expense processing

Regulatory Compliance: EOM computation and reporting

IT Application Controls: ERP and expense management system controls

Dynamic audit planning allows the annual audit plan to be revised based on emerging risks, regulatory changes, or significant events (e.g., a major IT project overrun or a whistleblower complaint about expense fraud).

Sample Risk Assessment for Branch Network

Branch	Expense Volume	B vs. A Variance	Last Audit	Compliance Issues	Risk Score	Priority
Mumbai (Central)	₹8.2 Cr	+18%	12 months	2 observations	72	High
Delhi (Connaught Place)	₹6.8 Cr	+8%	18 months	0 observations	58	Medium

Bengaluru (Koramangala)	₹5.4 Cr	+32%	24 months	3 observations	85	Very High
Chennai (Anna Nagar)	₹4.2 Cr	+5%	10 months	0 observations	42	Low
Kolkata (Park Street)	₹3.8 Cr	+12%	20 months	1 observation	65	Medium

Audit Reporting and Governance

Audit Reporting Standards

17.12 Internal audit reports on management expenses should adhere to the International Standards for the Professional Practice of Internal Auditing (IIA Standards) and the company's internal audit charter. Key reporting principles include:

- Factual accuracy: observations supported by evidence no speculation.
- Condition Criteria Cause Consequence (CCCC) structure for each finding.
- Risk graded findings: Critical, High, Medium, Low based on impact and likelihood.
- Constructive recommendations: specific, actionable and practical.
- Management action plan (MAP): management's agreed response with owner and target date.

Sample Audit Observation Format

Element	Detail
Observation Title	Inadequate Vendor Due Diligence for IT Service Vendors – Risk of Shell Vendor Payments
Risk Grading	HIGH
Condition (What Was Found)	During audit of IT vendor payments for FY 2024 25, the audit team identified 6 IT service vendors onboarded within the past 12 months with aggregate payments of ₹1.2 crore, where vendor due diligence

	was inadequate: (1) No GST registration verification for 3 vendors (2) No financial capability assessment for 4 vendors (3) Bank details for 2 vendors not independently verified (4) For 1 vendor, the primary contact email matched the personal email of an IT department employee.
Criteria (What Should Be)	The Vendor Empanelment Policy (approved by Board in April 2023) requires: (a) GST registration verification via government portal for all vendors (b) Financial assessment for vendors with annual billing potential exceeding ₹10 lakh (c) Independent bank account verification for all new vendors (d) Related party check against employee master.
Cause (Why Did It Happen)	The vendor onboarding team was not adequately trained on the 2023 revised policy requirements. Additionally, the ERP system does not enforce a mandatory checklist completion before vendor activation.
Consequence (Impact)	The company is exposed to shell vendor fraud risk. The IT department employee linked vendor requires immediate investigation. Estimated exposure: ₹1.2 crore in potentially questionable payments.
Recommendation	(1) Immediately suspend the vendor with a nexus to the IT department employee and initiate investigation (2) Conduct retrospective due diligence on all vendors onboarded in the past 18 months (3) Implement system enforced due diligence checklist in the vendor onboarding module (4) Conduct mandatory training for vendor onboarding team on revised policy (5) Introduce periodic vendor health checks (annual for high value vendors).
Management Action Plan	Owner: Head – Procurement Target Date: 60 days from report date. Management agrees to all recommendations. Investigation of the implicated vendor has been initiated.

Emerging Challenges and Current Scenario

17.13 The life insurance industry is undergoing rapid transformation driven by technology disruption, regulatory modernization, changing customer expectations and macroeconomic pressures. These forces are reshaping the nature and complexity of management expenses and internal audit must evolve to address them.

Key Emerging Challenges

Emerging Challenge	Impact on Expense Management	Audit Response
Rising Technology Costs	Cloud, AI, cybersecurity and digital transformation investments are growing at 20–30% annually, creating EOM pressure.	Dedicated IT expense audit cloud cost governance review IT ROI assessment.
Remote & Hybrid Workforce	New expense categories: home office allowances, VPN infrastructure, digital collaboration tools, remote security.	Policy audit for WFH expense framework analytics for remote work claims network security spend review.
ESG & Sustainability Expenditure	Increasing costs of sustainability reporting, green initiatives, CSR and ESG compliance infrastructure.	Verify ESG spend authorization and classification assess BRSR disclosure accuracy.
Data Privacy Compliance Costs	DPDP Act 2023 compliance requires data protection infrastructure, DPO appointment, consent management systems.	Audit DPDP compliance budget adequacy verify correct expense classification.

Increasing Outsourcing Dependence	More functions outsourced (policy admin, claims, IT, collections), creating complex vendor risk and cost management challenges.	Outsourcing cost audit vendor SLA compliance IRDAI outsourcing guideline compliance.
Inflationary Pressure	Rental, salary and vendor costs rising above budget assumptions, pressuring EOM ratios.	EOM forecast sensitivity analysis audit of mitigation measures.
IFRS 17/ IND AS 117 Transition	Requires significant reclassification of acquisition and operating expenses, new measurement approaches.	Audit expense classification under new standard verify actuarial compliance.
Embedded Finance & API Economy	New distribution models with fintech partners create novel expense structures (API fees, revenue shares).	Audit new partner agreements verify arm's length pricing regulatory approval verification.

Internal Audit Checkpoints

The following checklist is designed as a practical audit programme for a CA internal audit team. It is built from EOM Regulations, 2024, Master Circular on EOM, Master Circular on Submission of Returns, 2002 financial statement regulations, the corporate governance framework and Section 40 of the Insurance Act, 1938.

Sr. No.	Area of verification	Expected control/ regulatory requirement	Audit procedure	Documents / evidence to be verified	Source/ regulatory reference
1	Board approved EOM policy	Written Board approved policy covering cost effectiveness, additional allowances, allocation/apportionment and compliance mechanism	Review latest policy, approval date, revisions and implementation circulars test whether financial year methodology matches approved policy	Policy document, Board minutes, revision note, finance circulars	EOM Regulations 2024, Regulation 3
2	Board approved commission policy	Written policy for payment of commission may be subsumed in EOM policy Board policy on commission structure to be fair, reasonable and auditable	Review whether commission architecture and related payouts are clearly documented test annual Audit Committee review	Commission policy, Board/Audit Committee minutes, distribution circulars	EOM Regulations 2024, Regulation 4 EOM Master Circular 2024, Chapter I

3	Business plan	Annual Board approved business plan before start of year projected capital, solvency and projected EOM	Compare actual EOM and segment trends against business plan review periodic Board monitoring	Business plan, quarterly review packs, Board papers, working papers	EOM Regulations 2024, Regulation 5 EOM Master Circular 2024, Chapter II
4	Cost centre and GL mapping	Accurate classification between operating expenses, commission and non-insurance expenses	Perform GL walk through test mapping of major expenses review suspense and “others” heads	Chart of accounts, mapping matrix, trial balance, cost centre master	Preparation of Financial Statements Regulations 2002, Form A PL and Schedule 4
5	Policyholder vs shareholder allocation in life insurer	Expenses other than those directly related to insurance business should not be parked in insurance operating expenses	Test sample items from shareholders’ non-technical account and policyholders’ account review reclassifications	Ledger extracts, journal vouchers, month end reclassifications	Preparation of Financial Statements Regulations 2002, Form A PL

6	Allocation and apportionment methodology	Board approved basis for life insurers, CFO and Appointed Actuary responsible for allocation/apportionment	Reperform allocation for sample months verify basis changes and approvals test edge cases	Working papers, driver files, AA/CFO sign offs, approved basis sheet	EOM Regulations 2024, Regulation 3
7	Regulatory segment mapping for life insurer	Correct mapping across linked, non-linked non-participating and participating segments and sub lines	Reconcile product masters, actuarial product list and EOM return classifications test new/modified products	Product master, actuarial register, return mapping file, UAT sign offs	EOM Regulations 2024, Regulation 18 and Schedule I
8	Commission and solicitation related payments	Payments for procuring insurance business only to permitted persons in the prescribed manner total commission remains within EOM framework	Review channel payouts, marketing support, referral/service/lead contracts identify disguised commission or reward	Commission registers, vendor contracts, payout statements, legal opinions	Insurance Act, 1938, section 40 EOM Regulations 2024, Regulation 12

9	Additional allowance under insurtech and insurance awareness	Eligible expenditure only cap validation accrual basis depreciation on insurtech capex included as prescribed	Verify components, capitalization policy, depreciation basis and cap computation	Capex register, depreciation schedule, project approvals, computation sheet	EOM Regulations 2024, Regulation 10 EOM Master Circular 2024, Chapter III
10	Additional allowance under head office/ rural sector/ specified schemes	Claim supported by eligibility, prior year base, actual expenditure support and ceiling computations	Review scheme wise and geography wise premium data and supporting expenses verify claim logic	Scheme wise premium reports, branch data, working papers, management approval	EOM Regulations 2024, Regulation 11
11	Periodic monitoring of actual vs allowable and actual vs projected EOM	Management and Board committees should monitor EOM through MIS and exception escalation	Review monthly/quarterly dashboards test whether adverse trends triggered action	MIS packs, exception reports, emails, committee minutes	EOM Regulations 2024, Regulation 5 and Regulation 21 Corporate Governance Master Circular 2024

12	Excess EOM and charge to P&L	Excess over allowable EOM to be charged to Profit and Loss Account as prescribed	Recompute allowable and actual EOM verify accounting entry for excess	Compliance memo, return reconciliation, financial statement entries	EOM Regulations 2024, Regulations 19 and 20
13	Variable pay restriction	No variable pay where actual EOM exceeds projected levels by 10 percent or more, subject to regulatory carve out	Compare approved business plan with actual review NRC/HR decision and payroll impact	Business plan projections, annual EOM computation, payroll/NRC papers	EOM Regulations 2024, Regulation 21
14	Financial statement presentation and disclosure	Schedule wise presentation separate line item disclosure for material expenses note disclosure of policy revisions where required	Tie schedules to books review whether material expense lines were separately disclosed verify note on policy revisions	Final accounts, schedules, disclosure checklist, notes to accounts	Preparation of Financial Statements Regulations 2002 EOM Regulations 2024, Regulation 3 proviso

15	Return of Expenses of Management	Annual return signed by CEO, CFO, CCO and Appointed Actuary certified by statutory auditor reviewed by Audit Committee and approved by Board	Tie return fields to books and working papers verify signatories, auditor certificate, minutes and filing evidence	Signed return, statutory auditor certificate, Audit Committee minutes, Board minutes, filing acknowledgement	EOM Regulations 2024, Regulation 13 EOM Master Circular 2024, Chapter III
16	Return on payment of commission	Board approved and Audit Committee reviewed annual return filed within 45 days of year end	Verify completeness, cut off, approval trail and filing date	Return, Board minutes, Audit Committee minutes, filing proof	EOM Regulations 2024, Regulation 14 Master Circular on Submission of Returns, 2024

17	Audit Committee oversight	Audit Committee to oversee internal audit and overall management costs and monitor rectification	Verify whether management cost issues and audit findings were placed before the Audit Committee and acted upon	Audit Committee agenda, presentations, action taken reports	Corporate Governance Master Circular 2024

Key Analytics Use Cases

Sr. No.	Analytics Test	Objective	Indicative Exceptions/ Red Flags
1	Duplicate vendor and bank account scan across expense and commission ledgers	Identify duplicate or related party style payouts booked under different heads	Same bank account used for vendor fee and channel payout repeated small value splits
2	Channel wise and vendor wise spend trend analysis	Detect disguised commission or abnormal sales linked spend	Sudden increase in “marketing support”, “lead fees”, “business promotion” or “technology service” costs linked to premium growth
3	Product wise/ segment wise EOM ratio analysis	Identify distorted allocation to participating, non-participating or linked segments	Unusual expense spikes in one segment without corresponding business volume

4	Branch wise and cost centre wise ageing of accruals	Detect stale accruals, unsupported provisions and reversal patterns	Large round sum accruals repeatedly reversed and rebooked year end spikes
5	Manual journal entry analytics	Identify late or override based reallocations affecting EOM	Month end or year end entries by senior users entries bypassing workflow
6	“Others” and suspense head analysis	Detect parked expenditure and weak classification controls	High balances in generic expense heads repeated reallocations out of suspense
7	Actual versus projected EOM dashboard	Monitor risk of triggering Regulation 21 and breach of allowable limits	More than 10 percent variance from business plan projection without documented management action
8	Additional allowance computation analytics	Validate caps for Insurtech, awareness, rural sector and scheme related allowances	Claimed allowance exceeding actual spend, incremental premium logic or regulatory cap
9	System versus return reconciliation	Confirm that regulatory return numbers are traceable to books	Gaps between GL totals, allocation work papers and Schedule I/II return figures
10	User access and role conflict testing	Review segregation of duties over master changes, postings and return preparation	Same user maintaining cost centre master, posting journals and editing return template

Key Regulatory

Source	Issuing authority	Date/ year	Relevant section/ regulation/ paragraph/ chapter
The Insurance Act, 1938	Parliament of India	1938, as amended	https://irdai.gov.in/document detail?documentId=366196
Insurance Regulatory and Development Authority Act, 1999	Parliament of India	1999, as amended	https://irdai.gov.in/document detail?documentId=366291
Insurance Regulatory and Development Authority of India (Expenses of Management, including Commission, of Insurers) Regulations, 2024, F. No. IRDAI/Reg/2/196 /2024	IRDAI	2024	https://irdai.gov.in/document detail?documentId=4359902
Master Circular on Expenses of Management, including Commission, of Insurers, 2024	IRDAI	15 May 2024	https://irdai.gov.in/document detail?documentId=4886329
Master Circular on Submission of Returns, 2024	IRDAI	14 June 2024	https://irdai.gov.in/document detail?documentId=5050759

IRDA (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002, F. No. IRDA/Reg/03/2002	IRDAI	2002	https://irdai.gov.in/document detail?documentId=603541
IRDAI (Corporate Governance for Insurers) Regulations, 2024, IRDAI/Reg/7/201/2024	IRDAI	2024	https://irdai.gov.in/web/guest/document detail?documentId=4590027
Master Circular on Corporate Governance for Insurers, 2024	IRDAI	22 May 2024	https://irdai.gov.in/document detail?documentId=4916164
Compendium of Standards on Internal Audit	The Institute of Chartered Accountants of India	October 2022	https://internalaudit.icai.org/wp content/uploads/2026/03/Compendium of Standards on Internal Audit October 2022.pdf

Conclusion

The internal audit of management expenses in life insurance companies has evolved from a routine compliance exercise into a sophisticated, multi dimensional governance function. In an environment of regulatory rigor, digital transformation, cost optimization pressure and rising fraud complexity, the internal auditor plays a pivotal role in safeguarding policyholder interests, protecting corporate financial health and providing assurance to the Board and regulators.

The key imperatives for a modern management expense internal audit function in life insurance are:

1. **Adopt Risk-based Planning:** Prioritize audit coverage based on dynamic risk scoring, not historical conventions.
2. **Leverage Data Analytics and AI:** Move from sampling to 100% population testing using advanced analytics tools.
3. **Implement Continuous Auditing:** Real time monitoring of critical controls rather than periodic point in time reviews.
4. **Strengthen Fraud Prevention:** Proactive fraud risk assessment, red flag monitoring and investigation protocols.
5. **Align with Regulatory Evolution:** Stay current with IRDAI's EOM Regulations, outsourcing guidelines and RPT norms.
6. **Integrate ESG and Emerging Risks:** Incorporate ESG expenditure, DPDP compliance costs and emerging operating model risks into audit scope.
7. **Develop Future Ready Competencies:** Build data analytics, technology and strategic advisory capabilities within the audit team.
8. **Strengthen Audit Committee Governance:** Provide insightful, forward looking reports that drive meaningful governance actions.

Life insurance companies that invest in building a world class internal audit capability for management expense oversight will be better positioned to navigate the complex regulatory, competitive and operational landscape – delivering sustainable value to policyholders, shareholders and the broader economy.

Key Takeaway

The future of management expense internal audit is not about checking more transactions. It is about providing continuous, intelligent, data driven assurance that management expenses are efficiently incurred, properly governed, compliant with regulations and free from fraud. This transformation requires investment in technology, talent and audit methodology. But the returns, in terms of governance quality, fraud prevention and policyholder value, are immeasurable.

Chapter 18
Anti Money Laundering

Introduction

18.1 Life insurance companies are exposed to money laundering and terrorist financing risks due to the nature of products and transactions such as single premium policies, policy assignments, beneficiary changes, fund switches, third party premium payments and early surrenders. To mitigate these risks, insurers are required to establish a comprehensive Anti Money Laundering and Combating Financing of Terrorism (AML/CFT) framework in compliance with the Prevention of Money Laundering Act, 2002 (PMLA), Prevention of Money Laundering Rules, 2005, IRDAI AML/CFT Guidelines, FIU IND reporting requirements and other applicable regulatory provisions.

Scope and Objective

18.2 The objective of internal audit is to provide independent assurance on the adequacy and effectiveness of the insurer's AML/CFT framework in compliance with applicable laws, regulations and IRDAI guidelines, including customer due diligence, beneficial ownership identification, sanctions and PEP screening, transaction monitoring, suspicious transaction reporting, governance oversight and regulatory compliance. This chapter provides a risk-based audit framework to assist internal auditors in evaluating AML controls, identifying potential vulnerabilities and ensuring compliance with applicable regulatory requirements.

Life insurance products may be vulnerable to money laundering risks through the following:

- Large single premium policies
- Third party premium payments
- Early policy surrender
- Multiple linked policies
- Fund switching in ULIPs
- Assignment of policies

- Beneficiary changes

The scope of the internal audit is to review:

- Customer Due Diligence (CDD)
- Enhanced Due Diligence (EDD)
- Beneficial Ownership Identification
- Politically Exposed Persons (PEP) monitoring
- Sanctions screening
- Suspicious transaction monitoring
- Regulatory reporting to FIU IND
- AML governance framework

The Process Flow is Enumerated Below

1	**Customer Onboarding**	Customer Identification Program Collect and verify the applicant's name, address, date of birth and government issued ID.
2	**KYC Verification**	Acceptance of valid identity documents (PAN, Aadhar, CKYC, address proof, Identification obtained).
3	**Customer Risk Classsification**	Classification of Customers into High/Medium/Low risk with adequate documentation.
4	**PEP/Sanctions Screening**	PEP screenings require Senior management approval. Regular updation of sanctions and PEP databases.
5	**Policy Issuance**	Monitoring of freelook cancellations, Early surrenders, fund switches, beneficiary changes, Assignment changes.
6	**Premium Monitoring**	Monitoring limits for premiums received I cash. Approvals obtained for third party payments, high value premium, premium splitting.

7	**AML Alert Generation**	Set rules/criteria for AML alert generation duly tested and configured.
8	**AML Investigation**	Alert ageing reports, SLA compliance, investigation rationale, closure of alerts.
9	**STR Assessment**	STR reporting logs, submissions evidence, maintenance of STR register.
10	**FIU Reporting**	Timely submission of FIU filing.
11	**Ongoing Monitoring and Review**	Reporting to Board, Log monitoring, trend analysis.

Key Systems Involved

Sr. No.	System	Purpose
1	KYC Platform	Customer Verification
2	Policy Administration System	Policy issuance
3	Aml Monitoring System	Alert generation
4	Screening Engine	PEP & Sanctions Screening
5	FIU Reporting Module	STR Filing
6	Data Warehouse	AML Analytics
7	Compliance Portal	AML Governance Reporting

Illustrative Internal Audit Checklist

18.3 An illustrative internal audit checklist concerning key risks, control objectives, audit procedures relating to anti-money laundering is as follows:

Risk	Control Objective	Illustrative Audit Procedures
Governance Framework		
• Board approved AML Policy with periodic review • Appointment of Principal officer • Composition of AML Committee • Designated Director • AML Risk Assessment • Reporting • Regulatory Updates • Three Lines of Defence	Regulatory Compliance	• Obtain Board approved policy • Check for Annual review with Version Control. Whether policy updated for latest IRDA/FIU requirements • Verify appointment of Principal officer and reporting to FIU • Review Composition, frequency of meeting and Board reporting • Appointment as per PMLA requirements • Enterprise wide AML risk assessment conducted annually • AML reports submitted to Board/Audit Committee • The three defense lines clearly defined and documented

Customer Acceptance Policy & KYC		
• Customer Acceptance Policy • Issue policies post receipt of KYC documents (PAN, Aadhaar, address proof, identity proof, CKYC) • Identify beneficial owner • KYC deficiencies, exceptions, updation • Digital onboarding	• Regulatory Compliance • Customer Acceptance • Transparency of ownership	• Verify approved Policy • Verify KYC completion before policy issuance (validation and verification of PAN, Aadhar, CKYC) • Review beneficial ownership declarations and supporting documents • Review monitoring and closure mechanisms, periodic updation. • Check if e-controls are operating effectively
Customer Due Diligence (CDD)		
• Risk Classification Inadequate • Occupation Verification • Source of Funds/wealth • Beneficial Ownership • Related parties • Review Frequency	• Regulatory Compliance • Appropriate monitoring •	• Low/Medium/High risk categorization documented • Occupation captured and validated • Obtained for high-risk customers • Related party linkages identified • Periodic review performed based on risk category

Enhanced Due Diligence (EDD)		
Check whether: • High Risk Customers • Foreign Nationals • NRI Customers • High Premium Policies • Senior Management Approval • Periodic Review	Regulatory Compliance	• EDD conducted, additional verification performed, additional due diligence performed • Check if EDD is completed • Check if enhanced monitoring documented
PEP & Sanctions Screening		
• PEP Screening • Ongoing Screening • Family members • Sanctions screening • Matching resolution • Escalation process • Screening Logs	• Regulatory Compliance • Enhanced monitoring • Effective Screening	• Review PEP screening reports and exception handling conducted at onboarding • Review if periodic re screening performed • UN/UAPA lists screened, false positives documented • Review documentation of escalation framework • Review the audit trail
Premium Monitoring		
• Cash Premiums • Third party premiums	• Regulatory Compliance	• Review monitoring of limits

• High value Premiums • Premiums splitting • Multiple policies • Unusual pattern payments	• Prevention of layering • Detection of placement risk • Detection of suspicious relationship	• Review third party payment approvals and supporting documentation • Verify AML review of high value policies • Perform customer clustering analysis and relationship analysis • Review exception reporting
Policy Servicing Monitoring		
• Early surrenders • Free look Cancellations • Beneficiary Changes • Assignment cases • Fund Switches • Top up Premiums	• Regulatory Compliance • Detection of laundering patterns • Detection of suspicious behavior • Prevention of misuse	• Review surrendered policies against AML review criteria • Analyze free look trends • Review approvals and supporting documents • Check process of AML review performed • Verify how exception monitoring is conducted • Check process of AML review performed
Transaction Monitoring and Alerts		
• AML rules Engine • Alert generation,	• Effective Monitoring • Fraud Prevention	• Review AML rule configuration and

review and closure • Alert Ageing • Escalation • Repeat Alerts	• Customer protection	testing evidence • Review alert ageing reports and SLA compliance • Review closed alerts and investigation rationale • Verify documentation of timely escalation • Verify trend analysis conducted
Suspicious Transaction Reporting (STR)		
• STR identification, Investigation, Approval • STR register • FIU Filing • STR Register • Confidentiality • Audit Trail	Regulatory Compliance	• Verify if defined criteria is available, existence of approval hierarchy • Verify STR reporting logs and timely submission evidence • Compare identification date with filing date • Verify if STR register is maintained, restricted access maintained. • Check if complete documentation is available

AML Systems and IT Controls		
• User Access given on Need to Know basis • Maker checker in place • Rules changes • UAT • Interface Controls • Data integrity • Log Monitoring	System Integrity	• Review access given is as per role based • Review maker checker implemented for critical changes • Verify if rule changes are approved and documented • Verify if UAT is conducted before deployment • Verify if reconciliations are performed • Validation controls are operating • Verify if periodic review of logs is performed
Training and Awareness		
• Employee, sales force, intermediary Training • Certification • Training Records	Employee/ intermediary awareness	• Verify if AML training, awareness programs conducted • Annual Certification obtained • Training records maintained
Regulatory Reporting		
• FIU/IRDAI Reporting	Board Oversight	• Verify if reports are submitted within

• Regulatory Queries • Inspection Observations • Compliance Certification		timelines, AML disclosures completed • Verify if responses have been timely provided • Closure of Regulatory observations monitored • Verify if annual certification available

Audit Analytics/ CAATs

18.4 The following audit analytics may be need to identify anomalies, assess trends:

Sr. No	Area	Audit Analytics
1	Duplicate PAN Analysis	Detect linked customers
2	Common Bank Account Analysis	Detect suspicious funding
3	Early Surrender Analysis	Detect laundering indicators
4	Multiple Policy Analysis	Detect structuring
5	PEP exception analysis	Detect missed classification
6	Third party Premium Analysis	Detect layering
7	STR Trend Analysis	Regulatory Compliance
8	AML Alert Ageing	Timely investigation

Commonly Observed Irregularities/ Violations

18.5 The following are some commonly observed irregularities and instance of non-compliance in AML that may warrant specific attention :

- Incomplete KYC documentation.
- Missing beneficial ownership records.
- Weak PEP identification process.
- Sanctions screening deficiencies.
- Delayed STR filing.
- Weak third-party payment controls.
- Inadequate AML training records.
- Incomplete AML investigations.
- Deficiencies in AML governance reporting.
- Weak monitoring of early surrender transactions.

AML Red Flags

18.6 The following observation may be treated as Red Flags Audit finding:

- Multiple customers using same mobile number, email or bank account.
- Large single premium policies followed by early surrender.
- Frequent third party premium payments.
- Multiple policies purchased just below monitoring thresholds.
- Repeated fund switches in ULIPs.
- Frequent beneficiary changes.
- High risk customer without EDD.
- PEP customer not identified.
- Alerts repeatedly closed without adequate rationale.
- Long pending AML investigations.
- Unusual policy assignments.
- Multiple policies linked through common introducer/intermediary.

Key Regulatory References

Reference	URL
• PMLA 2022 • PMLA (Maintenance of Records) Rules, 2005	https://fiuindia.gov.in/
IRDAI Regulations • IRDAI AML/CFT Master Circulars	https://irdai.gov.in/regulations guidelines
• U IND Reporting Framework	https://fiuindia.gov.in
• UAPA Sanctions framework	https://nia.gov.in/uapa

Chapter 19
Outsourcing Functions

Introduction

19.1 Outsourcing can improve scalability, turnaround time and access to specialist capability however, it does not transfer the insurer's accountability for policyholder outcomes, regulatory compliance, confidentiality, or resilience. This chapter provides a risk based internal audit framework for outsourced arrangements, with particular focus on policyholder operations under the 2024 IRDAI framework.

Scope and Objectives

19.2 Audit coverage should include the complete outsourcing lifecycle: identification and classification of activity materiality and risk assessment due diligence approvals contracting transition service delivery data/cyber controls monitoring business continuity sub outsourcing complaints and remediation renewal/exit and regulatory reporting.

Objectives

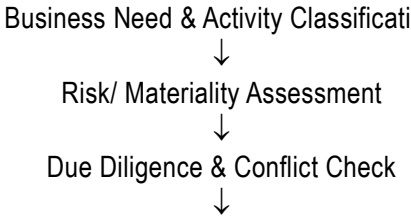
(i) Verify compliance with IRDAI outsourcing requirements and policyholder operation requirements

(ii) Assess whether prohibited/core functions remain under insurer control

(iii) Evaluate vendor governance, data protection, service quality and resilience and

(iv) Confirm that policyholder servicing, grievance handling and claims related support do not impair fairness, timeliness or accountability.

Process Flowchart



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Outsourcing Committee/ Board Approval

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Contract & SLA Finalisation

↓

Controlled Transition

↓

Ongoing Monitoring & MI

↓

Audit/ Compliance Review

↓

Renewal, Exit & Data Return/ Destruction.

Regulatory Framework

Reference	Audit relevance
IRDAI (Outsourcing of Activities by Indian Insurers) Regulations, 2017	Primary framework: Board approved policy, outsourcing committee, due diligence, contracts, monitoring, audit/access, confidentiality, BCP and exit.
IRDAI Master Circular on Operations and Allied Matters of Insurers, 2024 (19 June 2024)	Operational controls relevant to outsourced policy servicing, records, customer communications and insurer accountability.
IRDAI Master Circular on Protection of Policyholders' Interests, 2024 (5 September 2024)	Policyholder servicing, communications, grievance redressal, claims related service standards and fair treatment.
IRDAI Information and Cyber Security Guidelines, 2023	Third party technology risk, access management, incident response, cyber governance and assurance.
Digital Personal Data Protection Act, 2023	Data fiduciary accountability, processor controls, purpose limitation, security safeguards and breach governance.

Risk Control Matrix

19.3 The following are key risks and controls related to outsourcing function:

Sr. No.	Audit Bucket	Risk	Key Control	Rating
1	Governance	Outsourcing policy not current/ incomplete	Board approved policy defines permitted activities, materiality, due diligence, approval matrix, concentration, sub outsourcing, monitoring and exit annual review.	High
2	Activity classification	Core activity effectively outsourced	Documented classification legal/compliance review insurer retains decision rights for underwriting, claims settlement, investment, actuarial, compliance and internal audit.	High
3	Materiality	Material arrangement not escalated	Risk/materiality assessment considers policyholder impact, criticality, data sensitivity, substitutability and concentration	High

			committee approval.	
4	Due diligence	Inadequate vendor capability/ integrity	Financial, operational, cyber, legal, reputation, conflict and BCP due diligence reference checks and approval evidence.	High
5	Contracting	Contract lacks regulatory protections	Agreement includes SLA/KPI, audit and IRDAI access, confidentiality, data ownership, incident notification, BCP, sub contracting approval, indemnity, exit and destruction clauses.	High
6	Policyholder operations	Service provider causes customer detriment	TAT, quality, complaint, call monitoring and exception dashboards insurer retains escalation and final accountability.	High
7	Data & cyber	Unauthorised access/ data leakage	Least privilege access, encryption, logging, periodic access	High

			recertification, vulnerability management and incident escalation.	
8	Sub outsourcing	Unapproved fourth party dependency	Prior written approval, due diligence and flow down contractual clauses register of sub contractors.	High
9	Monitoring	SLA failures not remediated	Monthly MI, root cause analysis, corrective action tracker, penalties/service credits and management escalation.	Medium
10	BCP/ DR	Vendor disruption affects policy servicing	Tested BCP/DR, RTO/RPO alignment, alternate site capacity, insurer participation in tests and documented gaps closure.	High
11	Audit/ assurance	No independent assurance over vendor controls	Risk based audits, SOC/ISAE reports where relevant, onsite reviews, issue validation and regulatory access evidence.	Medium

12	Exit management	Data or service continuity compromised at exit	Exit plan, transition support, data return/destruction certificate, access revocation and post exit reconciliation.	High

Illustration Internal Audit Checklist

19.4 An illustration internal audit checklist covering audit areas key check points and analytical toll are as follows:

Sr. No.	Audit Area	Key Checkpoints	Audit Tools/ Analytics
1	Governance & approvals	Obtain outsourcing inventory reconcile with GL/vendor master and procurement spend verify policy/committee/Board approvals.	Spend analytics vendor concentration unapproved vendor detection
2	Classification	Test whether scope statements or SOPs delegate prohibited decision rights.	Keyword search in contracts/SOPs workflow log review
3	Due diligence	Verify financial, cyber, BCP, conflict and compliance checks before onboarding and renewal.	Expiry/renewal ageing missing document dashboard
4	Contracts	Test mandatory clauses, SLA definitions, audit rights, IRDAI access, sub contracting, data ownership and exit.	Contract clause checklist/ NLP review

5	Policyholder operations	Test outsourced call centre, document processing, premium servicing, policy issuance support and grievance routing against TAT and quality standards.	TAT ageing repeat calls complaint trend abandoned call analysis
	Claims support	Confirm vendors perform only support/assessment activities and insurer retains adjudication/settlement authority.	Workflow maker checker logs override analysis
6	Data/cyber	Review user access, privileged access, data transfers, logs, incident reporting and vulnerability closure.	Access conflict analytics dormant IDs log exceptions
7	SLA monitoring	Verify KPI reporting, breaches, root causes, service credits and closure validation.	SLA heat map breach recurrence ageing of CAPA
8	BCP/DR	Inspect test reports, RTO/RPO achievement, failover evidence and open issues.	Exception tracker test result trend
9	Financial controls	Validate invoices to approved rate cards, volume evidence, SLA adjustments and GST/TDS controls.	Duplicate invoice rate variance volume to invoice reconciliation

10	Exit/ renewal	Test exit readiness, data return/destruction, access revocation and transition controls.	Contract expiry dashboard post exit access scan

Red Flags

19.5 The following observations may be treated as red flags audit findings:

- Vendor staff have system rights enabling final underwriting or claims decisions.
- Policyholder complaints, repeat calls or TAT breaches are concentrated in one outsourced process.
- Contracts omit IRDAI/insurer audit access, data ownership, incident notification or exit obligations.
- Sub contractors are used without insurer approval or without flow down controls.
- SLA reports are manually prepared, lack source data reconciliation, or recurring breaches are closed without root cause evidence.
- Vendor invoices rise materially without corresponding transaction volumes or approved change orders.

Commonly Observed Irregularities

19.6 The following are some commonly observed irregularities in outsourcing function:

- Outsourcing register is incomplete or does not identify material/critical arrangements.
- Annual policy and Board/Outsourcing Committee reviews are not evidenced.
- Vendor due diligence is performed only at onboarding and not at renewal or after adverse events.
- Agreements do not contain adequate audit, regulatory access, BCP, sub contracting, data return or termination clauses.

- Insurer relies on vendor dashboards without independent validation of policyholder TAT, complaints or quality outcomes.
- Shared IDs, excessive access, delayed de provisioning and insufficient monitoring of data downloads are observed.
- Claims or underwriting support workflows permit vendor actions beyond permitted support roles.
- BCP tests exclude end to end policyholder servicing and do not evidence closure of test gaps.

Key Regulatory References

Document	Official source
Outsourcing Regulations, 2017	https://irdai.gov.in/document detail?documentId=604638
Master Circular on Operations and Allied Matters, 2024	https://irdai.gov.in/circulars
Master Circular on Protection of Policyholders' Interests, 2024	https://irdai.gov.in/circulars?filterEnt ities=ISNP&filtersApplied=true
Information and Cyber Security Guidelines, 2023	https://irdai.gov.in/guidelines

Note: Internal audit or should validate the latest IRDAI amendments, circulars and insurer specific directions in force as of the audit period before arriving at conclusions.

Chapter 20
Use of Data Analytics in Internal Audit

Introduction

20.1 Data analytics, in the context of internal audit, is the systematic examination of an organisation's data to obtain audit evidence, to identify exceptions, test controls across complete populations, detect patterns and anomalies, quantify risk and direct audit effort to where it matters most. For a life insurer, the business is, at its core, a data business: every policy, premium receipt, commission payout, surrender, claim and grievance exists first as a record in a system before it exists as anything else. Analytics therefore lets the internal auditor read those records directly, at scale.

The detailed list of analytic relevant to every function have been given in respective chapters of this Guide and Annexure 5 Data Analytics Use Case Library. This chapter provides that the data landscape that an auditor must understand before pulling a single extract, the discipline of ensuring the data is fit to rely on, the techniques that recur across every function and how artificial intelligence and machine learning are changing what good analytics looks like.

The Standards on Internal Audit issued by ICAI, in particular SIA 240, Use of Tools, together with SIA 230, Internal Audit Evidence SIA 220, Internal Audit Planning and SIA 210, Knowledge of the Entity and its Environment establish the obligations that govern the use of analytics and tools in an audit. Wherever relevant, this chapter makes reference to those obligations.

What Data Analytics Delivers and What Stands in its Way

20.2 Before turning to the data itself, it is worth being plain about what analytics is expected to deliver for a life insurer's internal audit and about the obstacles that routinely get in the way.

What it Delivers

Used well, technology enabled audit changes the assurance the function can offer along several dimensions:

Sr. No.	What it delivers	What it means for a life insurer	Why it matters
1	Full population coverage	Testing every commission payout, claim or free look reversal rather than a sample of a few dozen.	Higher assurance the exceptions are the exact records that failed, not an inference about the untested majority.
2	Shorter audit cycles	Automating extraction, matching and routine testing that previously took days.	Findings reach management sooner, so corrective action is timelier.
3	Greater accuracy and consistency	Rules applied identically across millions of records, free of manual handling error.	More reliable, more defensible audit conclusions.
4	Deeper visibility	Cross system joins and pattern analysis surface relationships no single process owner can see.	More impactful findings and better root cause insight.
5	Near real time assurance	Continuous monitoring of high-risk processes rather than a point in time review.	Issues are caught and addressed earlier, reducing financial and regulatory impact.

6	Better use of scarce resources	Auditor time redirected from data gathering to interpretation and judgement.	The function spends its hours where they add the most value.

What Stands in its way

The obstacles are as real as the benefits:

- **Skill Gaps:** Many auditors were trained in manual, risk based methods and may lack the skills to design and interpret analytics. The scarcer skill is not running a tool but translating population level output into an assurance conclusion. Continuous upskilling and access to data specialists, is part of the cost of doing this well.
- **Data Quality and Availability:** Extracts may be incomplete, undated, or drawn from a test environment out of sync with production status filters may silently exclude lapsed or surrendered policies and migration from a legacy policy administration system leaves artefacts behind. This is why the data integrity discipline comes before any analysis.
- **Cybersecurity and Data Privacy:** Giving auditors broad access to financial, medical and personal data for analytics creates real exposure under the Digital Personal Data Protection Act, 2023 and must be governed accordingly. SIA 240 makes protection of data security and confidentiality an explicit obligation.
- **Algorithmic Bias and Over Reliance:** An over trusted model can both flag the wrong things and miss what falls outside its parameters. Professional scepticism and corroboration remain essential the tool nominates, the auditor concludes.

Understanding the Life Insurer's Data Landscape

20.3 Before designing a single test, the internal auditor needs a working map of the systems a life insurer runs on, what each holds and critically, where they fail to agree with one another. This understanding is itself an SIA 210 obligation: knowledge of the entity and its environment includes knowledge of its information systems. For a life insurer, that map looks broadly as follows:

The Core Systems and what they hold

Sr. No.	System	What it holds	Typical analytics use
1	Policy Administration System (PAS)	The system of record for the policy: proposal, issuance, status, sum assured, premium, mode, riders, nominee, fund value (for ULIPs), endorsements, lapse, revival and surrender.	In force reconciliation, premium and status testing, free look and grace period checks, endorsement analysis.
2	Underwriting workbench	Proposal stage data: risk class, medical and financial underwriting decisions, ratings, exclusions, counter offers and the output of automated/rules based or ML underwriting engines.	Decision consistency testing, deviation from board approved underwriting authority, STP (straight through processing) rates, sub standard acceptance patterns.
3	Claims management system	Death, maturity, surrender, rider and health claim records: intimation, documentation, investigation notes, decision, repudiation reasons, TAT and payout.	Early claim detection, repudiation analysis, claims TAT, multiple claims against single policy, duplicate beneficiary and duplicate bank account testing, leakage.
4	Actuarial valuation system	Policy level data extracted for reserving and valuation, model point files, assumptions and reserve outputs.	Data integrity checks on the valuation extract, reconciliation of in force to PAS, reasonableness of

			assumption application.
5	General Ledger/ Finance	Premium income, commission expense, claims paid, management expenses, investment income and all journals.	Premium to GL reconciliation, commission to GL reconciliation, journal entry analysis, expense analytics.
6	Distribution/ Agency Management	Agent and intermediary master, licensing and appointment status, hierarchy, persistency, commission and contests/R&R.	Commission recomputation, orphan policy analysis, agent level persistency, dummy/benami agent detection, R&R eligibility.
7	AML/ Transaction monitoring	Customer risk categorisation, screening hits, premium funding patterns, alerts and STR workflow.	Alert quality testing, threshold tuning review, structuring detection, high-risk customer coverage.
8	CRM/ Grievance management	Customer interactions, complaints (including the IGMS/Bima Bharosa feed), resolution, TAT and free text descriptions.	Complaint root cause and TAT analysis, mis selling indicators from free text, repeat complainant detection.

The Reconciliation Problem and why it Matters

The single most important thing for an internal auditor to internalise about a life insurer's data is this: the core systems rarely tie out cleanly to one another and that is often by design rather than by error. The PAS counts policies by their administrative status. The General Ledger recognises income and expense by accounting rules and cut off. The actuarial valuation extract counts policies in force as at the valuation date under actuarial definitions that may

treat lapses, paid up policies and revivals differently again. The same "number of policies" or "premium" figure, pulled from three systems on the same day, can legitimately differ.

The first discipline of life insurance analytics is therefore the ability to take a difference between two systems and explain it as either (a) a timing or cut off difference, (b) a definitional difference, or (c) an unexplained break that warrants investigation.

Practical Reference: the three-way tie out

Before relying on any policy level or premium level analytic, establish the three-way relationship for the population you are testing: **PAS ↔ GL ↔ Actuarial valuation extract**. Document the reconciling items and their nature.

Getting the Data Right

20.4 An analytic conclusion drawn from an incomplete or inaccurate extract is worse than no conclusion, because it carries the appearance of rigour while being false. SIA 240 makes the point in obligation form: the auditor must validate that tool outputs are complete, accurate and aligned to the audit objective and SIA 230 governs the sufficiency and appropriateness of the evidence so obtained. In a life insurance setting, validating the data means working through a specific set of checks before any analysis begins.

Completeness: Do I have the Whole Population?

- **Tie Record Counts and Control Totals to Source:** The number of policies in the extract should reconcile to the in-force count in PAS total premium in the extract should reconcile to the premium register and to the GL.
- **Watch the Status Filter:** The most common completeness error in life insurance analytics is an extract that excludes lapsed, paid up, surrendered or reinstated policies because of a default status filter in the query. A persistency or claims test run on "active" policies only can be badly misleading.
- **Fix the "as at" Date:** Policies change state continuously. The auditor must know and document the moment an extract was taken.

Accuracy and Validity: can I trust Each Field?

- **Boundary and Reasonableness Checks:** dates of birth that imply ages outside the product's entry/maturity limits sum assured of zero or implausibly high commission rates outside the filed range negative premiums maturity dates before commencement dates.
- **Referential Checks Across Systems:** every commission record should map to a valid, in force policy and a validly appointed agent every claim should map to a policy that was in force on the date of the event.
- **Migration Artefacts:** where the insurer has moved from a legacy PAS to a new one, expect default values, truncated fields and broken mappings introduced by the migration. A spike in exceptions concentrated around the migration date is usually a data artefact, not a control failure but it must be confirmed as such.

Analytics Across the Internal Audit Lifecycle

Planning and Risk Assessment

Traditionally the audit plan reflected the auditor's judgement of where risk was likely to be. Analytics lets that judgement be informed by the data itself. A scan of the full commission population can reveal which branches or agents show the most anomalies a profile of claims can show which products or geographies carry the highest early claim or repudiation rates complaint data can point to the products generating disproportionate mis selling signals. Used this way, analytics decides where to audit.

Scoping and Sampling

Conventional sampling typically examines only a small fraction of the transaction population, often cited as somewhere between three and five percent and forms a view about the remaining majority that is never directly tested. Full population testing removes that inference: a control either held across every transaction or it did not and the exceptions are the exact records where it did not.

Where the data is available and reliable, the auditor can test the entire population every commission payout, every free look reversal, every claim rather than a sample of it. In such cases, the auditor's role shifts *upstream*: instead of spending time deciding which items to test, the effort moves to

deciding which patterns, behaviours and exceptions deserve attention in the first place.

Sampling Does not Disappear

Full population testing does not retire sampling. Where data is unreliable, unavailable, or where the matter under test is qualitative (the soundness of an underwriting judgement, the adequacy of a claim investigation), sampling and walkthroughs remain the right tools, as contemplated by SIA 230. The skill is knowing which transactions can be tested in full and which questions still require a human to open the file.

Fieldwork and Testing

During fieldwork, analytics supplies the exceptions that focus the auditor's manual work. Rather than reading files chosen at random, the auditor reads the files the analytics flagged, for e.g., the duplicate bank account, the out of range commission, the claim paid on a policy that lapsed before the event. Analytics narrows a population of millions down to the handful of records that actually warrant human judgement.

Reporting

Full population results change the texture of reporting. "We tested 30 commission payments and found 2 errors" becomes "We tested all 184,000 commission payments and identified 412 that breached the filed rate, totalling ₹X, concentrated in three branches." This way, the finding is quantified, complete and pinpointed, which is far harder to dismiss and far more useful to management.

A Working Toolkit of Analytics Techniques

20.5 The techniques below recur across almost every functional area of a life insurer. Each is illustrated with a life insurance example:

Duplicate and Overlap Detection

Identifying records that should be unique but are not. In a life insurer, duplicate detection is one of the highest yield techniques because duplication so often signals either fraud or control failure: the same bank account appearing across many unrelated death claims the same mobile number or email across hundreds of "distinct" proposals the same nominee across policies sold by one

agent duplicate premium receipts. Effective duplicate detection usually needs fuzzy matching names, addresses and bank details are entered inconsistently.

Gap and Sequence Analysis

Testing series that should be unbroken and sequential policy numbers, receipt numbers, cheque or payment instruction numbers for missing items, duplicates or out of sequence entries. A gap in receipt numbering may indicate suppressed or cancelled receipts a break in a claims payment sequence may indicate a payment made outside the normal workflow.

Digital Analysis (Benford's Law)

Benford's Law describes the expected frequency of leading digits in many naturally occurring datasets and divergence from it can flag manipulation. For example, in claim amounts clustering just below an authorisation threshold. It is a useful screen. However, it may also be widely misapplied. Benford's assumptions hold for figures that span several orders of magnitude and are not artificially constrained. Many life insurance amounts are *not* of that kind: commission is a fixed percentage of premium, sums assured cluster at round "marketing" values (₹5 lakh, ₹10 lakh, ₹1 crore) and premiums follow product pricing. Applying Benford to such fields produces "deviations" that are entirely innocent. Use it where the underlying amounts are genuinely free ranging, such as discretionary or investigated claim settlements and not as a blanket test.

Outlier and Anomaly Detection

Flagging values that sit far from the norm: a commission rate far above the filed slab, a claim TAT far beyond standard, a single agent's persistency far below peers, a surrender value that does not match the product formula. Simple outlier detection uses thresholds and standard deviations, whereas more advanced anomaly detection techniques (discussed in detail in 21.6) lets the data define what "normal" looks like and then identifies exceptions against that.

Relationship and Join Testing Across Systems

Much of the highest value testing in a life insurer comes by joining data from two or three systems. Join the claims system to the PAS to find claims paid on policies that were not in force on the date of event. Join commission to the agency master to find commission paid to agents whose appointment had

lapsed. Join the proposal data to the AML and employee masters to find policyholders, nominees or payers who are also agents or staff. A three way join of premium receipts, the policy master and the General Ledger surfaces, receipts not posted to any policy, premiums collected on policies already lapsed and amounts received but not recognised in the ledger. The exceptions that surface from cross system joins are frequently the ones that matter most, precisely because no single process owner can see them.

Ageing and Turnaround Time Analysis

Measuring elapsed time against a standard: claims settlement TAT against the regulatory limit, grievance resolution TAT against the IRDAI norm, free look refunds, unclaimed amounts ageing and premium in suspense ageing. Ageing analysis is straightforward to compute and maps directly to regulatory expectations, which makes it a reliable, defensible staple.

Trend, Ratio and Variance Analysis

Comparing values across time, segments or peers to surface what has moved and where. Persistency by cohort and distribution channel expense ratios against the regulatory allowable and across periods surrender rates by product repudiation rates by underwriting class. The auditor's task is to distinguish a movement explained by business reality from one that signals a control or reporting problem.

Text Analytics on Unstructured Data

A large share of a life insurer's most revealing information is not in neat numeric fields but in free text: claim investigation notes, grievance descriptions, medical underwriting remarks and agent communications. Traditional analytics cannot read these. Text mining and, increasingly, the language model techniques of 21.6 lets the auditor screen the entire body of free text for mis selling language, undisclosed material facts in underwriting remarks, or recurring themes in complaints.

Worked illustration Combining Different Analytical Techniques

Objective: Identify potential leakage in death claims.

Approach: (1) Extract the full death claim population and reconcile the count and value to the claims register and GL [21.3]. (2) Join to PAS and flag any claim where the policy was not in force on the date of death, or

where death occurred within the early claim window [21.5.5]. (3) Within the early claim subset, run duplicate detection on beneficiary bank accounts and on nominee identity across unrelated policies [21.5.1]. (4) Age the population by intimation to decision TAT and flag breaches of the regulatory limit [21.5.6]. (5) Screen the investigation free text of the flagged claims for inconsistent narratives [21.5.8]. (6) Open the flagged files and apply judgement.

Using Artificial Intelligence and Machine Learning in Analytics

20.6 Artificial intelligence has moved from the margins of internal audit to the centre of how leading functions think about analytics. For most of the history of audit analytics, the constraint was not imagination but mechanics. An auditor knew the test they wanted recompute commission against the filed slab, find claims paid on lapsed policies, etc. but executing it meant writing SQL to pull the data, scripting in Python or IDEA to run the logic and wrangling the output into something legible. That skill set usually sat with a small number of specialists and the ordinary auditor who lacked it was effectively locked out of the most powerful techniques, however well they understood the risk.

This is what has changed. Current general purpose AI assistants can now interpret a request expressed in plain language, generate the SQL query or Python code needed to satisfy it, execute that code against a spreadsheet or dataset and return the result, often with the analysis, the exceptions and a chart, in one pass. In effect, the layer of technical skill that used to stand between an auditor's question and the data has been substantially automated away. An auditor who could never have written a line of SQL can now interrogate a million-row premium register, profile it, join it to another file and surface the outliers, all by simply asking for it in plain language.

What AI Changes and What it Does Not

AI expands the surface over which that judgement can be applied but it does not replace professional judgement. SIA 240 points out that the internal auditor *should not rely solely on automated outputs* professional scepticism and contextual evaluation must be applied to all tool based findings and anomalies thrown up by a tool must be investigated further through corroborative procedures. An AI model that flags a transaction has not concluded anything.

It has nominated a record for a human to examine. The conclusion remains the auditor's and so does responsibility for it.

Practical use Cases for the Life Insurance Auditor

The following are the applications where AI and ML can be gainfully used in a life insurance internal audit today:

(a) Machine Learning Anomaly Detection Over Full Populations

Rule based exception testing finds what the auditor already knew to look for: it catches the breach of a threshold the auditor set. Unsupervised machine learning models invert this. They learn the normal structure of a dataset and surface the records that do not fit, including patterns the auditor never thought to specify. Run across the full commission, claims or surrender population, such models can cluster transactions and isolate the genuinely unusual: an agent whose business mix is unlike any peer's, a claims pattern that deviates from every known profile.

(b) Natural Language Processing and Language Models on Unstructured Text

Language models can screen the entire body of grievance descriptions for mis selling indicators read medical underwriting remarks for material facts that were noted but not acted upon review claim investigation narratives for internal inconsistency and compare large volumes of policy documents or marketing material against the filed terms. Work that was previously impossible at scale is now feasible.

(c) Document Review at Scale

Beyond free text fields, language models can compare a large set of issued policy contracts against the approved File and Use terms, or scan a corpus of advertisements against regulatory advertising norms, flagging departures for human confirmation.

(d) Predictive Prioritisation of Audit Effort

Risk scoring models can rank branches, agents, products or processes by their predicted likelihood of control failure, drawing on past audit findings, complaint data, persistency and loss experience. This sharpens risk based planning under SIA 220: instead of spreading coverage evenly or relying solely on intuition, the auditor directs scarce effort to the units the data predicts are riskiest.

(e) Process Mining

Process mining techniques reconstruct how a process actually ran, from the event logs the systems already generates and compare it against how it was designed to run. For a life insurer this can expose the real path of a claim or a policy alteration: where steps were skipped, where approvals were applied after the fact, where authority was overridden. It reveals deviations from documented controls without anyone having to describe the process from memory.

The "So What" Problem: From Exceptions to Assurance

A full population scan, especially an ML driven one, can generate thousands of exceptions. Without a disciplined way to interpret them, presenting the entire exception list as a report can overwhelm the business, bury the real issues among false positives and erode the credibility of analytics in the organisation. Therefore, in an AI and ML driven audit, the skill set to have is converting population level output into a defensible assurance conclusion.

The discipline that prevents the exception dump is triage: a structured way of separating noise from signal. The most useful single principle is to distinguish the isolated exception from the recurring pattern. A single out of range transaction may be a harmless error. The same exception clustering around one agent, one branch, one product, one system user, one third party administrator, or one reporting period is what most probably points to a process or governance weakness.

Sr. No.	Triage lens	Question the auditor asks	What a positive answer suggests
1	Concentration	Do the exceptions cluster around a specific agent, branch, user, product or TPA?	A localised control failure or possible collusion.
2	Recurrence	Is the same exception appearing across periods, or only once?	A persistent, systemic gap.
3	Timing	Do exceptions cluster at period ends, after	Possible manipulation, override, or a

		hours, or around a system change?	migration/data artefact to rule out.
4	Value and trend	Are the flagged items individually small but collectively material, or growing over time?	Aggregate materiality or a deteriorating control that a sample would have missed.
5	Corroboration	When the file is opened, does the underlying evidence confirm the flag?	A genuine finding as opposed to a false positive from data quality.

Practical Illustration

Analytics over a centralised finance function surfaces hundreds of manual journal entries posted after business hours. Individually, most look harmless. But once clustered by user, by reporting period and by approval override, a far smaller subset reveals a genuine governance concern. The lesson translates directly to a life insurer's manual premium adjustments, commission overrides, or claim decision reversals.

Governing the Auditor's Use of AI

(a) Validate the Tool Before Relying on It

Under SIA 240, analytical platforms and AI applications must be validated for reliability and integrity before their output is used, through trial runs, benchmarking against known outcomes and cross validation against manual procedures. For an AI model the auditor must understand the model's limitations, the risk of unreliable outputs and compensate through complementary procedures.

(b) Guard Data Security, Confidentiality and DPDP Compliance

A life insurer holds some of the most sensitive personal data there is like financial details, nominee information and, in underwriting and health claims, medical history. Feeding that data into AI tools, especially third party or cloud based ones, raises real obligations under the Digital Personal Data Protection

Act, 2023, which SIA 240 expressly names among the frameworks the auditor must respect. The internal auditor must ensure that the use of any tool complies with applicable data protection law, that adequate confidentiality, ownership and access controls exist where third party tools are used and that sensitive policyholder data is not exposed in the course of the audit's own analytics.

(c) Document the Use of the Tool

SIA 240 and SIA 250 require that the use of a tool be thoroughly documented: the purpose and scope, the inputs and configuration, the queries and parameters, the outputs and the auditor's interpretation and conclusions, together with any limitations or assumptions. For AI specifically, the working papers should distinguish clearly between what the tool found and what the auditor independently concluded and any limitation in the tool that affects the conclusion must be disclosed. Reports to the audit committee should preserve the same distinction between AI generated findings and the auditor's own judgement.

(d) Watch Bias and Explainability in Your Own Models

An anomaly model trained on historical audit findings or historical claims data inherits whatever bias is in that history it will tend to flag what was flagged before and overlook what was always overlooked. If the audit committee asks why a transaction was flagged and the only answer is "the model said so," the analytics has failed regardless of whether it was right. Boards increasingly expect AI driven conclusions to be explainable in plain governance terms.

Chapter 21
Cybersecurity and IT Controls

Introduction

21.1 The insurance industry has become increasingly dependent on digital technologies for policy administration, underwriting, claims processing, customer servicing, digital distribution and payment processing. While digital transformation has improved operational efficiency and customer experience, it has also expanded the cyber threat landscape. Life insurers maintain highly sensitive information, including personal, financial and health related data, making them attractive targets for ransomware, phishing, identity theft, data breaches and other cyberattacks.

Recognising these risks, the Insurance Regulatory and Development Authority of India (IRDAI) has strengthened its regulatory expectations through the IRDAI Information and Cyber Security Guidelines, 2023, supported by the IRDAI Master Circular on Operations and Allied Matters, 2024, Corporate Governance Regulations, 2024, the Digital Personal Data Protection Act, 2023 (DPDP Act) and other applicable regulatory requirements.

Cybersecurity is no longer solely an IT responsibility it is an enterprise wide governance issue requiring active oversight by the Board, senior management and business functions. Internal Audit provides independent assurance on the adequacy and effectiveness of cyber governance, IT controls, data protection and operational resilience. A modern cyber audit should extend beyond traditional IT General Controls (ITGCs) to include cloud security, identity and access management, API security, third party risk, cyber resilience, artificial intelligence (AI), data privacy and business continuity.

Regulatory Framework

21.2 Internal audits should be planned with reference to the applicable regulatory and statutory framework, while also considering recognised industry standards.

Regulation/ Standard	Audit Relevance
IRDAI Information and Cyber Security Guidelines, 2023	Governance, cyber risk management, incident response, vulnerability management, security operations and resilience.
IRDAI Master Circular on Operations and Allied Matters, 2024	Technology controls supporting policy administration, customer servicing and operational governance.
IRDAI (Corporate Governance for Insurers) Regulations, 2024	Board oversight, governance framework, internal controls and risk management.
IRDAI Outsourcing Regulations, 2017	Governance over cloud providers, TPAs and technology vendors.
Digital Personal Data Protection Act, 2023	Protection of personal data, security safeguards and privacy compliance.
CERT In Directions	Cyber incident reporting and log retention requirements.
ISO/IEC 27001:2022, NIST CSF 2.0 and COBIT 2019	International good practices for information security and IT governance.

Internal audit should evaluate not only regulatory compliance but also the maturity and effectiveness of the insurer's cybersecurity framework.

Cyber Governance

21.3 Cybersecurity governance establishes the framework through which the Board and senior management oversee cyber risks and ensure the protection of policyholder information and business operations.

The Board is ultimately responsible for approving the cybersecurity strategy, defining cyber risk appetite, reviewing significant cyber incidents and ensuring adequate investment in cyber resilience. The Chief Information Security Officer (CISO) is responsible for implementing the cyber security programme, monitoring emerging threats, coordinating incident response and reporting key cyber risks to senior management and the Board.

Internal audit should assess whether:

- Cybersecurity policies are Board approved and periodically reviewed.
- Cyber risks are integrated into the Enterprise Risk Management (ERM) framework.
- Roles and responsibilities of the Board, CISO, IT, Risk Management and Compliance functions are clearly defined.
- Significant cyber incidents and vulnerabilities are reported to appropriate governance forums.
- Independent assurance activities, including vulnerability assessments, penetration testing and internal audits, are performed periodically.

The audit should also evaluate the effectiveness of the Three Lines Model, ensuring clear accountability between operational management, risk oversight functions and Internal Audit.

Audit Objectives

21.4 The objectives of a cybersecurity internal audit are to:

- Assess the adequacy of cyber governance and Board oversight.
- Evaluate compliance with applicable IRDAI regulations and the DPDP Act, 2023.
- Review the design and operating effectiveness of IT General Controls (ITGCs).
- Assess logical access, privileged access and application security controls.
- Evaluate vulnerability management, security monitoring and incident response.
- Review third party cyber risk management, including cloud service providers and outsourced vendors.
- Assess business continuity, disaster recovery and cyber resilience.
- Evaluate controls over policyholder data, digital channels and emerging technologies such as AI.

Scope of Internal Audit

21.5 The audit scope should be risk based and cover governance, operational, technical and regulatory aspects of cybersecurity.

Key areas include:

Governance and Risk Management

- Cyber governance
- IT governance
- Enterprise cyber risk management
- Regulatory compliance

IT General Controls

- User and privileged access management
- Change management
- IT operations
- Database and configuration management

Cybersecurity Operations

- Network and endpoint security
- Vulnerability and patch management
- Security Operations Centre (SOC)
- Security Information and Event Management (SIEM)
- Incident response

Application Security

- Policy administration systems
- Underwriting systems
- Claims management systems
- Customer and intermediary portals
- Mobile applications
- API security

- Secure SDLC

Data Protection and Privacy

- Data classification
- Encryption
- Data Loss Prevention (DLP)
- Backup security
- Compliance with the DPDP Act, 2023

Third Party Risk

- Cloud service providers
- TPAs
- Technology vendors
- Digital partners
- Outsourcing governance

Business Resilience

- Business Continuity Management (BCM)
- Disaster Recovery (DR)
- Cyber resilience
- Crisis management

Emerging Risks

- Artificial Intelligence (AI)
- Generative AI
- Cloud concentration risk
- Software supply chain risk
- Quantum readiness

Cybersecurity Internal Audit Process Flow

21.6 A structured audit methodology helps ensure comprehensive coverage of governance, operational and technical controls.

Audit Planning & Regulatory Mapping

↓

Understand Business & Technology Environment

↓

Cyber Risk Assessment

↓

Review Governance & IT General Controls

↓

Evaluate Infrastructure, Applications & Data Security

↓

Assess SOC, Incident Response & Third Party Security

↓

Review Business Continuity & Disaster Recovery

↓

Perform Data Analytics & Control Testing

↓

Issue Audit Report & Track Corrective Actions

This approach enables Internal Audit to provide independent assurance on the effectiveness of cybersecurity governance, regulatory compliance and operational resilience while safeguarding policyholder information and supporting the insurer's strategic objectives.

Risk Control Matrix (RCM)

21.7 A Risk Control Matrix (RCM) enables Internal Audit to systematically evaluate the design and operating effectiveness of cybersecurity controls. The matrix should be aligned with the insurer's technology landscape, risk appetite and regulatory obligations. In addition to traditional IT General Controls (ITGCs), the audit should assess emerging risks arising from cloud adoption, digital distribution channels, APIs, artificial intelligence, outsourcing arrangements and operational resilience.

The following matrix provides an illustrative framework for internal audit.

Sr. No.	Audit Domain	Key Risks	Expected Controls	Illustrative Audit Procedures	Risk Rating	Primary Regulatory Reference
1	Cyber Governance	Weak governance, inadequate Board oversight	Board approved Cyber Security Policy, governance committees, periodic reporting	Review Board/Committee minutes, policy approvals, cyber dashboards and governance structure	High	IRDAI Information & Cyber Security Guidelines, 2023
2	Information Security Policies	Outdated or incomplete policies	Annual policy review and approval, policy dissemination	Verify policy version control, approvals and employee acknowledgement	High	IRDAI Information & Cyber Security Guidelines, 2023
3	IT Asset Management	Unknown or unmanaged assets	Complete inventory of hardware, software,	Reconcile asset inventory with CMDB and procure	High	IRDAI Information & Cyber Security Guidelines, 2023

			cloud and information assets	ment records		
4	Identity & Access Management (IAM)	Unauthorized system access	Role based access, Maker Checker, MFA, periodic access review	Test user provisioning, de provisioning, access recertification and privileged accounts	High	IRDAI Cyber Guidelines DPDP Act
5	Privileged Access Management (PAM)	Abuse of privileged credentials	Vaulting, session recording, approval workflows	Review privileged user logs, emergency access and password rotation	High	IRDAI Information & Cyber Security Guidelines, 2023
6	Change Management	Unauthorized or defective changes	Formal change approval, testing, segregation of duties	Sample changes and verify approvals, testing evidence and migration controls	High	IRDAI Information & Cyber Security Guidelines, 2023

7	Patch & Vulnerability Management	Exploitation of known vulnerabilities	Risk based patching, periodic vulnerability assessment	Review vulnerability reports, ageing analysis and closure evidence	High	IRDAI Cyber Guidelines CERT In
8	Network Security	External intrusion	Firewalls, IDS/IPS, network segmentation	Review firewall rule base, privileged exceptions and monitoring reports	High	IRDAI Information & Cyber Security Guidelines, 2023
9	Endpoint Security	Malware, ransomware	EDR, antivirus, device encryption	Analyse endpoint compliance dashboards and malware alerts	High	IRDAI Cyber Guidelines
10	Security Monitoring (SOC)	Delayed detection of attacks	SIEM, continuous monitoring, threat intelligence	Review SOC alerts, incident response timelines and	High	IRDAI Information & Cyber Security Guidelines, 2023

				escalation matrix		
11	Incident Response	Delayed containment and reporting	Incident Response Plan, escalation procedures, forensic readiness	Review incident register, root cause analysis and lessons learnt	High	IRDAI Guidelines CERT In
12	Data Protection & Privacy	Data leakage, privacy violations	Data classification, encryption, DLP, consent management	Review encryption standards, retention schedules and privacy controls	High	DPDP Act, 2023
13	Application Controls	Inaccurate policy or claims processing	Input validation, maker checker, audit trails	Test automated controls and exception reports in core systems	High	IRDAI Master Circular, 2024
14	API Security	API exploitation	Authentication, encryption, API	Review API inventory,	High	IRDAI Cyber Guidelines

			gateway security	penetration test reports and access controls		
15	Cloud Security	Misconfiguration and data exposure	Secure configuration, encryption, CSP monitoring	Review cloud security posture and third party assurance reports	High	IRDAI Cyber Guidelines
16	Third Party Risk Management	Vendor compromise	Security due diligence, contractual controls, periodic assessments	Review vendor risk assessments, SLA monitoring and audit reports	High	IRDAI Outsourcing Regulations
17	Business Continuity & Disaster Recovery	Extended business disruption	Tested BCP/DR, immutable backups, alternate site	Review DR test reports, recovery metrics and failover evidence	High	IRDAI Cyber Guidelines
18	AI Governance	AI misuse, model	AI governance policy,	Review AI inventory	Medium High	Emerging

		manipulation	human oversight, monitoring	, approvals, monitoring and risk assessments		Industry Practice
19	Digital Channels	Fraud through customer portals	MFA, transaction monitoring, fraud detection	Test authentication, transaction monitoring and customer alerts	High	IRDAI Master Circular
20	Internal Audit & Assurance	Ineffective independent assurance	Risk based IT audit plan, follow up mechanism	Review audit coverage, issue tracking and closure validation	Medium	IRDAI Corporate Governance Regulations

Comprehensive Internal Audit Programme

21.8 The internal audit programme should adopt a **risk based approach**, focusing on governance, preventive controls, detective controls, corrective controls and resilience capabilities. Audit procedures should combine document review, walkthroughs, interviews, configuration reviews, analytics, sampling and independent testing.

The following audit programme may be adapted based on the insurer's technology landscape and risk profile.

A. Cyber Governance

Audit Objectives

Evaluate whether cyber governance is appropriate, effective and aligned with the insurer's business strategy and regulatory expectations.

Documents to Review

- Information Security Policy
- Cyber Security Policy
- IT Strategy
- Board presentations
- Risk Committee minutes
- Information Security Committee minutes
- Cyber Risk Register
- Annual Information Security Report

Audit Procedures

- Review Board approval of cybersecurity policies.
- Verify whether cyber risks are included in the Enterprise Risk Register.
- Assess the adequacy of Board reporting.
- Review cyber Key Risk Indicators (KRIs).
- Evaluate governance structure and reporting lines.
- Verify independence of the CISO function.
- Assess cyber budget allocation and investment planning.

Expected Evidence

- Approved policies
- Committee minutes
- Risk dashboards
- Cyber maturity assessments
- Board presentations

Insurance specific Considerations

Internal audit should verify whether cyber risks relating to policy administration systems, claims processing, digital distribution channels and policyholder data are regularly reviewed by senior management and the Board.

B. Identity and Access Management (IAM)

Audit Objectives

Evaluate whether logical access to systems and information is adequately controlled.

Audit Procedures

- Review user provisioning process.
- Test user access approvals.
- Verify segregation of duties.
- Review privileged accounts.
- Validate dormant account reviews.
- Verify periodic access recertification.
- Review Multi Factor Authentication (MFA) implementation.
- Review emergency access procedures.

Expected Evidence

- User access matrix
- Joiner Mover Leaver reports
- Access approval forms
- Active Directory reports
- Privileged user reports

Sample Testing

Select samples covering:

- New users
- Terminated employees
- Third party users

- Temporary IDs
- Privileged IDs

Insurance specific Considerations

Special attention should be given to:

- Claims approval systems
- Premium collection applications
- Policy servicing platforms
- Bancassurance portals
- Agency portals
- Customer mobile applications

C. Change Management

Audit Objectives

Determine whether system changes are appropriately authorised, tested and migrated.

Audit Procedures

- Review Change Advisory Board approvals.
- Test emergency changes.
- Verify migration approvals.
- Review rollback procedures.
- Assess segregation between developers and production support.
- Verify post implementation reviews.

Expected Evidence

- Change requests
- UAT documents
- CAB minutes
- Migration approvals
- Rollback plans

Insurance specific Considerations

Evaluate changes impacting:

- Premium calculation engines
- Claims workflows
- Underwriting rules
- Commission calculations
- Product configuration

D. Vulnerability & Patch Management

Audit Objectives

Assess whether vulnerabilities are identified, prioritised and remediated within defined timelines.

Audit Procedures

- Review vulnerability scan reports.
- Analyse ageing of critical vulnerabilities.
- Verify patch deployment timelines.
- Review penetration testing reports.
- Validate remediation of high-risk findings.
- Assess exception approval process.

Expected Evidence

- VA/PT reports
- Patch dashboards
- Risk acceptance approvals
- Closure reports

Analytics

Internal audit should perform:

- Ageing analysis of vulnerabilities.
- Percentage of critical vulnerabilities pending.

- Patch compliance by server category.
- Repeat vulnerabilities.
- Exception analysis.

Insurance specific Considerations

Priority should be given to internet facing applications supporting:

- Online policy issuance
- Customer portals
- Mobile applications
- Payment gateways
- API integrations

E. Security Operations Centre (SOC)

Audit Objectives

Evaluate whether security monitoring effectively detects and responds to cyber threats.

Audit Procedures

- Review SIEM coverage.
- Evaluate alert monitoring.
- Review use cases.
- Test escalation procedures.
- Assess threat intelligence integration.
- Review incident closure reports.
- Evaluate SOC staffing.

Expected Evidence

- SIEM dashboards
- Incident logs
- SOC reports
- Threat intelligence reports
- Escalation matrix

Insurance specific Considerations

Verify monitoring of:

- Policy administration systems
- Claims systems
- Internet facing applications
- Customer authentication failures
- Payment gateway activity

F. Third Party Cyber Risk

Audit Objectives

Assess whether outsourced service providers maintain cybersecurity standards consistent with regulatory expectations.

Audit Procedures

- Review vendor onboarding.
- Review cybersecurity due diligence.
- Verify contractual security clauses.
- Review independent assurance reports (SOC 1/SOC 2, ISO 27001 certificates).
- Assess periodic vendor reviews.
- Verify exit management.

Expected Evidence

- Vendor assessments
- Contracts
- SLA reports
- Information security questionnaires
- Independent audit reports

Insurance specific Considerations

Review critical service providers including:

- Cloud providers

- TPAs
- Digital payment partners
- Call centres
- Data centres
- Managed Security Service Providers (MSSPs)
- Core insurance software vendors

Key Audit Focus

Throughout the audit programme, internal auditors should maintain particular focus on:

- Protection of policyholder and sensitive personal data.
- Compliance with the DPDP Act, 2023.
- Cyber resilience of core insurance operations.
- Security of digital distribution and servicing channels.
- Oversight of outsourced technology service providers.
- Effectiveness of governance and independent assurance mechanisms.

Installment 4 – Red Flags, Common Deficiencies, Emerging Risks and Regulatory References

Red Flags

21.9 During an internal audit of cybersecurity and IT controls, auditors should remain alert to indicators that may signify control weaknesses, governance failures, cyber compromise or regulatory non-compliance. While an isolated red flag may not necessarily indicate a material deficiency, multiple indicators should prompt a more detailed investigation.

Governance and Oversight

- Cybersecurity policy not approved or periodically reviewed by the Board.
- Absence of a Board approved cyber risk appetite.
- Cybersecurity not included as a standing agenda item in Board or Risk Committee meetings.
- No documented cyber maturity assessment or roadmap.

- Repeated postponement of remediation of high-risk cyber issues.
- Inadequate oversight of outsourced technology service providers.

Identity and Access Management

- Shared user IDs used for critical business applications.
- Generic administrator accounts without accountability.
- Privileged accounts assigned to business users without adequate justification.
- Dormant user accounts remaining active beyond the defined period.
- Delays in revoking access following employee separation or transfer.
- Excessive privileged access rights inconsistent with job responsibilities.
- Multi Factor Authentication (MFA) not implemented for privileged or remote access.

Infrastructure and Network Security

- Critical servers operating on unsupported operating systems.
- Internet facing systems with unresolved high-risk vulnerabilities.
- Firewall rules permitting unrestricted inbound or outbound access.
- Security patches significantly overdue for critical systems.
- Antivirus or Endpoint Detection and Response (EDR) solutions not deployed uniformly.
- Incomplete logging or monitoring of critical infrastructure.

Application Security

- Production changes implemented without approval or testing.
- Developers having unrestricted access to production environments.
- Inadequate segregation of duties between development, testing and production.
- Critical business applications without secure coding or vulnerability assessments.
- APIs exposed without authentication or encryption.

Data Protection

- Unencrypted storage of policyholder or health related information.
- Customer data copied to local devices or removable media.
- Absence of data classification and retention standards.
- Sensitive information transmitted through unsecured channels.
- Lack of monitoring over privileged downloads or bulk extraction of customer information.

Third Party Risk

- Cloud service providers not subjected to cybersecurity due diligence.
- Absence of security clauses in outsourcing agreements.
- No periodic review of vendor security posture.
- Third party access remaining active after contract termination.
- No independent assurance reports (e.g., SOC reports or ISO certification) for critical vendors.

Business Continuity and Incident Management

- Disaster Recovery (DR) tests not conducted within the prescribed frequency.
- Recovery Time Objectives (RTO) and Recovery Point Objectives (RPO) consistently not achieved.
- Backup restoration testing not performed.
- Cyber incidents recurring without root cause remediation.
- Delays in reporting reportable cyber incidents to appropriate authorities.

Commonly Observed Deficiencies

21.10 The following observations are frequently reported during internal audits of insurers and should receive focused attention.

Sr. No.	Area	Illustrative Deficiency	Potential Impact
1	Governance	Cyber strategy not aligned with enterprise risk management	Weak governance and oversight
2	Information Security	Policies outdated or not communicated	Inconsistent implementation
3	Asset Management	Incomplete inventory of IT assets	Unmanaged cyber exposure
4	User Access	Delayed de provisioning of users	Unauthorized access
5	Privileged Access	Privileged IDs not periodically reviewed	Increased fraud risk
6	Change Management	Emergency changes without post implementation review	Production instability
7	Vulnerability Management	Critical vulnerabilities pending beyond defined timelines	Increased cyber risk
8	Patch Management	Patch exceptions not approved	Exposure to known exploits
9	Network Security	Firewall rules not periodically reviewed	Unauthorized network access
10	Endpoint Security	Inconsistent deployment of EDR	Increased malware risk
11	Security Monitoring	SIEM not integrated with all critical applications	Delayed detection
12	Incident Management	Lessons learned not documented	Repeat incidents
13	Data Protection	Encryption not implemented for sensitive databases	Data leakage

14	Application Controls	Inadequate maker checker controls	Processing errors
15	API Security	Weak authentication mechanisms	Data compromise
16	Cloud Security	Misconfigured cloud storage	Public exposure of sensitive information
17	Vendor Management	Inadequate cyber due diligence	Third party compromise
18	Business Continuity	DR testing limited to infrastructure	Business disruption
19	AI Governance	No governance over GenAI tools used by employees	Data leakage and compliance risks
20	Internal Audit	Limited coverage of emerging cyber risks	Assurance gaps

Emerging Risks for Internal Audit

21.11 The cyber risk landscape continues to evolve rapidly. Internal audit plans should be refreshed annually to address new technologies, changing threat vectors and regulatory expectations. Audit should evaluate:

Artificial Intelligence (AI)

- Governance over approved AI use cases.
- Protection of confidential information used in AI tools.
- Validation of AI generated outputs.
- Human oversight over critical AI assisted decisions.
- Monitoring of model bias, accuracy and explainability.

Generative AI and Shadow AI

Employees increasingly use publicly available AI tools to draft communications, analyse data and generate code. Risks include:

- Disclosure of confidential policyholder information.
- Intellectual property leakage.

- Inaccurate AI generated outputs.
- Use of unapproved AI platforms.

Internal audit should assess whether management has established policies governing the use of Generative AI and implemented appropriate technical safeguards.

Cloud Concentration Risk

Reliance on a limited number of cloud service providers may expose insurers to systemic operational disruption.

- Multi region resilience.
- Exit strategies.
- Vendor dependency assessments.
- Periodic resilience testing.

API Ecosystem Risk

Insurance ecosystems increasingly rely on APIs connecting insurers with intermediaries, banks, aggregators, payment gateways and government platforms.

- API inventory.
- Authentication mechanisms.
- Encryption standards.
- API monitoring.
- Secure development practices.

Software Supply Chain Risk

Third party software components and open source libraries may introduce vulnerabilities.

- Software Bill of Materials (SBOM) where applicable.
- Vendor vulnerability monitoring.
- Secure code reviews.
- Patch governance.

Ransomware Preparedness

- Immutable backups.
- Offline backup strategy.
- Restoration testing.
- Ransomware playbooks.
- Crisis communication protocols.
- Cyber insurance coverage (where applicable).

Quantum Computing Readiness

Although still evolving, organisations should begin assessing:

- Cryptographic inventory.
- Long term data confidentiality.
- Transition planning towards quantum resistant cryptography.

Operational Resilience

Internal audit should move beyond disaster recovery testing to evaluate end to end operational resilience covering people, processes, technology, third parties and customer services.

Chapter 22
Financial Closing Process

Introduction

22.1 The financial closing process (FCP) in Indian life insurance companies is a highly specialized exercise that integrates conventional corporate accounting with actuarial science and regulatory compliance. Unlike typical businesses where profit determination is straightforward, insurers operate under long term contractual obligations that span decades. This necessitates a closing process that not only reconciles daily transactions but also validates solvency, ensures policyholder protection and aligns with statutory frameworks mandated by the Insurance Regulatory and Development Authority of India (IRDAI).

The objective of this report is to provide a detailed analysis of the scope, objectives and sub processes of the FCP, highlighting its unique features and regulatory underpinnings.

Scope and Objectives

22.2 Objective of Financial closing process are as follows:

- Ensure timely, accurate and compliant reporting of financial health.
- Prepare statutory accounts:

The Revenue Account (Policyholders' Account) is the primary financial statement for insurers under IRDAI regulations, presented in Form L 1. It captures premiums earned, reinsurance transactions, investment income and benefits/claims paid, ensuring transparency in policyholder fund management.

Structure of the Revenue Account (Policyholders' Account)

Key Components

- **Premiums Earned – Net**
    - Premium income (gross)
    - Less: Reinsurance ceded
    - Plus: Reinsurance accepted

- **Income from Investments**
  - Interest, dividends and rent (gross)
  - Profit/loss on sale/redemption of investments
  - Revaluation gains/losses
  - Other income
- **Other Income**
  - Fees, charges and miscellaneous receipts
- **Benefits Paid**
  - Claims settled (gross)
  - Less: Reinsurance recoveries
  - Add: Claims outstanding
- **Commission & Operating Expenses**
  - Commission to agents/brokers
  - Management expenses (subject to IRDAI limits)
- **Change in Valuation of Liabilities**
  - Actuarial valuation of reserves
  - Adjustment for linked/non-linked liabilities
- **Surplus/Deficit**
  - Transferred to Policyholders' Fund or Shareholders' Account

Mandatory IRDAI Forms

22.3 Insurance companies must prepare and disclose the following IRDAI prescribed schedules and forms:

Form No.	Description
L 1	Revenue Account (Policyholders' Account)
L 2	Profit & Loss Account
L 3	Balance Sheet

L 4	Premium Schedule
L 5	Commission Schedule
L 6	Operating Expenses Schedule
L 7	Benefits Paid Schedule
L 13	Reserve & Surplus
L 14/L 15	Investments (Shareholders & Policyholders)
L 23/L 24	Analytical Ratios & Valuation of Liabilities

Regulatory Basis

- Governed by Insurance Act, 1938 and IRDAI (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002.
- Must comply with Companies Act, 2013 and Indian Accounting Standards (Ind AS).
- Quarterly and annual disclosures are mandatory, with formats published on insurers' websites and filed with IRDAI.

Key Compliance Considerations

- Expense of Management must remain within IRDAI limits.
- Solvency Margin (minimum 150%) must be disclosed alongside the Revenue Account.
- Actuarial Certification is required for liability valuation.
- Transparency: All schedules must be published in public disclosures (quarterly/annual).

In Summary: The Revenue Account (Policyholders' Account) is presented in **Form L 1**, supported by detailed schedules (L 4 to L 7, etc.) and is a cornerstone of insurer reporting under IRDAI. It ensures policyholder funds are accounted for with full disclosure of

- Profit & Loss Account (Shareholders' Account)

Profit & Loss Account (Shareholders' Account) in the context of an Indian life insurance company. This is a critical part of financial reporting under IRDAI regulations and the Companies Act and it differs from the Policyholders' Account because it reflects the insurer's own profitability rather than the performance of insurance operations.

Purpose

22.4 The Shareholders' Account (Profit & Loss Account) shows the financial results attributable to shareholders. It captures:

- Income from investments of shareholder funds.
- Expenses incurred for managing shareholder activities.
- Transfers from the Policyholders' Account (if surplus exists).
- Tax provisions and appropriations.

This account essentially reflects the insurer's net profit or loss available for distribution (dividends, reserves, etc.).

Structure and Key Components

22.5 Structure and Key Components are as follows:

1. Income

- **Investment Income**: Interest, dividends and realized gains from shareholder fund investments.
- **Other Income**: Miscellaneous receipts not related to policyholder funds.

2. Expenses

- **Operating Expenses**: Management expenses attributable to shareholder activities.
- **Interest & Finance Charges**: If borrowings exist.
- **Depreciation/Amortization**: On shareholder owned assets.

3. Transfers

- **Transfer from Policyholders' Account**: Surplus arising in the policyholders' account may be transferred here, subject to IRDAI approval and actuarial certification.

- **Transfer to Policyholders' Account**: If there is a deficit in the policyholders' account, shareholders may need to support it.

4. Profit Before Tax

- Calculated after deducting expenses and adding transfers.

5. Taxation

- Provision for current tax.
- Deferred tax adjustments.

6. Appropriations

- **Dividend Declaration**: Interim/final dividend to shareholders.
- **Transfer to Reserves**: Statutory reserve requirements under the Insurance Act, 1938.
- **Retained Earnings**: Balance carried forward.

Format (Simplified)

Profit & Loss Account (Shareholders' Account)

Particulars	Amount (₹)
Income	
Investment Income	xxx
Other Income	xxx
Total Income	xxx
Expenses	
Operating Expenses	xxx
Finance Charges	xxx
Depreciation	xxx
Total Expenses	xxx
Profit Before Tax	xxx

Provision for Tax	xxx
Profit After Tax	xxx
Appropriations:	
Transfer to Reserves	xxx
Dividend	xxx
Balance carried forward	xxx

Regulatory References

- **Insurance Act, 1938** – governs statutory reserves and dividend distribution.
- **IRDAI (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002** – prescribes format for Shareholders' Account.
- **Companies Act, 2013** – provisions on dividend declaration, reserves and disclosure.
- **Income Tax Act, 1961** – taxation rules applicable to insurers.

In Essence: The Shareholders' Account isolates the insurer's own profitability, independent of policyholder operations, ensuring transparency for investors, regulators and the board. It is the account that ultimately determines dividend paying capacity and retained earnings.

Balance Sheet of Insurers

A balance sheet of insurers is a financial statement that shows the financial position of an insurance company at a specific point in time. It is structured like any corporate balance sheet, but insurers have unique features because of the nature of their business managing risks, collecting premiums and paying claims. Let me break it down clearly:

Structure of an Insurer's Balance Sheet

1. Assets

These represent what the insurer owns or controls.

- **Investments**: The largest portion, including government securities, corporate bonds, equities, real estate. Insurers invest premiums to generate returns.
- **Cash & Bank Balances**: Liquidity for immediate obligations.
- **Reinsurance Assets**: Recoverables from reinsurers for claims ceded.
- **Receivables**: Premiums due but not yet collected.
- **Deferred Acquisition Costs (DAC)**: Costs of acquiring new policies (like commissions) spread over the policy term.

2. Liabilities

These represent obligations the insurer must fulfill.

- **Policyholder Liabilities**:
  - **Life Insurers**: Mathematical reserves for future policy benefits.
  - **General Insurers**: Unearned premium reserves, outstanding claims reserves.
- **Claims Payable**: Reported but unpaid claims, plus IBNR (Incurred But Not Reported) claims.
- **Reinsurance Payables**: Amounts owed to reinsurers.
- **Debt & Borrowings**: If any, though insurers typically rely more on reserves than debt.
- **Other Liabilities**: Taxes payable, accrued expenses.

3. Equity (Shareholders' Funds)

This represents the net worth of the insurer.

- **Share Capital**: Funds invested by shareholders.
- **Reserves & Surplus**: Retained earnings, statutory reserves and contingency reserves.
- **Fair Value Reserves**: Unrealized gains/losses on investments.

Key Features Unique to Insurers

- **High Proportion of Liabilities**: Policyholder obligations dominate the balance sheet.

- **Asset Liability Matching**: Insurers must align investments with expected claim payouts (long term bonds for life insurance, liquid assets for general insurance).
- **Regulatory Requirements**: In India, IRDAI mandates solvency margins (minimum excess of assets over liabilities) to ensure financial stability.
- **Reinsurance Impact**: Both assets and liabilities are shaped by reinsurance contracts.

Example (Simplified Balance Sheet of an Insurer)

Assets	Liabilities & Equity
Investments – ₹10,000 Cr	Policyholder Liabilities – ₹8,000 Cr
Cash & Bank – ₹500 Cr	Claims Payable – ₹1,000 Cr
Reinsurance Assets – ₹300 Cr	Reinsurance Payables – ₹200 Cr
Receivables – ₹200 Cr	Other Liabilities – ₹300 Cr
DAC – ₹100 Cr	Equity (Capital + Reserves) – ₹1,600 Cr

In Summary: The balance sheet of insurers highlights how premiums collected are invested, how reserves are built to meet claims and how solvency is maintained to protect policyholders. Unlike manufacturing firms, insurers' balance sheets are liability heavy, reflecting their promise to pay future claims.

Scope

- Covers daily transactional accounting and long term actuarial valuations.
- Key areas include:
- IRDAI Compliance: Adherence to statutory guidelines.

Latest IRDAI Master Circular (May 2024) issued under Regulation 7 of the IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations, 2024:

Highlights of the Master Circular (May 2024)

1. Actuarial Functions

- Insurers must appoint a Chief Actuary approved by IRDAI.
- Actuarial valuations must follow Indian GAAP and IRDAI guidelines.
- Disclosure of assumptions (mortality, persistency, discount rates) is mandatory.
- Actuary must certify solvency margins and policyholder liabilities.

2. Finance Functions

- Insurers must maintain true and fair accounts in line with the Insurance Act, 1938.
- Quarterly and annual returns must be filed in prescribed formats.
- Internal audit and statutory audit requirements are reinforced.
- CFO must ensure compliance with prudential norms.

3. Investment Functions

- Investments must comply with Section 27 of the Insurance Act, 1938 and IRDAI Investment Regulations.
- Clear segregation between policyholder funds and shareholder funds.
- Exposure limits to a single entity, sector, or instrument are capped.
- Board approved Investment Policy is mandatory, reviewed annually.

4. Governance & Oversight

- Board of Directors must approve policies on actuarial, finance and investment functions.
- Annual review of compliance with Regulation 7 circulars.
- IRDAI may issue clarifications to remove interpretational difficulties.

Legal Reference

- **Regulation 7**: Empowers IRDAI to issue binding Master Circulars on actuarial, finance and investment functions.

- **Authority**: Derived from Section 34 of the Insurance Act, 1938 and Section 14 of the IRDA Act, 1999.
- **Applicability**: All insurers, including reinsurers, unless exempted.

In short, Regulation 7 is the enabling provision and the May 2024 Master Circular is the detailed compliance framework insurers must follow for actuarial, finance and

- **Dual Accounting Standards**: Alignment with Indian GAAP and IRDAI
- specific regulations.

Here's a detailed elaboration of the two points you mentioned : AS 3 (Cash Flow Statements) and AS 17 (Segment Reporting) in the context of Indian insurers under IRDAI's regulatory framework:

AS 3 – Cash Flow Statements (Direct Method)

- **Requirement**: Insurers must prepare their cash flow statements in accordance with Accounting Standard 3 (AS 3).
- **Direct Method**:
  - Cash flows from operating activities are presented by showing major classes of gross cash receipts and payments (e.g., premiums received, claims paid, commissions, reinsurance settlements).
  - This method provides greater transparency compared to the indirect method, as it shows actual cash inflows/outflows rather than reconciling net profit with cash.
- **Key Components**:
  - **Operating Activities**: Premium collections, claims settlements, reinsurance transactions, commissions and management expenses.
  - **Investing Activities**: Purchase/sale of investments, acquisition/disposal of fixed assets.
  - **Financing Activities**: Issue/redemption of shares, borrowings, dividend payments.
- **Regulatory Note**: IRDAI mandates the **Direct Method** for insurers to ensure clarity in cash movements, given the unique nature of insurance operations (large premium inflows and claim outflows).

AS 17 – Segment Reporting

- **Applicability**: AS 17 applies to all insurers, irrespective of listing status or turnover thresholds.
- **Purpose**: To provide detailed disclosure of financial performance across different segments of insurance business.
- **Segments in Insurance**:
  - Life Insurance (individual, group, pension, annuity)
  - General Insurance (motor, health, fire, marine, liability, etc.)
  - Reinsurance
- **Disclosures Required**:
  - Segment revenue, segment results, segment assets and liabilities.
  - Basis of segmentation (business lines, geographical areas).
  - Inter segment transfers and eliminations.
- **Why Mandatory for Insurers**:
  - Insurance companies often operate across diverse lines of business with different risk profiles.
  - Segment reporting ensures **policyholder protection**, **regulatory oversight** and **comparability** across insurers.
  - Even small or unlisted insurers must comply, as risk exposure in insurance is not proportional to turnover alone.

In summary:

- **AS 3 (Direct Method)** ensures insurers present transparent cash flow statements showing actual inflows/outflows.
- **AS 17 (Segment Reporting)** is **universally applicable to all insurers**, ensuring detailed disclosure of performance across different insurance segments, regardless of size or listing status.
- **Asset Liability Matching (ALM)**: Ensuring investments match policyholder liabilities.

Core Sub Processes

Data Aggregation & Reconciliation

- **Premium & Commission Reconciliation**: Matching collections across banks, agents and digital channels.
- **Claims Provisions**: Capturing settled claims, claims in progress and IBNR/IBNER claims.
- **Bank & Investment Reconciliations**: Aligning balances with custody accounts.

Actuarial Valuation (The Core Pillar)

- **Mathematical Reserves**: Present value of future benefits minus premiums.
- **Bonus Declaration**: Surplus distribution for participating products (90:10 ratio between policyholders and shareholders).

Investment Accounting & Fund Valuation

- Management of Life Fund, Pension & Annuity Fund, ULIPs.
- **NAV Calculation**: Daily computation and verification for ULIPs.
- **Prudential Norms**: Compliance with IRDAI's sectoral investment limits.

Provisioning, Tax and Consolidation

- **Solvency Margin Estimation**: Ensuring solvency ratio $\geq$ 1.50 as per IRDAI.
- **Taxation**: Specialized insurance tax structures based on actuarial surplus.
- **Financial Statement Preparation**: IRDAI prescribed formats for board approval and audit.

Regulatory Framework

Here's a comprehensive breakdown of the IRDAI (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002, along with a summary of Schedules A, B and C:

Overview of the Regulations

- **Authority**: Issued under the Insurance Act, 1938 and IRDA Act, 1999.

- **Applicability**: All insurers and reinsurers registered in India.
- **Objective**: To ensure uniformity, transparency and accountability in financial reporting.
- **Key Requirements**:
    - Preparation of financial statements in prescribed formats.
    - Submission of auditor's report in a standardized structure.
    - Management report highlighting governance, compliance and operational aspects.

Schedule A – Life Insurance Companies

- **Revenue Account**: Premium income, claims incurred, commissions, operating expenses.
- **Profit & Loss Account**: Transfer from revenue account, investment income, surplus/deficit.
- **Balance Sheet**:
    - Share capital, reserves, borrowings.
    - Policyholder liabilities (mathematical reserves).
    - Investments, fixed assets, cash & bank balances.
- **Notes & Schedules**: Detailed disclosures on investments, claims, solvency margin, contingent liabilities.

Schedule B – General Insurance Companies

- **Revenue Account**: Segment wise reporting (fire, marine, motor, health, etc.).
- **Profit & Loss Account**: Net underwriting results, investment income, operating surplus/deficit.
- **Balance Sheet**:
    - Shareholders' funds.
    - Technical reserves (unexpired risk reserve, claims outstanding).
    - Investments, debtors, cash & bank balances.

- **Notes & Schedules**: Segmental reporting, claims ageing, reinsurance arrangements, contingent liabilities.

Schedule C – Auditor's Report

- **Scope**: Independent audit opinion on financial statements.
- **Contents**:
    - Compliance with accounting standards and IRDAI regulations.
    - Adequacy of provisions for claims and reserves.
    - Verification of investments and adherence to IRDAI norms.
    - Confirmation of solvency margin compliance.
    - Observations on internal controls and governance.

Importance of These Schedules

- **Schedule A**: Ensures life insurers disclose actuarial reserves and policyholder liabilities transparently.
- **Schedule B**: Provides clarity on segment wise performance for general insurers.
- **Schedule C**: Strengthens governance by mandating independent auditor oversight.

In short, these regulations and schedules form the bedrock of financial reporting for Indian insurers, ensuring policyholder protection, solvency monitoring and regulatory compliance.

Key Takeaways

- The FCP is a multi disciplinary exercise, blending accounting, actuarial science and compliance.
- It ensures policyholder protection by validating solvency and prudent investment practices.
- The process is deadline driven, requiring coordination across finance, actuarial and investment teams.
- Ultimately, it bridges daily operations with long term sustainability, proving the insurer's ability to remain solvent and trustworthy.

ANNEXURES

Annexure 1
Eligibility Certificate and Appointment Formality of Internal Auditors

An eligibility or consent letter is a formal written document provided by a prospective auditor, confirming they meet the statutory requirements under the Companies Act, 2013 and IRDAI regulations to act as an internal auditor for a life insurance company.

Eligibility Criteria

As per Section 2 b (d) of the Master Circular Ref IRDA/F&I/CIR/INV/226/ 10/2022 dated October 27, 2022 on Investments following are the eligibility criteria for appointment of Internal Auditor

Professional Standing: Must be a Chartered Accountant (CA) registered with the Institute of Chartered Accountants of India or Cost Accountant (CMA), either in practice or employment, or another professional designated by the Board.

Experience: The Audit firm should have experience, for at least four years, in conducting reviews of Risk Management Systems and Process of either Banks or Mutual Funds or Insurance Companies or have, on behalf of IRDAI conducted Investment Inspection of Insurance Companies

Limit on number of Audits: On the date of appointment as an Auditor the Auditor must not hold more than two audits of Internal, Concurrent and Risk Management Systems Audit, all taken together.

Hence, the Audit firm, can at the maximum hold not more than three Audits (i.e., Investment Risk Management Systems and Process Audit, Internal Audit, Concurrent Audit – all taken together), apart from Statutory Audits at any point of time.

For this purpose, at the time of appointment, the insurer shall obtain a declaration to this effect from the firm of Chartered Accountants. The Insurer shall, file with IRDAI, the confirmation obtained from the Chartered Accountant firm, within 7 days of such appointment.

Additionally, an audit firm cannot simultaneously audit more than three insurance companies (with a maximum limit of two life or two general insurance companies).

Disqualification: The Auditor should not have been prohibited/debarred by any regulating agency including IRDAI, RBI, SEBI, ICAI etc.

Tenure: The Internal/Concurrent audit term shall be for the financial year and where the appointment is made during the course of the financial year, it shall be up to the end of that financial year.

Reporting: The Internal Auditor shall be appointed by the Audit Committee of the Insurer's Board and the Auditor shall directly report to the Audit Committee of the Insurer's Board.

Any change in Auditor during the middle of the term, shall be communicated to IRDAI with the reasons for such change. The new Auditor, only for the remaining term, shall be appointed only with the prior approval of IRDAI.

Re-appointment: The Internal/ Concurrent Auditor shall not be eligible for re appointment, with the same Insurer after serving three consecutive years or three years during the preceding five years.

Types of Audits: The Internal/ Concurrent Auditor appointed for the first time should NOT have conducted the following assignments for the same Insurer proposing to be appointed as Internal or Concurrent Auditor for Investment functions during a period of two years immediately preceding his appointment as Internal or Concurrent auditor.

(a) Statutory Audit

(b) Any Internal Audit

(c) Any Concurrent Audit

(d) Any consulting assignment, whether or not related to Audit functions

(e) Reviews or Certification of Investment Risk Management Systems and Process

Independence: No conflicts of interest exist with the Company or its KMPs

Information of Audit Firm for Internal/ Concurrent Audit to be filed with IRDAI

1. Name of the Chartered Accountant firm.

2. Year of establishing the firm, Partners with contact details.
3. Address of Head Office of the Audit Firm.
4. Experience Details, (relevant for Insurer's Risk Management Systems Audit/ Statutory Audit/ Internal Audit/ Concurrent Audit) as provided by the Firm.
5. Name of the Partner along with contact details, responsible for signing Risk Management Audit Report/ Internal Audit Report/ Concurrent Audit Report.
6. All the above information shall be filed with IRDAI, within 7 days from the date of appointment.

Sample Eligibility & Consent Letter Format

On the auditor's or audit firm's official letterhead.

[Date]

To,
The Board of Directors,
[Name of Life Insurance Company]
[Company Address]

Subject: Consent and Certificate of Eligibility for Appointment as Internal Auditor

Dear Sir/Madam,

With reference to your proposal/discussion regarding the appointment of our firm as the Internal Auditor of **[Name of Life Insurance Company]** for the Financial Year **[YYYY YY]**, I/we hereby convey my/our formal consent to act as the Internal Auditor of the Company.

I/We also certify that my/our appointment, if made, will be in accordance with the conditions prescribed under Section 138 of the Companies Act, 2013 and the guidelines issued by the Insurance Regulatory and Development Authority of India (IRDAI).

I/We further certify that:

1. I am/we are eligible for appointment and are not disqualified for appointment as an auditor under Section 141 of the Companies Act, 2013.

2. The proposed appointment is within the limits and conditions prescribed by the IRDAI regarding the number of concurrent/internal audits of insurance companies that an auditor can undertake.
3. I/We am/are not indebted to the company and have no material interest in or relationship with the company, its directors, or its key managerial personnel.
4. I/We am/are have not been prohibited/debarred by any regulating agency including IRDAI, RBI, SEBI, ICAI etc.
5. I/We have not been convicted of any offense involving fraud and there are no ongoing disciplinary proceedings against us with the ICAI/ ICMAI.

Details of the firm name, address, experience is presented below

Sr. No.	Requirements	Details
1	Name of the Chartered Accountant firm	
2	Year of establishing the firm, Partners with contact details	
3	Address of Head Office of the Audit Firm	
4	Experience Details, (relevant for Insurer's Risk Management Systems Audit/ Statutory Audit/ Internal Audit/ Concurrent Audit) as provided by the Firm	
5	Name of the Partner along with contact details, responsible for signing Risk Management Audit Report/ Internal Audit Report/ Concurrent Audit Report	

Kindly accept this letter as our formal consent and eligibility confirmation for the said appointment.

Thanking you,

Yours faithfully,

For [Name of Auditor/ Audit Firm]
[Signature]
[Name of the Auditor/ Partner]
[Designation]

Annexure 2
Illustrative (Sample) Internal Audit Report

ABC LIFE INSURANCE CO.

INTERNAL AUDIT REPORT:FY xxxx xx

AREA: XXXX For The Period xxxx

Detailed Report No: DR/xx/xxxx xx

1. INTRODUCTION

We, M/S XYZ, Chartered Accountants were appointed vide appointment letter dated xxxxx to conduct internal audit for ABC Life Insurance Company Ltd ("ABC"). One of the areas assigned to us was "xxxxx. As explained, the internal audit was expected to focus on process reviews and was not intended to be a detailed transaction based review.

The internal audit was performed by our team at the xxxx (location) from xxxx to xxxx. The reference period considered for our internal audit was April xxxx to December xxx and our samples for review were drawn from this period.

2. SCOPE & AUDIT APPROACH

We have covered the transaction for the period xxxx. For the purpose of checking, samples were selected based on the following:

Scope:

The internal audit scope is as per **Annexure I** to this report. As detailed in the scope, our audit covered the verification of operations performed by xxxxx

The internal audit work undertaken by us makes useful comments and suggestions and it should be appreciated that the report should not be relied upon to disclose all irregularities that may exist. All points have been discussed and agreed with the relevant manager(s) whose responses have been recorded.

Audit Approach:

The audit approach adopted by us comprised of:

- Initial meeting with Mr. xxx Head – xxx to understand our scope and timeline for execution.
- Interactions, to obtain broad understanding of xxx functions, with Ms xxx, Head –xxxx.
- Detailed interactions with various persons of the xxx team for in depth understanding of the processes and IT systems in use.
- Review of Standard Guidelines (Version x) and User Guide
- Review of previous audit report to understand areas of concern as identified therein.
- Process review to confirm whether processes as documented and explained are actually operational.
- Discussions of observations with concerned executives of xxx operations and discussion of draft report with Mr. xxx designation xxx. The Head xxxx has responded to our audit observations.
- Discussion of draft report with Mr. xxxx, Head Internal Audit
- Issue of final report, comprising of Executive Summary and Detailed report.

3. PROCESS/POLICY DOCUMENT RELIED UPON

Document	Version
Xxxx	
Xxxx	
Xxxx	
Xxxx	
Xx	

4. OVERVIEW

(Give a brief of operations of the area/function/department being audited)

5. AUDIT OBSEVATIONS

Points to be considered while drafting the observation

Field	Description
Observation ID	Unique audit observation reference number
Audit Area	Claims/ Commission
Process/ Sub process	Relevant process under review
Audit Theme	Operational/ Regulatory Compliance/ Financial Reporting/ Governance
Risk Rating	High/ Medium/ Low
Observation	Detailed description of the issue identified
Regulatory Reference	Applicable IRDAI regulation, circular, guideline or internal policy
No. of Exceptions	Number of deviations identified
Financial Impact	Actual or estimated financial impact
Risk Implication	Operational, financial, regulatory or reputational impact
Root Cause	Underlying cause of the deficiency
Recommendation	Auditor's recommendation
Management Action Plan	Agreed corrective action
Responsibility	Process owner responsible for remediation
Target Date	Agreed completion date
Status	Open/ In Progress/ Closed

(Presentation of Sample Observations)

CLAIMS

Particular	**Observation Title (Delay in Settlement of Death Claims)**	**Rating High**
Observation	Death claims were settled beyond timelines prescribed under applicable IRDAI regulations after receipt of complete documentation.	
Root Cause	Inadequate monitoring of ageing claims and lack of automated escalation controls.	
Implication	Regulatory non-compliance, customer dissatisfaction, grievance escalation and reputational risk.	
Recommendation	Implement system based ageing dashboards and escalation workflows for pending claims.	
Implementation Schedule 3 Months		**Responsibility** Configure automated alerts and establish periodic review by Claims Head.

Particular	Inadequate Investigation of Early Claims	Rating High
Observation	Investigation reports for selected early claims were incomplete or lacked documented approval prior to settlement.	
Root Cause	Weak supervisory review and ineffective maker checker controls.	
Implication	Increased exposure to fraudulent claims and financial losses.	
Recommendation	Strengthen investigation review controls and configure system restrictions to prevent settlement without requisite approvals.	
Implementation Schedule 3 Months	**Responsibility** Mandatory approval workflow to be incorporated in claims processing system. Head – Claims Operations	

Particular	Deficiencies in Claims Reserve Reconciliation (IBNR/ IBNER)	Rating High
Observation	Variances were observed between actuarial reserve calculations and balances recorded in financial books. Reconciliations were not performed on a timely basis.	
Root Cause	Absence of formal reconciliation ownership and review mechanism.	
Implication	Potential misstatement of technical liabilities and financial statements.	
Recommendation	Establish monthly reconciliation between actuarial and finance records with documented review and approval.	

Implementation Schedule	Responsibility
2 months	Joint reconciliation process to be implemented by Finance and Actuarial functions. CFO and Appointed Actuary

COMMISSION

Particular	Commission Paid to Ineligible Agents	Rating High
Observation	Commission payments were processed despite expiry of intermediary license and/or mandatory KYC documentation.	
Root Cause	Absence of automated validation controls within commission processing systems.	
Implication	Regulatory non-compliance and risk of payments to ineligible intermediaries.	
Recommendation	Introduce system validations to block commission payments where intermediary credentials are not current.	

Implementation Schedule	Responsibility
3 Months	Integrate agency management database with commission payment module. Agency Administration

Particular	Inadequate Review of Commission Accruals	Rating Medium
Observation	Commission payments were processed despite expiry of intermediary license and/or mandatory KYC documentation.	
Root Cause	Absence of automated validation controls within commission processing systems.	

Implication	Regulatory non-compliance and risk of payments to ineligible intermediaries.
Recommendation	Introduce system validations to block commission payments where intermediary credentials are not current.

Implementation Schedule	**Responsibility**
3 Months	Integrate agency management database with commission payment module. Agency Administration

Annexure I Detailed Audit Scope

Following are the list of processes audited by us.

Sr No	Process	Details of checking
	Xxxx	

Annexure 3
Sample Audit Programs

Internal Audit Programmes for a Life Insurance Company

Standards and Regulatory Basis

The audit programme should be framed under the ICAI Standards on Internal Audit.

The key SIAs to be referred to are:

SIA	Relevance to life insurance internal audit
QSIA 1 & QSIA 2	Covers quality assurance, peer review, independent assessment and continuous improvement of the internal audit function.
SIA 110 & SIA 120	Establishes the principles of internal audit and defines the scope, objectives and terms of the engagement.
SIA 130	Provides guidance on planning, managing, supervising and monitoring the internal audit function.
SIA 140 & SIA 150	Covers evaluation of internal controls and the entity's risk management framework.
SIA 160	Covers compliance with applicable laws, regulations, internal policies and regulatory requirements.
SIA 210 & SIA 220	Provides guidance on understanding the entity and developing a risk based audit plan and programme.
SIA 230	Prescribes requirements for obtaining sufficient and appropriate audit evidence.

SIA 240 & SIA 250	Covers the use of technology, data analytics and maintenance of audit documentation and working papers.
SIA 260 & SIA 270	Provides guidance on supervision of audit engagements and engagements of specialists where required.
SIA 280	Covers identification, evaluation and reporting of fraud and irregularities.
SIA 290	Provides guidance on communicating significant audit matters and recommendations to management and those charged with governance.
SIA 310 & SIA 320	Covers preparation of internal audit reports and issuance of assurance reports.
SIA 330	Covers reporting requirements for investigations, special reviews and other purpose specific engagements.

For the regulatory framework, the programme should be mapped to the Insurance Act, 1938, IRDA Act, 1999, Companies Act, 2013, applicable tax laws and current IRDAI regulations/ circulars. Key current regulatory anchors include the 2024 IRDAI regulations on corporate governance, actuarial/ finance/ investment functions, protection of policyholders' interests, registration/ capital structure, rural and social sector obligations, insurance products, expenses of management and related master circulars.

Overall Internal Audit Planning Programme

Area	Audit Programme
Audit Universe	Prepare a complete auditable universe covering governance, regulatory compliance, products, underwriting, policy servicing, claims, actuarial, investments, reinsurance, finance, distribution, customer protection, IT, outsourcing, HR, procurement, fraud, tax and branches.

Risk Assessment	Rate each auditable unit based on regulatory sensitivity, financial exposure, customer impact, fraud exposure, prior audit issues, system dependency and management override risk.
Annual Plan	Cover high-risk processes annually or quarterly. Cover moderate risk processes on rotation. Low risk areas may be covered once in two to three years, unless triggered by incidents.
Audit Charter	Verify approval of internal audit charter by Audit Committee/ Board. Confirm independence, access rights, reporting line and unrestricted access to records.
Resource Plan	Ensure team includes actuarial, investment, IT, cyber, regulatory and data analytics skill sets. Where not available internally, use experts under SIA 240.
Audit Programme Approval	Prepare assignment wise audit programme, including objective, scope, sampling, analytics, tests of design, tests of operating effectiveness and reporting timelines.
Reporting	Issue assignment reports, quarterly audit committee summaries, open issue tracker and repeat issue analysis.
Follow up	Validate action plan closure under SIA 390 do not close issues merely on management confirmation. Test actual implementation.

Sample Audit Programme by Auditable Area

Sections Z, AA and BB (fraud risk management, data privacy/ DPDP and business continuity) supplement the original auditable areas to give fuller coverage of current high-risk regulatory themes.

A. Corporate Governance and Board Oversight

Objective	To verify whether governance structures, Board committees and management oversight are operating effectively and in compliance with law, IRDAI regulations and internal policies.

Key Risks	Ineffective Board oversight, improper committee constitution, inadequate minutes, non-tracking of regulatory issues, conflict of interest, weak tone at the top.
Procedures	Review Board, Audit Committee, Risk Management Committee, Policyholder Protection Committee, Investment Committee and Product Management Committee constitution. Verify fit and proper declarations, independence, quorum, frequency of meetings, agenda quality and action taken reports. Review whether significant regulatory breaches, solvency position, claims performance, complaints, persistency, investments, frauds and outsourcing risks are escalated. Test closure of committee action points.

B. Regulatory Compliance and IRDAI Submissions

Objective	To verify whether the insurer has an effective compliance framework and timely, accurate regulatory submissions.
Key Risks	Late or inaccurate IRDAI submissions, non-compliance with product/ regulatory conditions, unreported breaches, weak compliance ownership, false certifications.
Procedures	Obtain regulatory compliance universe and submission calendar. Verify ownership, maker checker controls, evidence of review and sign off. Test sample returns submitted to IRDAI against source systems. Check treatment of regulatory inspection observations, penalties, advisories and directions. Verify breach register and Board/ Audit Committee escalation. Test whether circulars are tracked, interpreted and implemented through SOP updates.

C. Product Development, Approval and File & Use/ Use & File

Objective	To ensure products are designed, priced, approved, filed and launched in accordance with applicable IRDAI product regulations and internal governance.

Key Risks	Product mispricing, non-compliant benefits, misleading illustrations, inadequate actuarial/ pricing review, launch before approval, mismatch between filed version and sold version.
Procedures	Select sample products launched/ modified during the audit period. Verify Product Management Committee approval, actuarial sign off, legal/ compliance review, UIN, customer disclosures, benefit illustrations, surrender value design, commission structure and system configuration. Match policy bond, sales brochure, benefit illustration, web journey, proposal form and filed documents. Review post launch monitoring for persistency, complaints, claims, profitability and mis selling indicators.

D. Sales, Distribution and Intermediary Management

Objective	To verify whether sales through individual agents, corporate agents, bancassurance, brokers, web aggregators, POSP, digital channels and direct sales comply with regulatory and internal requirements.
Key Risks	Mis selling, unlicensed solicitation, excessive commission/ payouts, product pushed to unsuitable customers, fake leads, forged consent, undisclosed conflicts, dark pattern sales journeys.
Procedures	Review onboarding and licensing of intermediaries. Test sample agents/ intermediaries for valid license , training, exam status, appointment documentation and code of conduct acknowledgement. Review commission/ payout calculations against approved structures. Test sales calls, proposal forms, benefit illustrations, suitability checks, need analysis and customer consent. Review complaint data by channel and product. Test clawback controls for cancellations, freelook, lapse and early claims.

E. New Business, Proposal Processing and Underwriting

Objective	To verify that proposals are accepted, rejected, postponed or rated based on approved underwriting rules, delegated authority and evidence.
Key Risks	Inadequate risk assessment, bypassing medical/ financial underwriting, backdating, improper premium collection, incorrect risk commencement, management override, manipulated income/ medical records.
Procedures	Select sample issued, declined, postponed, rated up and high sum assured cases. Verify KYC, proposal completeness, income documents, medical reports, tele medical evidence, financial underwriting, occupation/ hobby risk, AML screening and reinsurer referral where applicable. Test underwriting authority matrix and override approvals. Verify date of proposal, receipt, underwriting decision, premium, risk commencement and policy issue. Review straight through processing rules and exception reports.

F. Premium Collection, Receipts, Persistency, Lapse and Revival

Objective	To ensure premiums are collected, receipted, allocated, refunded, revived and recognised correctly.
Key Risks	Misappropriation, unallocated premiums, delayed refunds, wrong premium allocation, incorrect grace period treatment, unauthorised revival, fake persistency.
Procedures	Reconcile premium receipts from payment gateways, banks, collection partners and policy admin system. Test suspense/ unallocated premium ageing. Review premium deposit/ refund controls. Verify renewal notices, grace period, lapse, paid up, revival, revival underwriting and interest calculations. Analyse persistency by product, channel, geography and agent. Test manual adjustments and backdated postings.

G. Policy Issuance and Policy Servicing

Objective	To ensure policy documents and servicing requests are processed accurately, timely and with valid customer authority.
Key Risks	Incorrect policy terms, delay in issuance, unauthorised nominee/ address/ bank changes, fraudulent assignment, wrong riders, servicing delays.
Procedures	Test sample policies for correct plan, UIN, premium, sum assured, term, riders, nominee and commencement date. Verify digital/ e policy issuance controls. Test servicing requests: nomination, assignment, address, contact, bank mandate, premium mode change, rider addition/ deletion, duplicate policy and ownership changes. Verify TAT adherence and maker checker controls.

H. Freelook Cancellation, Surrender, Maturity and Annuity Payouts

Objective	To verify that customer exits and benefit payouts are processed correctly and within applicable timelines.
Key Risks	Incorrect surrender value, delayed maturity payments, wrong bank account credit, unauthorised surrender, fraud in payout requests, incorrect tax deduction.
Procedures	Test freelook, surrender, partial withdrawal, maturity, survival benefit and annuity samples. Verify customer request, identity validation, bank verification, calculation logic, charges, fund value, TDS, approval and payout. Recompute surrender/ maturity values for sample cases. Check pending payout ageing and reasons.

I. Death Claims, Rider Claims and Claims Governance

Objective	To verify fair, timely and properly documented claim settlement/ repudiation.
Key Risks	Delayed claim settlement, improper repudiation, weak investigation, fraud, incorrect beneficiary payout, poor Board oversight of claim repudiation trends.

Procedures	Review claim SOP and delegation matrix. Test samples of paid, repudiated, pending, early, high value and investigated claims. Verify policy status, nomination/ legal heir documents, death certificate, medical/ hospital records, investigation reports, underwriting disclosures, Section 45 assessment, approval note and payout details. Review claims TAT, repudiation ratio, litigation and ombudsman cases. Check claims provisioning and outstanding claims ageing.

J. Customer Protection, Grievances and Policyholder Servicing

Objective	To verify whether the insurer treats prospects and policyholders fairly across solicitation, onboarding, servicing, claims and grievance redressal.
Key Risks	Mis selling, unresolved complaints, improper closure, poor root cause analysis, non-escalation to Policyholder Protection Committee, adverse ombudsman orders.
Procedures	Review complaint handling SOP, GRO structure and escalation matrix. Test complaints from CRM, Bima Bharosa, ombudsman, social media and regulator referrals. Verify classification, TAT, root cause, closure evidence and customer communication. Analyse complaints by product/ channel/ agent/ branch. Check whether repeated issues lead to process correction, training or disciplinary action.

K. Actuarial Function, Valuation, Reserves and Solvency

Objective	To review governance and controls over actuarial valuation, assumptions, reserves, solvency, bonus, asset liability management and regulatory actuarial submissions.
Key Risks	Inappropriate assumptions, understatement of liabilities, weak solvency governance, management pressure on actuarial judgments, incorrect bonus/ surrender values.

Procedures	Review Appointed Actuary appointment, independence, access and reporting to Board. Test controls over policy data extraction, reconciliation to financial records, assumption setting, experience analysis, reserves, solvency margin, ALM, bonus declaration, FCR and actuarial returns. Use actuarial expert support for technical recalculations. Check Board discussion of solvency, capital adequacy and stress testing.

L. Investments, Treasury and Fund Management

Objective	To verify that investments are made, valued, recorded, monitored and reported in accordance with law, IRDAI norms, Board approved investment policy and fund mandates.
Key Risks	Breach of exposure norms, unauthorised investments, incorrect valuation, front running/ conflict, weak segregation between policyholder/ shareholder funds, incorrect NAV.
Procedures	Review investment policy, Investment Committee oversight, front/ mid/ back office segregation and dealer limits. Test sample transactions for approval, counterparty, broker empanelment, price verification, settlement and accounting. Verify regulatory exposure limits, asset classification, valuation, impairment/ NPA treatment, custodian reconciliation and exception reporting. Review personal dealing/ conflict declarations.

M. Unit Linked Funds and Nav Controls

Objective	To verify accurate ULIP fund accounting, unit allocation, cancellation, switch, redemption and NAV computation.
Key Risks	Incorrect NAV, wrong unit allocation, late pricing, misstatement of fund value, customer loss, regulatory breach.
Procedures	Test NAV computation for sample dates and funds. Verify price feeds, expense accruals, fund charges, unit

	creation/ cancellation, switches, redemptions and reconciliations between policy admin, fund accounting and custodian. Review cut off controls for transaction timing. Test exception logs and manual overrides.

N. Reinsurance

Objective	To verify that reinsurance arrangements are properly approved, accurately administered and effectively monitored.
Key Risks	Inadequate risk transfer, missed cessions, incorrect premium/ claim recoveries, treaty non-compliance, concentration risk.
Procedures	Review reinsurance programme, treaty approvals, retention limits and Board/ Committee oversight. Test sample policies requiring cession. Verify facultative referrals, treaty cessions, reinsurance premium, commission, recoveries and bordereaux. Reconcile reinsurance balances and ageing. Review claim recovery follow up and reinsurer disputes.

O. Finance, Accounts and Financial Reporting

Objective	To verify reliability of financial reporting, accounting controls, reconciliations, expense controls and statutory reporting.
Key Risks	Misstatement of premium, claims, commission, investments, actuarial liabilities, expenses, tax, related parties and disclosures.
Procedures	Review monthly closing process, chart of accounts, manual journals, reconciliations and financial statement preparation. Test bank reconciliations, premium/ claims/ commission reconciliations, investment accounting, actuarial entries, GST/ TDS, provisions, accruals and related party disclosures. Review public disclosures and financial statements for consistency with books and regulatory returns.

P. Expenses of Management, Commission and Rewards

Objective	To verify that management expenses, commission, rewards and remuneration are within approved and regulatory limits and correctly classified.
Key Risks	Excess commission through disguised payouts, wrong expense allocation, breach of EOM limits, incorrect channel incentives, unsupported marketing spends.
Procedures	Review commission structures, reward schemes, sales contests, marketing support and channel payouts. Test payout calculations against policy, product, channel and premium data. Verify clawback controls for freelook/ lapse/ cancellation. Test expense classification, cost centre allocation and regulatory EOM reporting.

Q. AML, KYC, Sanctions and Suspicious Transactions

Objective	To verify effectiveness of AML/ CFT, KYC, sanctions screening and suspicious transaction reporting controls.
Key Risks	Onboarding without adequate KYC, money laundering through high premium policies, sanctions/ PEP exposure, forged documents, non-reporting of suspicious transactions.
Procedures	Review AML policy, customer risk categorisation, KYC controls and sanctions/ PEP screening. Test high premium, single premium, early surrender, refund to third party accounts, politically exposed persons, non-resident customers and unusual premium patterns. Review STR process, escalation to the Principal Officer and reporting to FIU IND. Test screening tool coverage, alert disposition and record retention.

R. IT general controls and cyber security

Objective	To verify whether IT systems supporting policy admin, underwriting, claims, finance, investments, CRM, data warehouse and portals are secure, available and controlled.

Key Risks	Unauthorised access, weak change management, cyber breach, data leakage, inaccurate automated processing, poor DR readiness.
Procedures	Test user access management, privileged access, password/ MFA controls, joiner mover leaver process, segregation of duties, change management, patching, vulnerability management, backup, DR, incident response and logs. Review application controls for underwriting, premium, claims, NAV, commission and accounting interfaces. Assess alignment with the IRDAI information and cyber security guidelines and SAR/ cyber incident reporting requirements.

S. Outsourcing and Third Party Service Providers

Objective	To verify whether outsourced activities are governed, risk assessed, contracted, monitored and auditable.
Key Risks	Loss of control over outsourced process, data leakage, service failure, non-compliance by vendor, weak SLA monitoring.
Procedures	Obtain complete outsourcing register. Classify vendors by criticality. Review due diligence, approval, agreement clauses, confidentiality, data protection, BCP, audit rights, subcontracting, SLA, incident reporting and exit plan. Test vendor performance reports and management reviews. Review TPAA/ SOC/ cyber assurance reports where available.

T. Rural and Social Sector Obligations

Objective	To verify fulfilment, measurement and reporting of rural and social sector obligations applicable to life insurers.
Key Risks	Incorrect classification, inflated reporting, inadequate documentation, shortfall in obligation, misstatement in IRDAI submissions.
Procedures	Review methodology for classification of rural/ social business. Test sample policies counted towards

	obligations for geography, customer category, product and documentary support. Reconcile reported numbers with policy admin system. Review exception/ shortfall reporting and Board oversight.

U. Branch Operations and Physical Controls

Objective	To verify branch level controls over sales, customer service, cash/ cheque handling, documents, records, complaints and assets.
Key Risks	Unauthorised cash handling, document loss, fake proposals, poor customer service, local mis selling, weak maker checker controls.
Procedures	Conduct branch visits based on risk rating. Verify cash/ cheque controls, receipt books, customer documents, physical security, pending proposals, servicing requests, complaint registers, agent interactions, records storage and asset verification. Perform surprise checks where warranted.

V. HR, Training, Conduct and Performance Management

Objective	To verify controls over employee onboarding, role allocation, training, code of conduct, performance incentives and disciplinary process.
Key Risks	Untrained staff handling regulated processes, conflict of interest, incentive driven mis selling, delayed access removal, misconduct not acted upon.
Procedures	Test employee onboarding, background checks, role based access, training completion, code of conduct declarations, conflict declarations and exit controls. Review sales incentive governance, disciplinary cases, whistleblower matters and mandatory compliance training.

W. Procurement, Administration and Fixed Assets

Objective	To verify procurement, vendor selection, contract management, payments, assets and administrative expenses.
Key Risks	Non-competitive procurement, inflated invoices, split purchases, related party vendors, duplicate payments, ghost assets.
Procedures	Test purchase requisitions, vendor onboarding, quotations/ tenders, approvals, PO, GRN/ service confirmation, invoice processing and payment. Review related party checks, contract renewals and vendor performance. Verify fixed assets physically and reconcile with FAR.

X. Legal, Litigation and Regulatory Actions

Objective	To verify whether legal cases, regulatory actions and contingent liabilities are tracked, assessed, escalated and accounted for.
Key Risks	Unrecorded liabilities, delayed response to notices, poor litigation management, adverse orders not escalated, weak provisioning.
Procedures	Obtain legal case register. Test cases involving claims repudiation, ombudsman, consumer forums, tax, employment, vendor disputes and regulatory matters. Verify legal opinion, provisioning/ contingent liability assessment, ageing, next hearing/ action, owner and Board/ Audit Committee escalation.

Y. Related Parties, Group Transactions and Capital

Objective	To verify related party transactions, promoter/ group arrangements, capital infusion, share transfers and intra group services.

Key Risks	Undisclosed related party transactions, non-arm's length charges, regulatory breach in capital/ shareholding, conflict of interest.
Procedures	Review related party master and declarations. Test service agreements, expense sharing, brand/ management charges, investments, loans/ advances if any, Board approvals and disclosures. Verify compliance for capital infusion, shareholding changes and regulatory approvals.

Z. Fraud Risk Management Framework

Added section — extends the original programme.

Objective	To verify that the insurer maintains an effective, board approved anti fraud framework covering prevention, detection, investigation, reporting and remediation across policyholder, intermediary, internal and external fraud, consistent with the IRDAI fraud monitoring framework.
Key Risks	Absence of a board approved anti fraud policy, no nodal officer/ fraud monitoring function, under reporting of frauds to IRDAI, weak red flag detection, no due diligence at onboarding, fraud losses not quantified, repeat modus operandi not addressed, whistleblower channel ineffective.
Procedures	Verify existence and board approval of the anti fraud policy and fraud monitoring framework, constitution of the fraud monitoring/ risk committee and appointment of a nodal officer. Test classification of frauds into internal, policyholder/ claimant, intermediary and external categories. Review fraud risk assessment, red flag indicators built into underwriting, claims and finance and use of analytics for early detection. Sample fraud cases for timeliness of detection, investigation quality, recovery action, disciplinary/ legal action and root cause closure. Verify periodic anti fraud due diligence at onboarding of intermediaries, employees and vendors. Test

	completeness and timeliness of fraud reporting to IRDAI and Board/ Audit Committee and reconcile the fraud register to reported numbers. Review the whistleblower mechanism, case disposition and protection of complainants.

AA. Data Privacy and DPDP Compliance

Added section — extends the original programme.

Objective	To verify whether the insurer collects, processes, stores, shares and retains personal and sensitive personal data of policyholders, prospects, employees and intermediaries in accordance with the Digital Personal Data Protection Act, 2023 and the DPDP Rules, 2025, alongside IRDAI data and outsourcing requirements.
Key Risks	Processing without valid consent or lawful basis, no privacy notice, excessive/ undocumented data collection, weak data principal rights handling, no breach notification process, unrestricted data sharing with intermediaries/ vendors/ group entities, indefinite retention, cross border transfer without controls, no data fiduciary accountability.
Procedures	Map personal data flows across onboarding, underwriting, servicing, claims, marketing, analytics and outsourced processing. Verify the consent architecture, privacy notices, lawful basis and consent withdrawal handling. Test the process for data principal rights access, correction, erasure and grievance and turnaround times. Review the personal data breach identification, containment and notification process against DPDP Rules timelines. Verify data sharing agreements, processor/ data fiduciary obligations, purpose limitation and retention/ deletion schedules. Review cross border transfer controls, role based access to personal data, masking/ encryption and vendor data protection clauses. Confirm appointment of and reporting by the data protection/ grievance officer where applicable.

BB. Business Continuity and Disaster Recovery

Added section — extends the original programme.

Objective	To verify whether the insurer can sustain critical policyholder facing and financial operations through disruption, with a tested business continuity plan and disaster recovery capability covering in house and outsourced processes.
Key Risks	No board approved BCP/ DR policy, critical processes not identified, recovery objectives undefined or unrealistic, untested DR, single points of failure, outsourced and cloud dependencies not covered, no crisis communication, prolonged outage of claims/ premium/ NAV processing.
Procedures	Verify board approval of the BCP/ DR policy, business impact analysis and identification of critical processes such as claims, premium, NAV, payouts and policyholder servicing. Review recovery time and recovery point objectives against business need. Test evidence of DR drills, failover results, backup restoration and gaps remediation. Assess coverage of outsourced, cloud and shared service dependencies in continuity arrangements and vendor exit plans. Review crisis management structure, escalation, communication to policyholders and the regulator and post incident reviews. Confirm continuity arrangements were invoked or tested for any actual disruption in the period.

Suggested Annual Coverage Map

Frequency	Areas
Quarterly/ continuous	Regulatory submissions, investments, premium reconciliations, claims, complaints, commission, open audit issues, solvency dashboard, IT incidents.

Half Yearly	Underwriting, policy servicing, outsourcing, AML/ KYC, ULIP NAV, expenses of management, branch audits.
Annual	Governance, product governance, actuarial process, reinsurance, finance reporting, cyber security, DPDP/ data privacy, rural/ social obligations, fraud risk framework, related parties, business continuity.
Once in 2–3 Years, Unless High-Risk	Procurement, fixed assets, HR, admin, legal process, training framework, low volume branches.

The internal auditor should not mechanically cover every area every year. The correct approach is to define the full audit universe, risk rate it, obtain Audit Committee approval for the annual plan and ensure that exclusions are documented with reasons.

Annexure 4

Audit Committee Reporting Deck

Section 1: Executive Summary & Action Taken Report (ATR)

Slide 1: Title & Meeting Details

- **Content:** Company Name & Logo, "Report to the Audit Committee for Quarter Ended [Month, Year]", Date of Meeting, Committee Members List.
- **Focus:** Clear version control and confidentiality markings.

Slide 2: Executive Dashboard/ Highlights of the Quarter

- **Content:** A high level overview highlighting the health of the control environment:
    - Number of internal audits completed vs. planned.
    - Summary of Statutory Auditor reviews (Clean vs. Qualified).
    - Critical regulatory/compliance breaches (if any).
    - Status of financial book closure timelines.
- **Peers' Insight:** Use a red amber green (RAG) status matrix for speed reading.

Slide 3: Action Taken Report (ATR) on Previous Minutes

- **Content:** Follow up table on specific directives given by the AC in past meetings.
- **Columns:** Agenda Item Ref, AC Directive/ Action Point, Target Date, Management Action Taken, Current Status (Open/Closed).

Section 2: Financial Performance, Reserves & Actuarial Governance

Slide 4: Financial Statements & Key Accounting Metrics

- **Content:** Summary of Revenue Account (Policyholders' Account/ Technical Account) and Profit & Loss Account (Shareholders' Account).

- **Key Metrics:** Gross Written Premium (GWP), Net Premium, New Business Premium (NBP) growth, Renewal Premium momentum and Net Profit after tax.

Slide 5: Key Insurance Financial Ratios

- **Content:** Quarter on quarter and year on year tracking of technical performance indicators:
    - **Solvency Ratio:** Current solvency vs. IRDAI's mandatory 150% threshold.
    - **Persistency Ratios:** 13th month, 37th month and 61st month persistency trends.
    - **Expense Ratios:** Commission Ratio, Opex Ratio and total Expense of Management (EoM) vs. regulatory limits.
    - **Conservation Ratio:** Percentage of renewal premium retained.

Slide 6: Actuarial Valuation & Mathematical Reserves

- **Content:** Certification from the Appointed Actuary (AA).
- **Key Details:** Movement in Mathematical Reserves, updates to core valuation assumptions (mortality, morbidity, lapse rates, discount rates) and results of the Peer Review of Actuarial Valuation if conducted during the period.

Section 3: Internal & Concurrent Audit Reviews

Slide 7: Internal Audit Progress & Plan Status

- **Content:** Progress tracking of the Board approved Annual Audit Plan.
- **Key Details:** Audits completed this quarter, audits delayed/deferred (with rationale) and field work status for the upcoming quarter.

Slide 8: Summary of Open Audit Findings (The Risk Profile)

- **Content:** A macro view of the company's remaining vulnerabilities.
- **Key Details:** Ageing analysis of open points (>90 days, >180 days over target date), split by risk severity (Critical, High, Medium, Low) and by core function (Underwriting, Claims, IT, Agency/Bancassurance channels, Finance).

Slide 9: Flashlight on "Critical & High" Rated Internal Audit Observations

- **Content:** Deep dive into the most severe findings from recent audits.
- **Format:** For each critical issue, outline: Root Cause, Financial/Regulatory Exposure, Management Remediation Action Plan and Committed Closure Date.

Slide 10: Investment Concurrent Audit Report

- **Content:** Outcomes of the continuous audit of treasury and investment workflows.
- **Key Details:** Confirmation of strict adherence to IRDAI Investment Regulations, monitoring of sector/group exposure limits, details of any passive breaches and tracking of non-performing assets (NPAs).

Section 4: Statutory Audit, IFC & Whistleblower Mechanisms

Slide 11: Statutory Auditors' Limited Review Report

- **Content:** Notes from the joint Statutory Auditors regarding the quarterly financial review.
- **Key Details:** Significant accounting treatments, adjustments made to provisions, auditor observations and confirmation of un modified/clean draft opinions.

Slide 12: Internal Financial Controls (IFC) & Operating Effectiveness

- **Content:** Quarterly assessment of internal controls over financial reporting.
- **Key Details:** Testing outcomes for core financial systems (e.g., automated premium accounting, claims reserve computation, automated systems interfacing between core insurance software and ERP systems).

Slide 13: Whistleblower & Fraud Analytics Framework

- **Content:** Reporting under the IRDAI Insurance Fraud Monitoring Framework.
- **Key Details:** Statistics on fresh cases received vs. closed, summary of major policyholder/intermediary fraud cases detected, root cause fixes

implemented and a brief report on Whistleblower complaints investigated independently.

Section 5: Regulatory Compliance, RPT & Sign offs

Slide 14: Regulatory Compliance Dashboard & Litigations

- **Content:** Assessment of the company's standing with IRDAI, SEBI, PMLA and Income Tax authorities.
- **Key Details:** Showcases show cause notices received, status of active regulatory inquiries, tracking of customer grievances (Grievance Disposal Ratio) and material tax/legal litigations.

Slide 15: Related Party Transactions (RPT) Review

- **Content:** Compliance tracking under Section 188 of the Companies Act and SEBI LODR.
- **Key Details:** Summary of material transactions during the quarter (especially with banking partners for Bancassurance agreements), status against prior omnibus approvals and verification of arm's length pricing.

Slide 16: Mandatory Approvals & Committee Recommendation

- **Content:** Formal wrap up listing matters requiring the AC's approval or recommendation to the Board of Directors.
- **Key Items:** Approval of the Financial Results, adoption of statutory declarations/certificates and endorsement of modifications to internal corporate policies (e.g., AML policy, Whistleblower policy).

Section 6: Appendices/ Annexures (Linked)

- *Note: This directly links to your granular data backup pages, such as the master open audit tracker log, complete text of statutory certifications and detailed RPT transaction lists.*

Annexure 5
Data Analytics Use Case Library

Part A: How to Use this Library

This Annexure is the working companion to Chapter 21, Use of Data Analytics in Internal Audit. This Annexure supplies the tests: a library of executable analytic use cases organised by the functional areas of this Guide. The intended use is that, when scoping any functional audit, the auditor opens the relevant section of this library, selects the use cases proportionate to the risk assessment and adapts the specified logic to the insurer's systems and data model.

Prerequisites that Apply to Every Use Case

- **Data Validation before Reliance:** Apply the completeness, accuracy and validity discipline of Chapter 21, record counts and control totals tied to source, status filters examined, the as at date fixed before running any test. For policy and premium level populations, the three way PAS ↔ GL ↔ actuarial tie out (operationalised as FC 02) is the foundation.

- **Triage, not Exception Dumps:** Interpret output through the triage lenses of Chapter 21, concentration, recurrence, timing, value and corroboration. The tool nominates the auditor concludes.

- **Corroboration:** An analytic flag becomes a finding only after the underlying record, file or evidence confirms it. Report confirmed exceptions, quantified populations and root causes not raw flag counts.

- **Documentation under SIA 240 and SIA 250:** For every test executed: purpose and scope, extract specification and as at date, validation performed, queries or scripts (or, for AI assisted work, the prompts and the validation of generated logic), parameters, output, triage applied and the auditor's conclusion distinguishing what the tool found from what the auditor concluded.

Important Note 1: Regulatory anchors cited in this library (for example, the IRDAI Master Circular on Protection of Policyholders' Interests, 2024 the IRDAI (Expenses of Management, including Commission, of Insurers) Regulations, 2024 the IRDAI (Insurance Products) Regulations, 2024 the AML/CFT Master Guidelines and provisions of the Insurance Act, 1938 such

as Sections 38, 39, 40, 41, 42, 45, 27A and 64VB) are stated as at the date of publication of this Guide. Specific timelines and thresholds embedded in test logic the 30 day free look period, claim settlement timelines, the 14 day grievance resolution norm, the ten year transfer of unclaimed amounts to the Senior Citizens' Welfare Fund and rural/social sector self-certification caps under the applicable rural and social sector framework must be verified against the regulations in force at the time of the audit and the parameters updated accordingly.

Important Note 2: Several functional chapters of this Guide carry their own "Audit Analytics/ CAATs" tables in different chapters of this guide New Business, Claims, Relationship and Complaint Handlin), Anti Money Laundering, Investments, Commission, Advertisements, the compliance analytics listed at Chapter 11 Legal and Compliance and the mis selling analytics in Chapter 13. Those tables identify the analytics at summary level within the flow of each process this Annexure supplies the corresponding executable specification the data, the test logic and the interpretation of exceptions.

Part B: The Use Case Library

A. New Business and Proposal Processing and New Products (Chapter 5: New Business)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
NB 01	Proposal to issuance turnaround and pending proposal ageing. Objective: verify proposals are decided (issued,	Proposal register from PAS/new business system: proposal receipt date, first deposit receipt/pay ment date,	Compute elapsed days from proposal receipt and separately from the date on which additional requirements were fulfilled, to the decision date for the full population. Age all open proposals	Aged open proposals with deposits held indicate weak pipeline control and potential interest

	declined or cancelled) within internal and regulatory turnaround times and that no proposal remains open indefinitely with customer money held.	additional requirement raised date, additional requirement received date, decision date, decision, status, product, channel.	as at the extract date. Stratify by product, channel and branch. Flag proposals open beyond the applicable internal/regulatory turnaround and proposals "decided" on the same day they were logged in volumes inconsistent with underwriting requirements.	liability on delayed refunds impossibly fast decisions indicate underwriting bypass or backdated logging.
NB 02	Proposal deposit and refund testing. Objective: confirm that proposal deposits on declined, cancelled or withdrawn proposals were refunded in full, within the prescribed time, with interest where applicable.	Proposal register receipting system (amount, date, mode) refund/payout file (payee, account, date) GL proposal deposit control account.	Join declined/cancelled/ withdrawn proposals to refunds. Recompute refund amount and the days from decision to refund. Compare the payee bank account on the refund with the account or instrument from which the deposit was received. Reconcile the residual proposal deposit control account to unrefunded items and age it.	Unrefunded deposits, refunds beyond the regulatory turnaround without interest, or refunds routed to accounts different from the source of funds (a fraud and money laundering indicator).

NB 03	Duplicate and multiple proposal detection. Objective: identify the same life proposed multiple times for aggregation against financial underwriting limits and for detection of proposal splitting to stay below medical or financial thresholds.	Proposal population with PAN, date of birth, mobile, e mail, address issued policy master for the same life identifiers.	Fuzzy match proposals on PAN, date of birth plus name, mobile and e mail. For each matched life, aggregate proposed plus in force sum assured and compare with the financial underwriting grid and the non-medical limit. Flag clusters of proposals for one life logged within a short window across branches or agents.	Aggregate exposure above the limit that individual proposals evaded proposal splitting patterns concentrated in an agent or branch suggest deliberate circumvention of underwriting.
NB 04	Backdating and period end clustering. Objective: detect risk commencement dates set earlier than permitted relative to proposal and premium	Proposal date, first premium receipt/realisation date, risk commencement date, logging user, agent, branch contest calendar from the	Compute (risk commencement date minus receipt date) and (risk commencement date minus proposal date) for the full population. Flag negatives beyond the company's permitted backdating window. Plot issuance date density around period ends and	Backdating beyond policy, or issuance clustering at cut offs unsupported by receipt dates, indicates manipulation of dating for targets, contests or premium

	receipt dates and clustering of dating around month, quarter and contest cut offs.	R&R function.	contest cut offs and compare with the receipt date density.	rate advantage with knock on effects on commission, R&R and actuarial data.
NB 05	Section 64VB risk assumed before valid premium receipt/payment. Objective: confirm that risk commencement does not precede valid premium receipt, payment, guarantee or deposit as contemplated under Section 64VB of the Insurance Act, 1938 and that dishonoured instruments	Risk commencement date from PAS premium receipt/payment and banking/realisation dates from the receipting system and bank statements guarantee/deposit records, where relevant dishonour file.	For the full issued population, compare risk commencement date with the valid premium receipt/payment/guarantee/deposit date used by the insurer to assume risk. Separately, match cheque/NACH/mandate dishonours to policy status and accounting reversals to confirm that the policy did not remain on risk after dishonour and that premium income was reversed where required.	Cover commencing before a valid Section 64VB basis, or a policy remaining in force after first premium dishonour without prompt reversal, indicates a statutory/compliance breach or a serious process failure. Treat dishonour handling as a separate control test rather than equating

	are reversed promptly.			every pre realisation case with a violation.
NB 06	Data quality and KYC completeness screening. Objective: measure the reliability of the customer master at the point of entry the foundation on which every downstream analytic in this library rests.	Proposal/customer master: DOB, PAN, mobile, e mail, PIN code, income, occupation, nominee fields, CKYC/KYC identifiers.	Screen for null, default and junk values (repeated digit mobiles, PIN 000000, DOB defaults such as 01 01 1900, income exactly at grid thresholds) test PAN structure validity count customers sharing a mobile or e mail beyond a family plausible threshold test CKYC identifier presence against the KYC norms applicable at issuance.	High junk value density localised to a channel or branch indicates data entry being gamed to pass validations shared contact details across many customers is a classic indicator of agent controlled communication and mis selling risk.
NB 07	Benefit illustration compliance. Objective: verify that a signed or digitally acknowledg	Policy population illustration repository metadata (illustration ID, generation	Join policies to illustrations flag missing illustrations, illustrations generated after proposal signing and illustration assumptions outside	Missing or post dated illustrations are a policyholder protection breach and a leading

	ed benefit illustration at the current IRDAI prescribed assumed rates/ applicable product circular parameters exists for every eligible policy sold and that the illustration precedes or accompanies the proposal.	date, assumed rates, e sign/scan flag) product master.	the current regulatory/product parameter table applicable on the generation date. Where illustrations are digital, test the customer acknowledgement flag across the population.	indicator of mis selling concentrations by agent or branch should feed the composite conduct risk score.
NB 08	Vernacular declaration and distance marketing consistency. Objective: test that policies sold to customers whose declared language or channel required additional safeguards	Proposal data with language/education declarations, channel and sub channel codes pre issuance verification call (PIVC) logs and outcomes welcome call records.	Join the issued population to PIVC records flag issuances without a successful verification where the channel or customer profile mandated it analyse verification call failure/retry patterns and issuances that proceeded despite failed verification.	Issuance despite failed or absent verification defeats the strongest anti mis selling control at the point of sale patterns concentrated in a sub channel indicate the

	(vernacular declaration, call verification) carry evidence of them.			control is being treated as a formality.
NB 09	Policy document dispatch, electronic issuance, CIS delivery and acknowledgement analytics. Objective: verify that every issued policy was dispatched or credited to the e Insurance Account within the prescribed timeline, with proof of delivery and accompanied by the Customer Information Sheet in the required format/langu	Issuance register with issue and dispatch dates dispatch/courier file with POD status and delivery date e policy/eIA credit log CIS generation, delivery and acknowledgement flags customer language/local language indicator free look cancellation file (PS 01).	Compute issue to dispatch and dispatch to delivery intervals across the population flag missing or failed POD and undelivered/returned policies still shown as in force test CIS generation, delivery and acknowledgement for every issuance, including local language requirements where applicable cross check the delivery date used by the FLC module against the POD/eIA credit date rather than the dispatch date.	Returned undelivered policies signal contactability or ghost customer risk an FLC clock running from dispatch instead of receipt systematically shortens the policyholder's statutory free look right. Missing CIS acknowledgement is a policyholder protection control failure, not merely a

	age since the delivery date anchors the free look clock.			documentation gap.
NB 10	Group business member data completeness. Objective: test that group policies carry complete, valid member level data lives covered, sums assured, nominee details, certificate/CIS status and entry/exit dates so that coverage, premium, servicing and future claims can be administere	Group master policies member data files (identifiers, DOB, cover amount, entry/exit dates, nominee, certificate/CIS issue status) premium billing per scheme master policyholder records claims on group policies.	Profile member files for missing or defaulted identifiers, duplicate members within and across schemes, members outside eligible age bands, missing nominee details and missing certificate/CIS records reconcile lives billed to lives in the member file per scheme trace a sample of group claims back to a valid member record as at date of event.	Premium billed for more (or fewer) lives than the member file supports is a revenue integrity error missing member certificates/ CIS or nominee details create policyholder protection exposure claims paid on lives absent from the member data show the scheme is being administered on trust, not data the classic group

	d per member.			business audit failure.
NB 11	Premium receipt, banking and channel settlement reconciliation. Objective: verify that premium collected through branches, agents, payment gateways, NACH/UPI, bank partners and other channels is completely banked, settled, allocated to policies and reconciled to the GL.	Receipting system with receipt ID, policy/proposal, amount, mode, payer and timestamp bank statements payment gateway/NACH/UPI settlement reports agent collection records PAS allocation status GL premium and suspense accounts.	Match every receipt to bank/settlement credit and PAS allocation age unmatched receipts and settlement breaks test chargebacks, failed transactions and duplicate receipts reconcile aggregate collections by channel to GL and premium registers flag agent collected amounts not deposited within policy timelines.	Unmatched bank credits, unallocated premium or channel settlement breaks indicate customer money is outside the policy administration control path agent collection delays and payment gateway breaks can create both policyholder harm and revenue cut off errors.
NB 12	Bima ASBA/ premium blocking mandate analytics, where implemented. Objective:	Mandate/blocking records from the bank/payment partner proposal status and	For every proposal using mandate blocking, compare proposal decision date with debit/release date flag debits before acceptance where	Blocked funds remaining after decline/non-issuance create customer

	test that premium is blocked, debited, released or refunded in line with the insurer's Bima ASBA or similar mandate blocking process.	decision dates debit/release timestamps refund records customer communication logs.	not permitted, blocks not released promptly on decline/non-issuance, failed releases, duplicate debits and customer complaints linked to blocked funds.	harm without corresponding risk assumption debits before acceptance or duplicate debits indicate that the new business and payment partner workflows are not synchronised.
NB 13	Group insurance policyholder protection and payout routing analytics. Objective: test whether member level certificates/ CIS, consent or confirmation , assignment limits and claim payout	Group master policy terms member certificates/ CIS issue logs member consent/confirmation data where applicable loan outstanding data for credit linked schemes nominee/be	Match every covered member to certificate/CIS issuance and nominee/beneficiary records for credit linked schemes, compare assignment or master policyholder payout with outstanding loan at claim date and verify any excess payout to nominee/member flag schemes where member confirmation/consen	Group schemes can fail at member level even where the master policy is clean payout to a lender or master policyholder beyond outstanding exposure is direct customer/be

	routing operate correctly in group schemes, especially credit life.	neficiary records claim payout files.	t evidence is absent despite being required by product/process.	neficiary harm and should be escalated as a policyholder protection finding.
NB 14	Product/UIN and File and Use sale eligibility. Objective: verify that every policy and rider sold maps to an approved product/rider UIN and was sold only during its permitted approval/launch/withdrawal period and through permitted channels.	Product master with UIN, approval, launch, modification and withdrawal dates rider to base mapping policy issue/proposal/risk commencement dates channel/product eligibility rules filed product documents and approval records.	Join every issued policy and rider to the product master as at proposal and risk commencement date flag sales before approval, after withdrawal, under obsolete versions or with riders not approved for the base plan compare channel/product combinations with approved distribution permissions.	Sale of an unapproved, withdrawn or incorrectly versioned product is a product governance breach with customer remediation implications rider/base mismatches and channel ineligible sales indicate that PAS configuration is not aligned with the filed product design.
NB 15	Product parameter and system	Filed product parameter	Compare critical parameters across filed product	A single misconfigured product

	configuration integrity. Objective: test whether PAS, illustration, servicing and commission parameters match the filed/approved product terms.	matrix PAS configuration tables premium/rating tables benefit illustration engine parameters charge, surrender value, loan, revival, rider, tax and commission mapping tables.	documents, PAS, BI generator and servicing/commission systems using effective dated tables flag premium rate, benefit, charge, surrender, loan, tax, rider or commission parameters that differ from the approved product matrix or remain active after a product/version change.	parameter creates population wide underpayment, overpayment, mis selling or regulatory filing risk mismatches across PAS and the BI engine are especially severe because the customer is shown one product and administered another.

B. Underwriting (Chapter 6: Underwriting)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
UW01	Deviation from delegated underwriting authority. Objective: confirm every underwriting	Underwriting decision log (case, decision, deciding user, sum assured, rating/loading) board approved authority matrix HR/user master	Map each decision to the decider's authority limits at the decision date. Flag decisions above	Above authority decisions concentrated in one underwriter or one product indicate either a

	decision was taken within the deciding user's delegated financial and medical authority.	mapping users to grades.	authority, self referrals (the same user recommending and approving) and approvals by users whose grade changed after the fact.	broken workflow control or deliberate routing self approval is a segregation of duties failure regardless of outcome.
UW 02	Non medical limit compliance. Objective: verify no case was issued on a non-medical basis where age, sum assured or disclosed history required medical examination.	Issued population with age at entry, aggregate sum assured (use NB 03 aggregation), medical requirement grid, requirement status data, disclosed medical history flags.	Recompute the medical requirement for every issued policy from the grid and compare with requirements actually raised and completed. Aggregate sum assured per life so that splitting cannot defeat the grid.	Issuance without mandated medicals transfers unpriced mortality risk onto the book a cluster around one branch or agent, combined with NB 03 splitting, is a strong fraud signal.
UW 03	Rule engine override and STP analysis. Objective: understand where the automated	Rule engine decision (accept/refer/decline, reasons) final human decision overriding user subsequent policy	Compute the straight through processing rate by product and channel. Isolate cases	A user or unit whose overrides show materially worse downstream experience is

	underwriting engine's decisions are being overridden by humans, by whom and with what outcome.	outcome (early claim, lapse, FLC).	where the engine's refer/decline was converted to an acceptance profile by overriding user and trace those policies' early claim and early lapse experience against the non-overridden book.	accepting risk the engine correctly refused absent worse experience, persistent overrides may instead mean the engine's rules are miscalibrated both are findings.
UW 04	Loading and counter offer consistency. Objective: test that extra mortality loadings and counter offers are applied consistently for comparable risk profiles and not waived	Decision data with rating class, loading applied, medical findings codes authority matrix waiver/approval trail.	Cluster cases by risk profile (age band, sum assured band, disclosed condition codes) and compare loadings within clusters. Flag zero loading acceptances inside clusters where peers were loaded and loadings	Inconsistent loading is anti selective and discriminatory in both directions reductions correlated with specific intermediaries suggest commercial pressure overriding risk judgement.

	without authority.		reduced after intermediary escalation without documented medical basis.	
UW 05	Financial underwriting income multiple testing. Objective: verify sum assured granted is within the income multiple grid and that declared income is internally consistent for the same life across proposals.	Proposal income declarations, occupation, age income multiple grid aggregated sum assured per life (NB 03) income proof requirement status.	Recompute the maximum permissible sum assured per life from the grid and compare with the aggregate granted. Flag lives whose declared income differs materially across their own proposals and high sum assured supported by income declarations exactly at grid break points.	Over insurance relative to income creates moral hazard, over insurance, anti selection and fraud risk inconsistent self declared income for the same life indicates the declarations are being written to fit the grid.
UW 06	Early claim feedback loop to underwriting . Objective: trace early claims and repudiations	Early claim population from the claims system (CL 02) underwriting decision data for those policies (decider, engine	For every early claim, retrieve the underwriting pathway: engine decision, human	Over representation of a particular underwriter, waived requirement or override

	back to the underwriting decision to identify systematic acceptance quality problems.	result, requirements waived).	overrides, requirements waived, medical/non-medical basis. Compare the distribution of these attributes in the early claim population against the issued book.	pattern in early claims is direct evidence of an acceptance quality weakness that pure claims analytics cannot attribute.
UW 07	Per life exposure aggregation against retention. Objective: confirm the underwriting system aggregates all in force exposure on a life so that reinsurance triggers and financial limits operate on the true total (links to RI 02).	Policy master with life identifiers sum assured by cover and rider reinsurance cession records retention limits.	Independently aggregate sum assured per unique life using deterministic (PAN) and fuzzy (name + DOB) matching. Compare with the system's own aggregation and with cessions actually made. Flag lives whose true aggregate crosses retention with	A gap between the auditor's aggregation and the system's means the per life accumulation logic is broken unreinsured concentration the insurer does not know it holds.

			no or partial cession.	
UW 08	Pending requirement ageing and auto closure. Objective: verify that proposals pending underwriting requirements are chased and closed or declined within the defined period rather than left open.	Requirement raised and requirement received dates per proposal proposal status communication logs.	Age open requirements across the population test whether the auto cancellation rule fired at the defined threshold flag proposals issued with requirements shown as pending or received after the decision date.	Requirements "received" after decision indicate post facto papering of files aged pending proposals with deposits held revert to the NB 02 refund exposure.

C. Reinsurance (Chapter 7: Reinsurance)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
RI 01	Unceded risk above retention. Objective: identify policies whose retained sum	Policy master (sum assured, plan, riders, status) cession/borderea u data (ceded amount, treaty, reinsurer) board approved	For the full in force population compute retained amount = sum assured minus ceded amount, at policy and	Retained exposure above limit may indicate breach of board approved retention/treat y logic and

	assured exceeds the board approved retention limit with no or insufficient cession.	retention schedule by product/risk class.	per life level (with UW 07 aggregation) and compare against the applicable retention. Flag exceedances and quantify the unprotected exposure.	should be verified against treaty terms, facultative covers and specific approvals before conclusion concentration in a product points to a mapping error in the cession logic rather than one off misses.
RI 02	Per life accumulation across products. Objective: verify the accumulation system recognises the same life across multiple policies and product types and triggers cession on the	As for UW 07, plus treaty terms defining per life limits.	Aggregate exposure per unique life across individual, group and rider covers identify lives whose combined exposure crossed the retention while each policy individually stayed below it verify cession was triggered on the	Accumulation failures are invisible policy by policy and surface only at claim time exactly when the insurer can least afford them.

	combined exposure.		combined amount.	
RI 03	Bordereau to PAS two way reconciliation. Objective: confirm the cession statements sent to reinsurers agree with the policy administration system in both directions.	Quarterly/monthly bordereaux PAS in force extract for the same as at dates treaty applicability rules.	Reconcile both ways: policies meeting cession criteria but absent from the bordereau (under cession) and bordereau lines with no matching in force policy or with mismatched sum assured, age or premium (over cession or stale data).	Under cession creates uncovered exposure over cession leaks reinsurance premium on risks that no longer exist both recur wherever bordereau generation is a manual or semi manual extract.
RI 04	Reinsurance premium recomputation and duplicates. Objective: recompute ceded premium against treaty rate tables and detect duplicate	Bordereau premium lines treaty rate tables (by age, risk class, cover type) payment records to reinsurers.	Recompute premium per ceded life from treaty rates and compare with the bordereau run duplicate detection on (policy, cover period) pairs across successive bordereaux reconcile	Rate table version errors and duplicate cession of the same cover period are the two most common leakages they are silent because reinsurers rarely challenge over

	premium cessions.		bordereau totals with amounts actually remitted.	payment line by line.
RI 05	Lifecycle reversals lapse, surrender, reduction. Objective: verify that policy status changes flow into the reinsurance account as premium adjustments or clawbacks in the following bordereau.	PAS status change log (lapse, surrender, paid up, reduction, revival, FLC) with effective dates subsequent bordereaux and adjustment lines.	For each status change in the period, look for the corresponding adjustment in the next bordereau cycle age unadjusted items recompute the proportionate premium refund due.	Unadjusted lapses and surrenders mean the insurer keeps paying reinsurance premium on inactive, lapsed or reduced risk an expense leak that compounds every cycle until reconciled.
RI 06	Claims recovery completeness and ageing. Objective: confirm every paid claim above retention	Paid claims file with sum assured and retention split recovery bookings and receipts treaty terms including event definitions and exclusions.	Join paid claims above retention to recoveries recompute the recoverable amount per treaty age booked but unreceived recoveries and	Unraised or aged recoveries are direct P&L leakage a rising ageing profile with one reinsurer flags either a documentation weakness

	generated a reinsurance recovery, recompute the recovery and age outstanding recoverables.		identify disputed items flag claims where recovery was never raised.	on the insurer's side or a counterparty dispute the audit committee should know about.
RI 07	Facultative placement timing. Objective: test that risks beyond treaty capacity were not put on risk before facultative acceptance was confirmed.	Facultative placement records (offer, acceptance date, terms) policy risk commencement dates for the affected cases.	Compare risk commencement date with facultative acceptance date for every facultative case flag cover bound before confirmation and cases where terms bound differ from terms accepted.	Binding before facultative confirmation leaves the insurer holding the full risk in the gap period a small population, but each exception is individually material.
RI 08	Treaty result and reinsurance accounting analytics. Objective: test treaty economics beyond	Treaty terms and amendments reinsurance premium, claim recovery, profit commission, experience refund and reinstatement premium	Recompute profit commission, experience refund and reinstatement premium under treaty terms reconcile treaty statements to	Treaty account errors can reverse the economics of reinsurance even when cession is complete reinsurer declines

	cession and recovery profit commissio n, experience refund, reinstatem ent premium, recapture, exclusions and reinsurer disputes.	statements reinsurer dispute correspondence accounting entries.	GL identify claims declined or reduced by reinsurers and trace the cause to underwriting, documentation or treaty exclusions test recapture or treaty change effective dates against the bordereau.	clustered by product or underwriting pathway reveal control failures that the insurer only sees after a claim.

D. Policy Servicing (Chapter 8: Policy Servicing)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
PS 01	Free look cancellation analytics. Objective: test FLC refund correctness and turnaround and use FLC concentratio n as a mis selling detector.	FLC register (request date, receipt of policy date, decision, refund amount and date) policy data (premium, charges, medical costs) agent/branch mapping.	Recompute the refund (premium less permitted deductions) for the full FLC population compute request to refund turnaround against the applicable regulatory limit, including the seven day refund expectation and interest for delay where applicable for linked policies,	Excess deductions, wrong NAV dates and delayed refunds are direct policyholder harm FLC requests wrongly rejected as out of window (often by using

			verify the unit value/NAV date used for refund test rejected FLC requests against the 30 day free look window using the date of receipt of the policy document rank agents and branches by FLC rate.	dispatch date instead of receipt date) are a recurring regulatory finding high agent level FLC rates feed the conduct score.
PS 02	Lapse and revival integrity. Objective: verify revivals were effected with the required declarations , medicals and interest and detect revive to claim patterns.	Lapse and revival transactions with dates revival requirements grid interest computation parameters claims file for revived policies.	Recompute revival interest across the population test revival medical/declaratio n of good health requirements against the grid by lapse duration compute the interval from revival to subsequent claim intimation and flag short interval cases (link to CL 02).	Revival immediately preceding a death claim is a classic fraud pattern (reviving a policy on a life already dead or dying) waived revival requirement s concentrate d in a branch indicate the control is discretionar y in practice.

PS 03	Surrender value recomputation. Objective: recompute guaranteed and special surrender values against the product terms, including the special surrender value requirements of the IRDAI (Insurance Products) Regulations, 2024 and the applicable master circular and test payout turnaround.	Surrender transactions (policy, date, amount paid) product master (GSV factors, SSV basis, paid up formulae) premium history payout dates.	Recompute GSV and SSV per policy from product parameters and premium history compare with amount paid compute request to payment turnaround against the prescribed servicing timeline, including the seven day settlement expectation and interest for delay where applicable reconcile total surrenders paid with the GL.	Systematic under payment (or over payment) points to a product parameter error in the servicing system one wrong factor mis prices every surrender of that product turnaround breaches carry interest and regulatory consequences.
PS 04	Surrender to new policy churn. Objective: detect policy churning	Surrender population new business register common life identifiers agent codes on both	Match surrenders to new proposals on the same life within a defined window (e.g., 90–180 days) compare the agent	An agent whose customers repeatedly surrender and repurchase

	surrenders followed by new policies on the same life, generating fresh first year commission at the customer's cost.	sides commission file.	on the old and new policy quantify surrender charges borne by the customer and first year commission generated rank agents by churn count and value.	is manufacturing commission from customer value destruction the strongest single mis selling signature in servicing data and a reportable conduct finding.
PS 05	Policy loan analytics. Objective: verify loans were granted within surrender value limits, interest accrues correctly and foreclosure triggers operate.	Loan master (principal, date, rate, repayments) concurrent surrender values product loan rules foreclosure/auto termination log.	Recompute the maximum loan (percentage of surrender value) at grant date across the population recompute interest accrued identify policies where loan plus accrued interest approaches or exceeds surrender value and test whether the foreclosure/notification process fired flag loans on pure risk policies, linked policies/ULIPs, or	Loans exceeding limits, loans granted on ineligible products, or unforeclosed loans that have consumed the policy value convert a secured advance into an unsecured loss interest recomputation

			product variants where policy terms do not permit loans.	differences usually trace to a rate table or day count configuratio n error.
PS 06	Fund switch and NAV cut off testing (ULIP). Objective: verify switch, redemption and premium allocation transactions received the NAV of the correct day under the applicable cut off rules.	ULIP transaction log with request timestamp, transaction type, NAV date applied NAV series by fund cut off rules.	For the full transaction population, derive the NAV date that should apply from the timestamp and cut off rule and compare with the NAV date actually applied profile exceptions by transaction channel and user test frequent switcher patterns and switches initiated through internal user IDs rather than customer channels.	Wrong day NAV application redistributes value between the policyholder and the fund internal user initiated switches clustered before sharp NAV moves indicate possible front running of known price events.
PS 07	Top up premium compliance. Objective: test top up premiums against product limits and	Top up transactions base premium history product top up rules (proportion limits, sum assured multiple, due premium status, lock	Recompute the permitted top up capacity per policy and the mandatory additional sum assured verify due premiums were paid up to date before top up	Limit, lock in and eligibility breaches indicate configuratio n gaps the top up then surrender

	the required sum assured multiples.	in/withdrawal restrictions and last five year restrictions where applicable).	acceptance flag top ups above capacity, without the required SA adjustment, within restricted contract periods, or withdrawn/partially withdrawn before the applicable lock in except on complete surrender screen for large single top ups shortly before surrender (link to ML 05).	pattern is a laundering typology in which the insurer is used as a pass through.
PS 08	Nomination, assignment and contact change risk analytics. Objective: detect servicing changes nominee, assignee, bank account, mobile, e mail, address whose timing or destination indicates	Servicing change log with before/after values, dates, initiating user/channel payout files agent and employee masters.	Flag changes effected shortly before a surrender, loan or claim payout match new bank accounts and contact details against agent and employee masters and against details recurring across unrelated policies test assignments to unrelated third parties for the required insurer scrutiny under Sections 38/39 of the Insurance Act.	A bank account change followed within days by a payout, or a new contact detail shared with an intermediary , is the signature of payout diversion fraud recurring assignee entities across

	payout diversion.			policies may indicate premium financing or laundering arrangements.
PS 09	Premium suspense and unallocated money. Objective: age and test the resolution of premium received but not allocated to any policy.	Suspense/unallocated receipt ledger with receipt date, amount, mode, resolution date and mode GL control account.	Age the unresolved population profile resolution modes (allocated, refunded, written back to income) flag write backs to income of customer money reconcile the ledger to the GL control account and to bank.	Customer money written back to income instead of refunded is both a policyholder protection and an unclaimed amount classification failure a growing suspense age profile indicates the allocation process is losing to the receipt volume.
PS 10	Unclaimed amounts lifecycle. Objective: test the completeness of	Payout due population (maturities, survival benefits, FLC/surrender refunds, claim payouts returned)	Independently rebuild the unclaimed population from payout due data (due but unpaid beyond the	An independently rebuilt unclaimed population larger than the

	unclaimed amount identification, its ageing, interest accrual, disclosure and transfer of amounts unclaimed beyond ten years to the Senior Citizens' Welfare Fund.	unclaimed register interest accrual records SCWF transfer records website disclosure extract.	settlement period) and reconcile with the registered unclaimed database recompute interest accrual age the population and verify ten year old amounts were transferred to SCWF sample match the public search facility against the register.	registered one is the key finding here amounts never made it into the unclaimed process at all, which no test of the register itself can reveal.
PS 11	Renewal, grace period and auto lapse correctness. Objective: verify grace periods, late fees and lapse triggers are applied per product terms across the renewal population.	Premium due and receipt data product grace rules by mode status change log mandate (ECS/NACH) failure files.	Recompute grace period expiry per policy mode and compare with the actual lapse date applied test late fee computation analyse mandate failure follow up (retry, customer contact) and the conversion of failures to lapse flag policies kept in force beyond grace with no premium.	Policies on risk beyond grace without premium reprises the Section 64VB issue in renewal form premature lapsing harms customers and persistency alike mandate failure neglect is a leading root

				cause of unintended lapse.
PS 12	Paid up value correctness. Objective: recompute reduced paid up sum assured and related values for policies converted to paid up status.	Paid up conversions with premium paid counts product paid up formulae subsequent claim/surrender payouts on paid up policies.	Recompute paid up sum assured from premiums paid over premiums payable and the product formula for the full converted population trace a recomputed value through to any subsequent payout.	A formula or rounding error here silently mis states values for a population that, by definition, is no longer paying attention making full population recomputation the only realistic detective control.

E. Claims (Chapter 9: Claims)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
CL 01	Claim to policy validity join. Objective: confirm every paid claim maps to a policy validly in	Full paid claims file (policy, event date, cause, amount, payee) PAS status history rider attachment and	Join claims to the policy status timeline and test in force status as at the event date (not the intimation date) test that lapsed/paid up policies were paid only their reduced	A claim paid on a policy not in force at the event date is leakage of the purest kind clusters usually trace

	force on the date of the insured event, with the claimed cover attached.	premium status.	entitlement verify rider claims against rider premium status (see CL 10).	to status history gaps from system migration which must be proven, not presumed.
CL 02	Early claim detection and profiling. Objective: identify death claims arising within a short duration of issuance or revival and test whether the mandated investigation rigour was applied.	Claims with event and intimation dates policy commencement and last revival dates investigation records underwriting pathway data (UW 06).	Compute duration from commencement (and from last revival) to death for every death claim band the population (e.g., under 6, 6–12, 12–36 months) verify investigations were conducted for early claims per policy profile early claims by agent, branch, product and underwriting pathway.	Early claim concentration by intermediary is the strongest organised fraud indicator in a life book early claims decided without investigation, or investigated by the same agency showing anomalous clearance rates (CL 08), compound the signal.
CL 03	Claims turnaround and interest on delay.	Claim event log: intimation, requirement raised/received	Compute each interval across the full population from claim intimation,	Serial requirement raising that extends the

	Objective: test settlement timelines against the norms of the IRDAI Master Circular on Protection of Policyholders' Interests, 2024 including the intimation based timelines for death claims and the investigation timeline where warranted and verify penal interest was paid on delays.	, investigation start/close, decision and payment dates interest payments.	requirement raising/receipt, investigation start/close, decision and payment separately analyse the "requirements complete" date for manipulation (requirements raised seriatim to delay processing) recompute interest due on delayed settlements and compare with interest actually paid.	practical turnaround is a conduct red flag even where the system clock appears compliant unpaid delay interest is a direct, quantifiable policyholder protection breach.
CL 04	Payee integrity duplicate and related party accounts. Objective:	Claim payout file (payee name, account, IFSC) agent, employee and vendor/investigator masters	Run exact and fuzzy duplicate detection on payee accounts across the claims population join payee accounts and contact details to	One account absorbing multiple unrelated death claim payouts is close to

	detect claim proceeds routed to bank accounts recurring across unrelated claims or belonging to agents, employees or investigators.	with bank details nominee data.	agent, employee and investigator masters flag payouts to accounts differing from the registered nominee's validated account.	conclusive evidence of diversion or impersonation an employee or investigator account in the payee file is an immediate escalation, not a routine finding.
CL 05	Repudiation analytics and Section 45 compliance. Objective: analyse repudiation patterns and confirm no policy was repudiated on grounds barred by the three year non-contestability rule in Section 45 of the Insurance Act.	Repudiated claims file with grounds, policy duration at repudiation, deciding authority Ombudsman/consumer forum outcomes.	Compute policy duration for every repudiation from the later of policy issuance, risk commencement, revival or rider commencement date, as applicable, to the date of death/event flag repudiations on misstatement/non-disclosure grounds beyond the Section 45 period analyse repudiation rates by product, channel and underwriter track reversal rates at Ombudsman and courts by ground.	A Section 45 barred repudiation is a statutory violation exposed in litigation with certainty high reversal rates on a particular ground show the claims function applying a standard that external forums consistently reject.

CL 06	Claim amount recomputation. Objective: recompute the payable amount sum assured plus accrued bonuses and rider benefits, less policy dues for the full paid population.	Paid claims policy benefit structure bonus declaration history outstanding loan/premium dues payout amount.	Rebuild the payable amount per claim from benefit parameters and bonus history net dues compare with the amount paid investigate both over and under payments reconcile total claims paid with the GL.	Systematic differences trace to bonus history or dues netting configuration under payments are policyholder harm, over payments are leakage both from the same root.
CL 07	Decision reversal and reopening patterns. Objective: analyse claims first repudiated and later paid and claims reopened after closure, for what they reveal about first decision quality and	Claim decision history with all statuses and deciding users forum/escalation source of reversal.	Identify all repudiate then pay and reopen then pay sequences classify by reversal trigger (internal review, Ombudsman, court, grievance) profile the original deciders and the reversing authorities test authority levels on reversals.	Internal reversals concentrated with one approver may indicate either a well functioning review or an override channel the file review distinguishes them a high external reversal rate quantifies the cost of poor first decisions.

	override risk.			
CL 08	Investigation and investigator analytics. Objective: evaluate the external investigation ecosystem: allocation, turnaround, outcome mix and fee patterns by agency.	Investigation assignments (agency, dates, outcome, fee) claim outcomes agency empanelment data.	Compute per agency turnaround, recommendation mix (genuine/fraud/inconclusive), fee per case and outcome versus final decision agreement flag agencies with outlier clearance rates or fees test geographic allocation against empanelment.	An agency clearing early claims at rates far above peers is either the best or the most compromised in the panel fee outliers and allocation concentration to it decide which.
CL 09	Maturity and survival benefit payout completeness. Objective: verify every matured policy and due survival benefit was paid or correctly moved into the unclaimed process.	Policy master with maturity/survival benefit due dates payout file unclaimed register (PS 10).	Generate the due population independently from the policy master match to payouts and to the unclaimed register the residual due, unpaid and not in unclaimed is the finding age and quantify it.	Due amounts that vanished between the payout and unclaimed processes are the population most exposed to internal misappropriation, precisely because no one is

				asking for them.
CL 10	Rider claim validity. Objective: test rider claims (accidental death, critical illness, waiver) against rider premium status and rider specific conditions.	Rider claims rider attachment and premium payment history rider terms (waiting periods, definitions, exclusions).	Join rider claims to rider premium status at event date test waiting period compliance computationally (event date versus rider commencement plus waiting period) flag critical illness claims within waiting periods and accidental death claims where the base was paid but rider conditions were unexamined.	Riders are administered less rigorously than base covers waiting period breaches are computable violations that file review alone rarely catches at population scale.
CL 11	Multiple claim and identity reuse screening. Objective: detect the same life, claimant or documentation appearing across multiple claims within the insurer and,	Claims population with deceased life identifiers, claimant identifiers, hospital/certificate references historical claims archive new business register (for XF 04).	Fuzzy match deceased life identifiers across the claims archive match claimant identities and documents (death certificate numbers, hospital registrations) across claims screen new proposals against previously claimed lives (deceased identity reuse).	The same death certificate or the same deceased identity appearing twice is fabricated death fraud a proposal on a life the insurer has already paid a death claim on should be

	where industry data is accessible, across insurers.			impossible if the screen finds one, the new business defence has a hole.
CL 12	Approval authority threshold analytics. Objective: detect settlements engineered around the delegated claims approval matrix amounts clustering just below approval limits, claims split into components to stay under a level and approvals by users at or beyond their delegated authority.	Claims payment file with approver ID and approval level delegated authority matrix with limits per level user master mapping approvers to grades component wise payout detail (base claim, interest, rider) per claim.	Band settlement amounts against each approval threshold and test for abnormal density immediately below limits (threshold hugging) aggregate component payouts per claim and re derive the authority level the total should have required join approver to the matrix and flag approvals above delegated limit, self approvals and maker–checker performed by the same or related users.	Density piling up just under an approver's limit is the statistical signature of authority avoidance a claim whose components individually sat within one level but whose total required a higher one shows the matrix is applied per transaction, not per claim a control design flaw with fraud utility.

CL 13	Outstanding claims reserve movement and stale claim analytics. Objective: test the integrity of the outstanding claims population that intimated claims are reserved promptly and adequately, reserves move with case facts and stale open claims are not parking either delay or earnings managemen t.	Claim intimation register outstanding claims listing with reserve amount and history by month settlement file with final paid amounts GL outstanding claims control account.	Reconcile the intimation register to the reserve listing to test completeness and intimation to reserve lag age open claims and flag long stale cases with no activity compare final settled amounts with last held reserves to measure reserve adequacy by product and cell profile reserve releases and strengthenings around period ends tie the listing total to the GL.	Intimated claims absent from the reserve listing understate liabilities settled to reserved ratios systematical ly above one reveal under reserving releases clustering at quarter ends with re establishme nt after indicate possible period end reserve manipulation requiring actuarial finance joint review route to FC 01 and the actuarial chapter's controls.

F. Investments (Chapter 10: Investments)

ID	Use case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
IN 01	Exposure and prudential norm testing at daily granularity. Objective: test single investee, group and industry exposure norms and pattern of investment requirements under Section 27A of the Insurance Act and the IRDAI investment framework, across every day of the period rather than at reporting dates.	Daily holdings by fund/segment, or opening holdings plus full trade ledger sufficient to reconstruct daily positions issuer group industry mapping master regulatory limits fund AUM series.	Recompute exposure percentages daily per fund and at controlled fund level where daily holdings are not stored, reconstruct daily positions from opening holdings plus trades rather than testing only reporting dates flag any intra period breach that had reverted by the reporting date test the issuer group mapping master itself for stale or missing group linkages.	Intra period breaches invisible at month end reveal window dressing the mapping master is the usual root cause an unmapped group entity understates group exposure everywhere at once.
IN 02	Approved investment	Holdings with rating history per	Reconstruct each	Delayed reclassificatio

	classification and downgrade response. Objective: verify classification between approved and other investments and timely reclassificati on and action on rating downgrades.	instrument rating agency feeds classification flags in the investment system Investment Committee actions on downgrades.	instrument's rating timeline and test the classification flag against it at each date compute time from downgrade event to system reclassification and to committee action flag holdings below investment grade retained beyond policy timelines.	n flatters the approved investment pattern and can conceal a regulatory breach slow committee response to downgrades is a governance finding independent of the accounting one.
IN 03	NAV recomputatio n and cut off application. Objective: independentl y recompute unit fund NAVs and test the application of declared NAVs to unit transactions (with PS 06).	Fund level assets, liabilities, units outstanding by day declared NAV series unit transaction log NAV error/compensatio n log.	Recompute NAV for each fund day from components and compare with declared NAV beyond tolerance reconcile the NAV error log with recomputation differences and test policyholder compensation for errors verify cut off application per PS 06.	Recomputatio n differences absent from the error log mean the error detection control itself failed uncompensate d NAV errors are quantifiable policyholder harm.

IN 04	Inter fund transfer testing. Objective: test transfers of securities between unit funds and between policyholder and shareholder funds for pricing, authorisation and pattern.	Inter fund transaction log with security, funds, price, timestamp, authoriser contemporaneous market prices.	Compare every inter fund transfer price with the market price at transfer time flag off market transfers and quantify the value moved between funds profile frequency, direction and timing (e.g., before valuation dates) and test authorisation.	Off market inter fund transfers redistribute value between sets of policyholders (or to shareholders) invisibly direction consistent patterns before valuation dates indicate deliberate performance management.
IN 05	Dealing room conduct analytics. Objective: screen the trade blotter for conduct risk broker concentratio n, off hour deals, price deviation and front running indicators.	Trade blotter with timestamps, broker, counterparty, price broker limits market price/volume series employee personal dealing disclosures, where disclosures contain ISIN/security, date and account level details sufficient for matching.	Compute broker wise volumes against approved limits flag trades time stamped outside market hours or priced beyond tolerance from contemporaneo us market levels sequence fund trades against price moves and, where reliable employee	Broker concentration beyond limits plus price deviation clustering with the same broker is the classic quid pro quo signature timestamp anomalies often reveal that the blotter is being written up after the fact.

			personal dealing data exists, against employee dealing disclosures for front running patterns.	Employee front running analytics should be treated as targeted testing where the underlying disclosure data is sufficiently granular.
IN 06	Settlement failure and DVP exception analysis. Objective: analyse failed and delayed settlements and exceptions to delivery versus payment discipline.	Settlement records with due and actual dates custodian fail reports exception approvals.	Age and profile settlement fails by counterparty, instrument and desk test that exceptions carried the required approvals correlate repeat fail counterparties with continued dealing.	Recurrent fails with a counterparty the desk keeps trading with indicates the risk framework is being overridden by relationship considerations.
IN 07	Custody reconciliation. Objective: reconcile the investment system's holdings to custodian and	Holdings per investment system custodian/depository statements reconciliation workpapers and break log.	Independently reconcile positions at multiple dates age unreconciled breaks test that breaks were resolved by	Aged breaks between books and custody are the precondition for misappropriation of

	depository records at full population.		correction rather than write off verify segregation of fund level holdings at the custodian.	securities the audit interest is less the break than the discipline of its resolution.
IN 08	Valuation source and stale price testing. Objective: test the pricing of thinly traded and unquoted instruments for staleness and manual override.	Instrument level price sources and dates manual price change log with user and rationale valuation policy.	Flag instruments carried at unchanged prices beyond policy defined staleness thresholds extract all manual price overrides and test authorisation and rationale quantify the portfolio share dependent on model or manual prices.	Stale and overridden prices concentrate exactly where losses hide a rising share of manually priced assets is an early warning indicator for the audit committee.
IN 09	Investment income recomputation. Objective: recompute interest, dividend and amortisation income across the debt book	Instrument master (coupon, day count, purchase price, maturity) corporate action feeds income postings in GL.	Recompute accrued interest and premium/discount amortisation per instrument per period match dividend receipts to corporate action announcements	Recomputation catches day count and amortisation configuration errors that misstate both income and policyholder bonuses unmatched

	and reconcile to the GL.		reconcile recomputed income to GL income lines by segment.	corporate actions indicate income leakage.
IN 10	Fund performance variance analytics. Objective: analyse fund returns against benchmarks and peers to direct audit attention, not to second guess investment judgement.	Fund NAV/return series declared benchmarks expense/charge data per fund.	Compute tracking difference by fund and period flag persistent underperformance beyond expense drag and abrupt performance shifts around personnel or mandate changes use results to prioritise deeper testing (IN 04, IN 05) on outlier funds.	Performance variance is a pointer, not a finding: its audit value is telling the auditor which fund's trades and transfers to put under the microscope.

G. Distribution: Agency and Intermediary Management (Chapter 13: Agency Licensing Function)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
AG 01	Business sourced by invalid intermediaries. Objective: confirm every	New business register with sourcing codes and proposal dates agent/intermed	Join every policy to its intermediary's validity timeline as at the proposal date	Business by unlicensed persons is a statutory breach that also invalidates

	policy's sourcing intermediary held a valid appointment/license on the proposal date, per Sections 40 and 42 of the Insurance Act and the applicable IRDAI appointment framework.	iary master with appointment, renewal, suspension and termination dates specified person (SP) master for corporate agents.	flag business sourced during expired, suspended or pre appointment periods for corporate agent business, test SP code validity separately from the corporate agent's own registration.	the commission paid on it (CM 02) clusters immediately after mass license expiry dates indicate the validity check is not wired into the sourcing workflow.
AG 02	Post termination activity. Objective: detect sourcing, servicing or system activity by intermediaries after termination or surrender of appointment.	Termination log new business and servicing transaction logs with initiating codes/user IDs system access logs commission payouts (CM 02).	Search all transaction and access logs for terminated codes and IDs after the termination date test whether system access was revoked within policy timelines trace any post termination business to how the front end accepted it.	Post termination activity means deactivation is manual and lagging combined with continued commission flow it suggests the termination exists on paper only.

AG 03	Dummy and benami agent detection. Objective: identify agent records that are fronts sharing bank accounts, contact details or identity documents with employees, other agents or customers.	Agent master (PAN, bank account, mobile, e mail, address) employee master customer master commission payout file.	Run cross master fuzzy joins on PAN, bank account, mobile and e mail among agents, employees and high value customers flag agents whose entire book traces to one employer group or one employee's customer base test agents with sourcing activity but no independent contact footprint.	An agent sharing a bank account with an employee is a conduit for routing commission to staff a fraud and a conflict of interest violation benami agents also corrupt every persistency and conduct metric built on agent codes.
AG 04	Orphan policy management. Objective: test the identification, reallocation and servicing of policies whose sourcing agent has exited.	Policy master with current servicing agent mapping agent exit log reallocation records persistency and complaint data for orphan cohorts.	Independently derive the orphan population (in force policies mapped to exited agents) and compare with the reallocated population age unallocated orphans compare	A large unallocated orphan population with visibly worse persistency quantifies the customer value cost of distribution churn an argument no anecdote can

			persistency and complaint incidence of orphan cohorts against the serviced book.	make as well as the data.
AG 05	Agent persistency and quality scoring. Objective: compute persistency (13th/25th/37th /49th/61st month) and quality indicators at agent level and test whether the insurer's empanelment and reward decisions respond to them.	Policy status history by sourcing agent FLC, early lapse, early claim and complaint data by agent R&R qualification lists (RR 01).	Compute cohort persistency per agent build a composite quality score (persistency, FLC rate, early claims, complaints) test the tail whether persistently bottom decile agents continue to be empanelled, promoted or rewarded.	Bottom decile agents receiving contest rewards is the sharpest possible demonstration that the incentive system rewards volume over quality this analytic supplies the named list.
AG 06	Sourcing code misuse. Objective: detect business logged under codes of persons who could not have sourced it employees on	New business register with sourcing code, logging user, branch and customer geography HR leave and exit data agent address/geogr aphy data.	Join sourcing activity to HR absence/exit records for employee codes compute geographic distance between customer and sourcing agent	Business logged under absent employees' codes or distant agents' codes reveals code lending usually to route commission or contest credit

	leave or exited, agents in other geographies, or house codes.		locations at population scale profile house/direct codes for volumes inconsistent with their purpose.	to someone other than the actual seller, defeating conduct accountability.
AG 07	Appointment prerequisites integrity. Objective: verify every appointed agent has the mandated training, examination and KYC records, tested as data rather than by file sampling.	Agent master training and examination records (dates, scores, centre) appointment dates identity document metadata.	Join appointments to training/exam records and flag appointments preceding exam passage or lacking records screen exam data for anomalies identical scores in batches, single centre concentration, exam to appointment intervals of implausible speed.	Appointments without valid prerequisites are regulatory violations individually batch anomalies in exam data point to systematic short circuiting of the qualification process.

H. Commission and Remuneration (Chapter 14: Commission)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
CM 01	Full population commission recomputation. Objective: recompute every commission payout against the board approved commission structure under the IRDAI (Expenses of Management, including Commission, of Insurers) Regulations, 2024 and the rates applicable to the product, channel, premium type and policy year.	Commission transaction file premium receipts it was computed on policy master (product, term, channel, policy year) board approved commission schedule with version history.	Rebuild expected commission per transaction from the rate schedule version in force on the trigger date compare with paid amounts beyond a tolerance reconcile total recomputed commission to the GL commission expense analyse differences by product, channel and rate master version.	Differences cluster around rate master version changes and manual interventions a recomputed total that will not reconcile to the GL means payouts are occurring outside the commission system the more serious finding. See the worked example in Part C.
CM 02	Commission to invalid intermediaries. Objective: identify	Commission payouts with intermediary code and trigger date	Join each payout to the validity timeline at the commission	Payouts to invalidly appointed persons breach Section 40 and

	commission paid where the intermediary's appointment was expired, suspended or terminated at the relevant date (extends AG 01/AG 02 into the payout).	intermediary validity timelines.	trigger date separately test renewal commission against the entitlement rules for exited agents (heirs, terminated for cause exclusions) quantify and age recoverable amounts.	are recoverable renewal commission continuing to agents terminated for fraud indicates the termination reason does not reach the payout system.
CM 03	Clawback completeness. Objective: verify commission clawback was raised and recovered for every FLC, early lapse and surrender falling within the clawback window and age the recoverable book.	FLC, lapse and surrender events with dates (PS 01/02/03) clawback rules by product/channel clawback raised and recovered records agent ledger balances.	Independently generate the clawback due population from servicing events and rules match against clawbacks actually raised recompute amounts age raised but unrecovered balances and test set off against ongoing payouts flag write offs and their authorisation.	Unraised clawbacks are silent leakage that servicing data alone reveals a growing unrecovered book with continuing gross payouts to the same agents means the set off mechanism is not operating.

CM 04	Duplicate payout detection. Objective: detect the same commission entitlement paid more than once and payouts to duplicate intermediary identities.	Commission transactions keyed by policy, period and payout type intermediary master with bank details (AG 03 joins).	Run duplicate detection on (policy, premium instalment, payout type) fuzzy detect near duplicates across reprocessing runs and system migration boundaries combine with AG 03 to catch the same real person paid under multiple codes.	Exact duplicates trace to reprocessing without reversal common around migrations and rate corrections person level duplicates via multiple codes are fraud, not error.
CM 05	Manual intervention and rate master change analytics. Objective: profile every manual override, off system payout and rate master change for authorisation, timing and concentration.	Commission system override log rate master change log with user and timestamp off cycle/manual payment records approval workflow data.	Extract all manual interventions test each against the approval matrix profile by user, agent benefited and timing (period end, contest cut off spikes) test rate master changes for maker checker and for	Manual overrides concentrated in one user–agent pairing, or retroactive rate changes before contest cut offs, convert a computation process into a discretionary one the core risk in this cycle.

			retroactive effect.	
CM 06	Hierarchy and override commission correctness. Objective: recompute supervisory/override commission against the distribution hierarchy in force at the trigger date.	Hierarchy master with change history override commission payouts base commission transactions they derive from.	Recompute override entitlements from the hierarchy version at trigger date flag overrides paid on hierarchies changed retroactively test circular or self referencing hierarchy structures.	Retroactive hierarchy edits before payout runs are the standard mechanism for diverting override commission circular structures indicate master data manipulation.
CM 07	Remuneration within EoM linkage. Objective: aggregate commission, rewards and other intermediary remuneration and test consistency with the insurer's EoM position and board policy (links to ME 01, RR 02).	Commission, R&R and other remuneration ledgers by intermediary and segment EoM computation workings board approved policy limits.	Aggregate total remuneration per intermediary and per segment reconcile to the EoM computation's remuneration lines flag intermediary level totals inconsistent with board policy caps or with the pattern the policy contemplates.	Remuneration reaching intermediaries through non-commission lines (rewards, reimbursements, event sponsorships) understates the true acquisition cost in exactly the way the EoM framework was designed to expose.

CM 08	Tax deduction correctness on payouts. Objective: test TDS under Section 194D (and GST treatment where applicable) across the commission payout population.	Payout file with gross, TDS, net intermediary PAN status TDS returns filed, Form 26Q data and challans applicable rate table by period GST treatment where the intermediary arrangement makes it relevant.	Recompute TDS per payout at the rate applicable in the period (including higher rates for inoperative/absent PAN) reconcile deducted totals with TDS returns, Form 26Q, challans and ledger balances flag payouts with no deduction and valid looking gross ups test GST treatment only where applicable to the payout structure.	Under deduction creates a direct tax exposure with interest and penalty payouts engineered as non-commission heads to avoid TDS also surface in the CM 07 aggregation.
CM 09	First year versus renewal classification. Objective: verify commission is classified and rated correctly between first year and renewal, including	Commission transactions with year of policy classification premium history with revival and mode change events.	Recompute the policy year of each premium from the premium history and compare with the classification the rate applied focus on revival premiums,	First year rates applied to renewal premium is over payment the reverse understates acquisition cost both distort the EoM computation and the agent's

	around revivals, reinstatements and premium mode changes.		mode changes and backdated policies (NB 04) where misclassification concentrates.	true economics.
CM 10	Dormant agent payout anomalies. Objective: flag renewal commission streams to long dormant agents where servicing details changed recently the payout diversion pattern applied to commission.	Renewal commission payouts agent activity data (last sourcing, last login) agent master change log (bank, contact) with dates.	Identify agents with no sourcing activity beyond a threshold but continuing payouts join to master data changes and flag bank/contact changes shortly preceding payout runs verify change authorisation and customer… agent confirmation where required.	A dormant agent's bank account changing just before payouts is the same diversion signature as PS 08, exploited against the insurer's longest tail payment stream.

I. Rewards and Recognition (Chapter 15: Rewards and Recognition)

ID	Use case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates

RR 01	Contest eligibility recomputation. Objective: independently recompute qualification for each contest from source business data and compare with the declared winners.	Contest rules (criteria, measurement window, exclusions) new business, persistency, FLC and lapse data by intermediary for the window declared qualifier lists and rewards disbursed.	Rebuild each qualifier list from source data applying the rules, including exclusions for FLC, early lapsed and subsequently cancelled business compare with the declared list in both directions recompute reward values.	Qualifiers who fail recomputation typically because FLC/lapse exclusions were not applied mean rewards were paid on business that evaporated omitted qualifiers indicate manual tampering with the list.
RR 02	R&R cost capture and valuation. Objective: verify all R&R costs, including benefits in kind (travel, conventions, gifts), are captured, valued and included in remuneration and EoM computations.	R&R expense ledgers event and travel vendor invoices qualifier lists (RR 01) EoM workings (ME 01) CM 07 aggregation.	Match event and travel spend to qualifier lists and allocate per intermediary test valuation of benefits in kind against invoices trace the aggregate into the EoM computation and the intermediary level remuneration view test tax treatment (TDS/perquisite)	R&R cost that never reaches the per intermediary remuneration view is the standard route for exceeding intended remuneration invisibly untaxed benefits in kind add a compliance exposure on top.

			of non-cash rewards.	
RR 03	Threshold clustering and cut off manipulation. Objective: detect qualification manufactured at contest cut offs through backdating, advance premium or churned business.	Contest window business with logging and risk commencement dates (NB 04) premium receipt dates churn data (PS 04) qualifier margins over thresholds.	Compute each qualifier's margin over the threshold profile the density of business logged in the final days of windows join marginal qualifiers to backdating, advance premium and churn flags from NB 04 and PS 04.	Qualifiers who cross thresholds only with cut off clustered, backdated or churned business earned the reward from manipulation the pattern also predicts post contest FLC and lapse spikes worth testing directly.
RR 04	Rewards to restricted recipients. Objective: test that rewards were not extended to intermediary categories or persons for whom the regulatory framework or board policy restricts them.	Qualifier and reward lists intermediary type master board policy and applicable regulatory restrictions employee master (for staff routed as agents, AG 03).	Screen reward recipients against restricted categories and against the AG 03 dummy agent flags test group entities and referral partners receiving R&R outside the remuneration framework.	Rewards to restricted or front recipients convert R&R into an unregulated remuneration channel the finding is the channel, not the individual trip.

J. Advertisements and Market Conduct Communications (Chapter 16: Advertisements)

ID	Use case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
AD 01	Advertisement register completeness and approval integrity. Objective: verify every released advertisement exists in the register with the required approvals and retention under the IRDAI (Insurance Advertisements and Disclosure) Regulations, 2021.	Advertisement register (ID, versions, approvals, release/withdrawal dates) marketing spend ledger media agency release schedules digital platform postings.	Reconcile the register against marketing spend and agency release data to find released but unregistered material test approval workflow completeness per register entry verify withdrawn products' advertisements were actually pulled (register versus live media check).	Spend without a register entry is the completeness finding that register only review cannot produce live advertisements for withdrawn products are a direct regulatory violation with customer remediation consequences.
AD 02	Corpus wide language screening. Objective: screen the full text of advertisements, sales scripts and	Full text corpus of registered advertisements, digital creatives, tele calling scripts and standard sales presentations.	Run keyword and model based screening for prohibited claim patterns (assured/guaranteed returns on non-guaranteed products, tax	Model output is a nomination, not a conclusion every flag needs human confirmation

	benefit communications against prohibited language norms guarantees, misleading return claims, disparagement using text analytics or language models (Chapter 21, paragraph 21.6.2).		claims beyond law, comparative disparagement) route flagged items to human review measure violation density by channel and creative source.	a violation density skewed to one channel's locally produced material shows where central approval is being bypassed.
AD 03	Intermediary digital content surveillance. Objective: test the insurer's monitoring of agent and third party generated online content marketing its products.	The insurer's own social media monitoring output complaint texts referencing online promises (GR 03) approved social listening tool results, search engine indexed sampling and documented manual review of public product mentions.	Evaluate the coverage and follow up of the insurer's monitoring process independently review approved social listening/search results and sampled public content for product mentions with prohibited language avoid covert or terms of service breaching scraping join confirmed violations to the	Unmonitored intermediary content is where exaggerated return promises are most likely to appear monitoring without documented follow up against identified intermediaries is surveillance theatre.

			responsible intermediary and test disciplinary follow through.	

K. Management Expenses and Expenses of Management (EoM) (Chapter 17: Management Expenses)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
ME 01	EoM computation validation. Objective: independently rebuild the EoM computation under the IRDAI (Expenses of Management, including Commission, of Insurers) Regulations, 2024 and test compliance with limits and the board approved policy.	Trial balance by cost centre and segment EoM workings and returns filed premium data driving allowable limits board policy.	Recompute allowable limits from premium data rebuild actual EoM from the ledger including items routed through other heads (CM 07, RR 02) compare with the filed return test segment wise allocation and any forbearance conditions.	Differences between the auditor's rebuild and the filed return usually sit in classification remuneration like spend parked outside EoM heads an insurer near its limit has a structural incentive for exactly that misclassificatio n, which is why the rebuild must be independent.
ME 02	Expense allocation and apportionment testing.	Cost centre expense data allocation driver data	Reperform allocations from drivers and rules	Mid year allocation rule changes that conveniently

	Objective: test the bases used to allocate expenses across segments and between policyholder and shareholder accounts, for consistency and manipulation.	(policy counts, premium, headcount) allocation rules with change history segmental results.	across the population of cost centres flag rule changes mid year and quantify their segmental effect test expenses charged to policyholder funds against the permissible charge framework.	relieve a constrained segment are the finding costs pushed to policyholder accounts that belong to shareholders are both an EoM and a fairness issue.
ME 03	Vendor and payables analytics. Objective: run classical procure to pay analytics duplicates, splitting, master data risk across the full vendor spend.	Vendor master with bank details and change log PO, GRN and invoice populations payment file employee master (for XF 01 joins) approval matrices.	Detect duplicate invoices (exact and fuzzy on vendor amount date reference) flag invoice and PO splitting just below approval thresholds test vendor master changes (especially bank accounts) around large payments join vendor identifiers to the employee master profile round sum and	Split transactions clustered under one approver's threshold expose approval matrix evasion a vendor sharing a bank account with an employee is an immediate escalation duplicate payment recoveries typically self fund this analytic many times over.

			period end invoices.	
ME 04	Payroll and workforce analytics. Objective: test payroll completeness and validity ghost employees, post exit payments, anomalous components.	Payroll register by month HR master with join/exit dates attendance/bio metric or system login data bank accounts on payroll.	Join payroll to HR status per month and flag payments outside employment periods duplicate detect bank accounts across employees correlate sustained zero attendance/zero login with continued pay profile allowance and overtime outliers by approver.	Payments after exit and shared bank accounts are the ghost employee signatures the login based presence test works even where biometric data is unreliable.
ME 05	Period end expense behaviour. Objective: analyse accrual, provision and expense booking behaviour around period ends for	Expense postings with posting and document dates accrual and reversal entries budget versus actual by cost centre (feeds FC 01).	Profile expense booking density in the final days of periods against the run rate trace period end accruals to subsequent reversals and re bookings flag cost centres that	Accrue and reverse cycles that shift expense across periods and cost centres steered onto budget by period end entries, indicate results management which in an

	smoothing or deferral.		land exactly on budget through late adjustments.	EoM constrained insurer has regulatory as well as reporting consequences.

L. Anti Money Laundering and Financial Crime (Chapter 18: Anti Money Laundering)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
ML 01	Cash transaction aggregation and CTR completeness. Objective: independently aggregate cash receipts per customer per month and verify Cash Transaction Reports to FIU IND capture the reportable population under the PMLA framework and the IRDAI	Receipting data with mode, amount, date, customer identifiers CTR filings for the period.	Aggregate cash receipts per customer per calendar month across all policies and branches compare the above threshold population with CTRs filed test the aggregation logic in the insurer's own system against the auditor's independent aggregation.	CTR gaps usually trace to aggregation failures cash split across policies or branches that the system counts separately the independent aggregation is the only way to prove completeness rather than sample it.

	AML/CFT Master Guidelines.			
ML 02	Structuring detection. Objective: detect premium payments structured just below cash and identity document thresholds.	Receipting data with amounts, modes, dates threshold values applicable in each period customer/payer identifiers.	Compute the density of receipts in narrow bands just below thresholds versus the surrounding distribution flag customers with repeated just below threshold cash receipts across days or policies profile branches with skewed banding.	A receipt distribution spiking just under a threshold is not customer coincidence branch level skew indicates staff coaching the structuring.
ML 03	Third party premium payment analysis. Objective: identify premiums paid by persons other than the policyholder and test the	Payer identifiers on receipts (account name, instrument data, payment gateway metadata) policyholder identifiers agent and employee masters.	Match payer identity to policyholder identity across the receipt population profile mismatches by relationship where captured flag	An agent funding many customers' premiums signals either premium financing (a conduct issue), business manufactured for contests (RR 03), or laundering through

	insurer's handling of the third party payment risk.		payers who fund many unrelated customers' premiums particularly agents or employees join to refund destinations (ML 08).	insurance wrappers the follow up distinguishes which.
ML 04	Risk categorisation and EDD coverage testing. Objective: test customer risk categorisation completeness and whether enhanced due diligence actually occurred for high-risk and PEP customers.	Customer master with risk category and review dates PEP/sanctions screening results EDD documentation flags product and transaction risk factors.	Test category assignment against the board approved risk model by recomputing expected category from factors flag high-risk customers past their review date verify EDD documentation flags for the high-risk and PEP populations test unresolved screening hits with active transactions.	Customers whose recomputed risk exceeds their assigned category show the model being overridden at onboarding transacting customers with unresolved screening hits collapse the entire screening control's purpose.

ML 05	Single premium and early exit typologies. Objective: detect the classic insurance laundering pattern large single or top up premiums followed by early surrender, loan or assignment.	Single premium and top up transactions (PS 07) subsequent surrender, loan and assignment events with intervals payout destinations.	For every large single premium or top up, compute the interval to the first value extraction event (surrender, maximum loan, assignment) flag short interval extractions, especially with payout to a different account than the funding source (ML 08) aggregate by customer and introducer.	Money entering as premium and leaving within months as "insurance proceeds" is layering concentration under one introducer converts scattered anomalies into a typology finding for STR consideration (ML 06).
ML 06	Alert pipeline and STR discipline. Objective: evaluate the transaction monitoring alert pipeline volumes, ageing, disposition	Alert data (rule, date, assigned analyst, disposition, dates) STR filings rule/threshold configuration change log.	Compute alert ageing and disposition mix by rule and analyst flag analysts with outlier closure speed or near total "not	An analyst bulk closing alerts, or a threshold change that silenced a rule, hollows the pipeline invisibly the sharpest test is confrontation patterns the auditor found

	quality and the conversion to Suspicious Transaction Reports.		suspicious" rates test threshold changes for authorisation and for suppression effect (alert volume collapse after a change) trace ML 05 type independent findings back to whether the system alerted on them.	that generated no alert measure the monitoring system's real sensitivity.
ML 07	Sanctions and watchlist rescreening. Objective: independently rescreen the customer, nominee, payer and payee populations against current sanctions and watchlists and evaluate	Full party population (customers, nominees, assignees, payers and payees on claims and refunds) current licensed sanctions/watchlist data the insurer's screening configuration and hit logs.	Rescreen the full party population, including nominees and payout payees whom onboarding screening often misses, using the insurer's licensed tool in reperformance mode or an approved independent screening	Parties the auditor's licensed/approved screen catches but the insurer's missed typically nominees and payees added post onboarding define the screening perimeter gap precisely. Ad hoc spreadsheet matching should not be treated as a substitute for licensed

	fuzzy match quality.		vendor compare hits with the insurer's own test match threshold configuration with seeded name variants.	sanctions screening.
ML 08	Refund and payout destination integrity. Objective: test that refunds and early exit payouts return to the source of funds or a validated account of the entitled party.	Refund and payout files with destination accounts original funding instrument/accou nt data account validation (penny drop) logs servicing change log (PS 08).	Match payout destinations to funding sources for FLC refunds, proposal deposit refunds and early surrenders flag third account payouts and test the validation performed join with PS 08 pre payout account changes.	Money in from one account and out to another is the laundering completion step and the fraud diversion step in the same movement this single join serves both the AML and the fraud programme.

M. Outsourcing (Chapter 19: Outsourcing Function)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates

OS 01	Outsourcing perimeter completeness. Objective: identify outsourced activities being performed outside the approved outsourcing register, per the IRDAI outsourcing framework (now within the Operations and Allied Matters of Insurers Regulations, 2024).	Approved outsourcing register full vendor payment population with expense heads contract repository metadata system user IDs by organisation.	Classify vendor spend by service nature and flag payments whose service description matches outsourceable activities but whose vendor is absent from the register reconcile register entries to live contracts and to actual spend (dormant approvals, unapproved activity).	Outsourcing discovered through the spend ledger rather than the register means the governance framework covers only what chose to enter it the completeness finding that register based review cannot make.
OS 02	SLA performance recomputation . Objective: recompute vendor SLA achievement from raw transaction data rather than accepting vendor reported MIS and test	Raw transaction/ticket data from outsourced processes (timestamps, outcomes, error flags) contracted SLA definitions vendor MIS as reported penalty/credit ledger.	Recompute each SLA metric from raw data and compare with vendor reported figures quantify penalties due under the contract versus levied profile SLA misses by	Vendor reported SLAs that outperform recomputation reveal measurement gaming (timestamp manipulation, exclusion abuse) penalties due but never

	penalty enforcement.		process and period.	levied show contract management as a filing function, not a control.
OS 03	Vendor concentration and related party screening. Objective: analyse dependence concentration and screen vendors for undisclosed relationships with employees, agents or group entities.	Vendor master and spend by vendor corporate registry/beneficial ownership data where available employee and agent masters (XF 01) related party disclosures.	Compute spend concentration by vendor and by critical process join vendor identifiers, directors and bank accounts to employee/agent masters compare findings with declared conflicts and related party disclosures.	Critical process dependence on one vendor is a resilience finding an undisclosed employee interest in a vendor is a conduct finding the joins produce both from the same data.
OS 04	Vendor access and data exposure testing. Objective: test that vendor personnel's system access is provisioned, restricted and revoked in line with contracts and data	Vendor user ID population with entitlements and last use contract start/end dates vendor personnel rosters data access logs for sensitive tables.	Flag vendor IDs active past contract end or absent from current rosters test entitlement breadth against the contracted scope profile vendor access to sensitive policyholder data (medical,	Live access after contract expiry is the recurring finding in every environment tested vendor entitlements broader than the contracted process

	protection obligations.		financial) against necessity, in view of DPDP Act obligations.	indicate provisioning by template rather than by need.

N. Legal and Compliance (Chapter 11: Legal and Compliance)

ID	Use case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
LC 01	Obligations register and regulatory change coverage testing. Objective: test the completeness and currency of the compliance obligations register (Chapter 12, paragraph 12.4) and whether regulatory changes actually landed in processes, systems, contracts and board approved policies.	Obligations register with owner, source, risk rating and last review date independent obligation list built from IRDAI's regulations, master circulars and gazette notifications regulatory change log board policy inventory with review due dates and approval minutes contract repository with amendment dates.	Reconcile in both directions independent obligation list to register (completeness) and register to owner, evidence and review date (currency) join the change log to implementation artefacts and test that changes with transition windows produced process, system, policy or contract amendments within the window	An obligation absent from the register is unmanaged by design, not by lapse the highest severity finding in this domain a regulatory change logged as "noted" with no downstream artefact means the change management process ends at circulation policies past their review date with unchanged content

			(paragraphs 12.5.2, 12.10.7) compare board policy review due dates with actual approval dates (paragraph 12.3.5).	indicate the policy inventory is a shelf, not a control.
LC 02	Regulatory returns universe timeliness, acknowledgement and source reconciliation. Objective: independently build the returns population from the Master Circular on Submission of Returns and test each filing for timeliness, accuracy against source systems and pre filing governance approval (paragraph 12.6).	Independent returns inventory from the master circular the insurer's filing calendar portal acknowledgements and timestamps the filed returns GL, policy administration and actuarial source data for key figures governance minutes or approvals for returns requiring pre filing approval under law, circular, board policy or the insurer's internal filing matrix.	Reconcile the independent inventory to the filing calendar and flag returns absent from the insurer's own calendar compute filed versus due dates from acknowledgement timestamps, not preparation dates reconcile reported figures to GL/PAS/actuarial sources and test consistency across related returns for the same period for returns requiring governance	A return missing from the insurer's calendar will never be filed or tested unless someone outside the first line finds it which is exactly what this test does figures that do not tie to source make the filing an unsupported certification approval recorded after filing is governance applied after the event.

			approval under law, circular, board policy or internal filing matrix, compare the approval date with the filing date.	
LC 03	Rural and social sector obligation analytics. Objective: test the classification and counting behind the rural and social sector obligation return (paragraph 12.8) the qualifying population, the denominator, duplicates and the self-certification concentration.	Policy level data with address, location and scheme/beneficiary identifiers the allocated gram panchayat mapping Gram Sachiv certificates and rural self-certification flags group policy member data and counting basis the obligation computation and return social sector self-certification flags with logging dates.	Test lives reported as rural against the allocated gram panchayat mapping from policy address data test Gram Sachiv certificate coverage and compute rural self-certification against the applicable cap test social sector lives for scheme membership or beneficiary identifiers on file verify the denominator (total lives covered) and the group counting basis	A year end surge of self-certified lives is the signature of an obligation being closed on paper rather than met in the field rural self-certification beyond the permitted cap, social sector self-certification beyond the permitted cap, a shortfall against the statutory percentage, or a denominator error that manufactures achievement is a statutory breach

			detect double counting across obligations and policies compute the social sector self-certified proportion against the permitted cap and run a time series of self-certification logging dates, treating a final quarter surge as a trigger for enhanced verification.	reportable in the return itself.
LC 04	Tax and information reporting analytics. Objective: test withholding on policyholder payouts, GST output liability and FATCA/CRS reporting completeness (paragraph 12.9). Commission side TDS is	Payout files (surrenders, maturities, other taxable policy payouts) with TDS deducted and exemption basis product taxability master TDS returns and challans premium register by product GST returns customer master with citizenship, residence and	Recompute TDS on the policy payout population under Section 194DA against the recorded exemption logic (including Section 10(10D) eligibility flags) and reconcile deducted totals to returns and challans rebuild expected GST	Taxable payouts with no deduction and no documented exemption basis are direct statutory exposure with interest and penalty consequences a premium register to GST gap is leakage in one direction or

	covered at CM 08.	indicia fields the FATCA/CRS reported accounts file.	output liability from the premium register by product taxability and reconcile to GST returns independently rescreen the customer base for FATCA/CRS reportable indicia and compare with the population actually reported.	the other reportable accounts the rescreen finds but the insurer never reported define the information reporting perimeter gap.
LC 05	Litigation register and repeat litigation analytics. Objective: test the completeness and management of the central litigation register (paragraph 12.10.6) and what repeat litigation says about unremediated process	Litigation register across all matter types with counsel, stage, next hearing and limitation dates, claim amounts, provisions and contingent liability assessments external counsel billing data Ombudsman and consumer forum data	Test register completeness by joining matters referenced in counsel invoices, Ombudsman data and demand notices to the register flag matters with past due next hearing dates or unmonitored limitation dates compare provisions and	A matter that appears in counsel billing but not in the register means the register is fed by memory, not process a cluster of similar matters is a process defect the insurer is paying to re litigate instead of fixing trace it to the claims,

	defects. Ombudsman outcome analytics sit at GR 05.	settlement approvals.	contingent liability classifications with matter ageing and demand amounts test settlement approvals against delegated authority cluster matters by product, channel, branch and claim type to identify issues being litigated repeatedly.	servicing or sales control that keeps producing it.
LC 06	Regulatory findings, commitments and enforcement analytics. Objective: test the single register of inspection findings, show cause matters, penalties, appeals and regulatory commitments (paragraph 12.11),	The findings and commitments register with owner, due date, status and closure evidence IRDAI correspondence , inspection reports and orders penalty and disgorgement accounting entries appeal records regulatory approval	Test register completeness against source correspondenc e including commitments made in letters, emails, meetings and approval conditions, which are missed precisely because they are not periodic filings age open findings	A repeat finding is direct evidence the remediation process does not work, whatever the closure documentatio n said a disgorgement order followed by the same transaction pattern in the live system converts a

	including genuine closure and post disgorgement decommissioning.	conditions and management representations.	by owner detect repeat findings across periods and locations verify penalty and disgorgement amounts are recorded, accounted and disclosed, with appeal status tracked for disgorgement orders, run a transactional trace over the subsequent months to confirm the offending product, payout or expense structure was actually decommissioned in production, not merely committed to.	closed regulatory matter into a live enforcement risk.
LC 07	Related party tagging and mischaracterised payment screening. Objective: detect related party payments	Full vendor payment population RPT register and approvals group entity, director, KMP and intermediary	Join vendor identifiers, directors and bank accounts to the related party universe and flag payments to	A payment stream that scales with premium sourced through the payee is remuneration

	not identified as such and expense structures marketing, consultancy, advertisement, administration that function as remuneration for business (paragraphs 12.3.4, 12.12.1). Links CM 07, ME 03 and OS 03.	relationship data expense head mapping business volume data by intermediary, channel and referral partner.	related parties absent from the RPT register or lacking the required approval profile large marketing, consultancy and administrative payments for correlation with business volumes sourced by or through the payee and for step changes around contest periods or EoM pressure compare the resulting reclassification view with the EoM computation's expense heads (ME 01).	wearing an expense label simultaneously an EoM overstatement in the wrong head, a Section 40 exposure and the exact pattern paragraph 12.12.1 describes as payments mischaracterised to stay below the regulatory radar.

O. Grievance Redressal and Policyholder Protection (Chapter 12: Relationship and Complaint Handling)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
GR 01	Grievance turnaround and lifecycle testing. Objective: test complaint resolution against the regulatory timeline (resolution within 14 days under the 2024 policyholder protection framework) across the full population, including the integrity of "resolved" status.	Complaint records: receipt, acknowledgement, resolution dates, category, status changes, reopen flags customer confirmation data where captured.	Compute turnaround across the population and flag breaches test resolution date integrity by measuring reopen rates, complaints "resolved" within implausibly short intervals of receipt and closures without a recorded response or confirmation to the complainant profile by category, branch and channel.	Bulk same day resolutions with high reopen rates indicate closure management, not resolution category level turnaround skews point to processes, not complaint handlers, as the constraint.
GR 02	Bima Bharosa (IGMS) reconciliation and mirroring. Objective:	Internal CRM complaint extract Bima Bharosa extract for the	Two way match on complaint identifiers and attributes flag regulator	Complaints reclassified into softer categories between

	reconcile the internal complaint database with the regulator's Bima Bharosa records in both directions and test whether the insurer's complaint portal is mirrored/synchronised with Bima Bharosa as required.	insurer API/interface or mirroring logs classification mapping between the two.	visible complaints absent internally (intake failure), internal complaints unregistered with the regulator where registration was required and complaints not mirrored within the expected interface timeline compare category classifications for systematic softening.	systems (mis selling recorded internally as "service delay") distort both the regulator's view and the insurer's own conduct analytics.
GR 03	Complaint text mining for root cause and conduct. Objective: mine complaint free text at corpus scale for mis selling indicators, recurring failure themes and emerging issues	Full complaint text corpus with metadata (product, agent, branch, date) resolved root cause codes as recorded.	Run theme extraction and mis selling language detection over the corpus compare machine derived themes with the recorded root cause codes attribute conduct	The gap between what complainants say and what root cause codes record is itself the finding coding practices that launder mis selling into service categories new theme

	(applying Chapter 21, paragraphs 21.5.8 and 21.6.2).		flagged complaints to intermediaries and feed AG 05 scoring track theme emergence over time.	emergence gives audit an early warning capability no periodic review has.
GR 04	Complainant network and linkage analysis. Objective: link complaints to the transactions they concern and identify repeat complainants, complaint to exit patterns and agents whose customers complain in clusters.	Complaint records with policy linkage servicing and claims events for linked policies intermediary mapping.	Join complaints to subsequent policy behaviour (FLC, surrender, claim dispute) compute repeat complainant and per agent complaint incidence normalised by book size identify clusters where one agent's customers file near identical complaints.	Complaint clusters with common language across one agent's book corroborate the mis selling signal from PS 04 and AG 05 complaint then surrender sequences quantify the retention cost of unresolved grievances.
GR 05	Ombudsman and forum outcome analytics. Objective: analyse Insurance Ombudsman	Ombudsman/forum case register with issue, outcome, award, compliance date internal	Compute win/loss and award patterns by issue type test Ombudsman award compliance	Paying awards late is a discrete compliance breach with penalty exposure losing the

	and consumer forum outcomes, compliance timelines for awards and what recurring losses say about internal decision standards.	decisions that were appealed (CL 05, CL 07 links).	against the mandated 30 day timeline, subject to appeal carve outs where applicable compute delay/penalty exposure trace recurring losing issues back to the internal decision standard that produced them.	same issue repeatedly while the internal standard stays unchanged means the organisation is buying the same lesson at retail, case after case.

P. Financial Close and General Ledger (Chapter 22: Financial Closing Process)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
FC 01	Journal entry analytics. Objective: screen the full manual journal population for override risk using the standard high-risk attributes, tuned to	Complete JE population with user, timestamp, source, approver chart of accounts with risk tags period calendar HR role data.	Extract manual and top side entries score by risk attributes posted outside hours, at period end, round sum, self approved, by IT or service accounts, to revenue/reserve/suspense accounts cluster by user and account as per the triage framework in	Individual attributes are noise the finding lives in combinations a service account posting round sum period end entries to premium

	insurance accounts.		Chapter 21, paragraph 21.6.3.	suspense is a different universe from a routine accrual and scoring is what separates them.
FC 02	PAS to GL three way reconciliation. Objective: perform the premium, commission and claims tie out between the policy administration system, the GL and the actuarial extract that Chapter 21, paragraph 21.2.2 establishes as the foundation discipline.	Period transaction totals and record counts from PAS by type corresponding GL account activity actuarial valuation extract control totals interface logs (IT 05).	Reconcile each flow (premium, commission, claims, surrenders) between PAS and GL at count and value classify differences as timing, definitional or unexplained reconcile the actuarial extract's in force and premium to both investigate unexplained residuals to transaction level.	Persistent unexplained residuals mean transactions exist in one system but not another the precondition for both misstatement and concealment the classification discipline prevents the reconciliation from dying in "known difference" folklore.
FC 03	Suspense and control account discipline.	All suspense/control account activity with	Build entry level ageing per account test clearance mode distribution	Suspense that empties for the balance

	Objective: age and test every suspense and control account for clearance behaviour, write back practice and period end management.	entry level detail ageing at multiple dates write off/write back entries with approvals (extends PS 09 beyond premium suspense).	(matched, refunded, written back) flag balances that dip at period ends and rebuild after test write back authorisation and P&L destination.	sheet date and refills in week one is being parked, not cleared write backs of customer money to income recur here as they did in servicing.
FC 04	Cut off testing at population scale. Objective: test recognition of premium, commission and claims in the correct period across all transactions bracketing period ends.	Transactions dated in a window around each period end with event, receipt/realisation and posting dates reversal entries in the subsequent period.	Compare event/realisation dates with posting periods for the full bracketing window quantify recognition shifted across the boundary in each direction profile early recognition concentration by branch or channel against targets.	Premium recognised before realisation restates the Section 64VB issue in accounting form branch concentrated early recognition around targets is results manipulation with a named owner.
FC 05	Policyholder –shareholder account integrity. Objective: test transfers	Fund wise GL transfer entries with approvals expense allocation	Extract all inter fund transfers and test authorisation and basis reconcile expense attribution to the ME 02 allocation	Shareholder costs borne by policyholder funds, or income

	and expense/income attribution between policyholder and shareholder funds against the regulatory framework and board approvals.	output (ME 02) surplus distribution workings.	output test investment income attribution between funds against asset ownership records.	attributed against asset ownership, is misappropriation between stakeholder classes even when the consolidated totals are perfect only fund level analytics can see it.

Q. IT General Controls and Access Analytics (Chapter 21: Cyber Security and IT Controls)

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
IT 01	Access lifecycle testing against HR reality. Objective: test the full user population of critical applications against HR status leavers, movers, dormancy.	User lists with entitlements and last login for PAS, claims, commission, investment and finance systems HR master with exit/transfer dates access request/approval records.	Join users to HR status flag active accounts of exited staff and access retained after role transfers profile dormant accounts test a sample free population match of provisioning against approvals.	Exited user access to payout capable systems is the single most exploitable ITGC failure mover accumulated access is subtler and larger and only the population join reveals

				its true extent.
IT 02	Segregation of duties conflict analytics. Objective: detect toxic entitlement combinations within and across applications and, critically, whether conflicting access was actually used.	Entitlement data across applications mapped to business functions SoD conflict matrix transaction logs by user.	Run the conflict matrix across the combined entitlement population, including cross application conflicts (e.g., agent master maintenance in one system plus payout release in another) for each conflicted user, query transaction logs for actual exercise of both sides of the conflict.	Possessed but unused conflicts are provisioning findings exercised conflicts the same user changing a bank account and releasing the payment to it are incidents to investigate and the transaction log join is what tells them apart.
IT 03	Privileged activity and direct data change monitoring. Objective: test privileged and direct database activity against production data	Privileged account inventory database audit logs for direct changes to policy, commission, claims and rate tables change ticket references firefighter/emergency access logs where database logs are not available, application audit	Extract direct data modifications to critical tables match each to an approved change or incident ticket profile unmatched changes by account, table and timing test emergency access sessions for post use review where database logs are	A direct update to the commission rate table with no ticket is an override of every application control built above it this analytic is the reason

	underlying financial and policy records.	logs, API logs, admin console logs, vendor SOC/ISAE reports and managed service provider confirmations.	unavailable, triangulate through application/API/admin logs and vendor assurance reports rather than dropping the test.	the business analytics elsewhere in this library can be trusted at all.
IT 04	Change management conformance. Objective: test that production changes followed the approved path population matching deployments against tickets rather than sampling tickets against deployments.	Deployment/release logs from production change tickets with approvals and test evidence flags emergency change records.	Match every production deployment to an approved ticket (the direction that finds unauthorised change) profile emergency changes for volume and post facto approval discipline test developer access to production against the deployment population.	Sampling tickets finds sloppy paperwork matching deployments to tickets finds unauthorised change the direction of the test is the control insight.
IT 05	Interface and batch completeness monitoring.	Interface run logs with record counts in/out, failure and rejection files reprocessing	Reconcile record counts across each interface hop for the period age unreprocessed	Rejected records that were never reprocessed are

	Objective: test the completeness and error handling of the interfaces this library depends on PAS to GL, PAS to actuarial, receipting to PAS, commission to payments.	records FC 02 reconciliation results.	rejections correlate interface failure dates with FC 02 unexplained differences test alerting on batch failure.	transactions that silently exist on one side only the mechanical origin of most "unexplained" reconciliation residue.
IT 06	DPDP, consent, data retention and sensitive field access analytics. Objective: test whether policyholder personal data, especially medical and financial data, is	Consent logs customer data inventory retention schedule data access logs for sensitive ields bulk download/export logs vendor data sharing logs deletion/anonymisation records.	Profile access to sensitive fields by user, role, vendor and purpose flag bulk downloads, after hours access and access by users/vendors without business need compare retained records with the retention schedule reconcile vendor data transfers to contracts and consent/purpose documentation test deletion/anonymisation completion	Excessive retention, broad sensitive data access or undocumented vendor sharing converts an operational data store into a regulatory and privacy exposure bulk downloads are also a leading

	accessed, retained, shared and deleted in line with documented purpose, consent and retention rules.		for expired retention cases.	indicator of data leakage risk.

R. Cross Functional Fraud and Integrity Analytics (Cross functional (multiple chapters))

ID	Use Case and Audit Objective	Data Required (Source → Fields)	Test Logic	What an Exception Indicates
XF 01	Employee–agent–customer–vendor identity triangle. Objective: run a unified identity resolution exercise across all party masters to find the same person appearing in roles that should not coincide.	Employee, agent, customer, nominee, vendor and investigator masters with PAN, bank account, mobile, e mail and address, using hashed or masked identifiers where feasible for matching and triage.	Build a single resolved identity graph across masters using deterministic and fuzzy matching flag prohibited or high-risk role combinations employee as agent (AG 03), employee as vendor (ME 03/OS 03), investigator as payee (CL 04), agent as premium payer (ML 03) maintain	Each edge in the graph is a conflict the individual masters were designed never to reveal building it once services a dozen use cases across this library, but it should be treated as a programme

			the graph as reusable audit infrastructure with documented purpose, restricted access, false positive review and controlled circulation of named exceptions.	level analytic with privacy controls rather than an unrestricted routine extract.
XF 02	Nominee and beneficiary network analysis. Objective: detect networks of policies sharing nominees, beneficiaries or payout destinations that individual policy controls cannot see.	Nominee/beneficiary data across the policy population claim and payout destination data (CL 04, ML 08) agent linkage.	Construct a network of lives–nominees–accounts flag nominees appearing across unrelated lives, especially within one agent's book overlay claim events to find networks already monetising.	A nominee node connected to many unrelated insured lives, sourced by one intermediary, is the structure of organised fabricated claim fraud visible only as a network, never as a policy.
XF 03	Deceased identity and prior claim reuse screen.	Historical death claim and intimation records with life identifiers	Fuzzy match incoming proposal lives and changed	A proposal on a life already claimed

	Objective: screen all new proposals and servicing changes against lives on whom the insurer has already paid death claims or holds death intimations.	new business register servicing change log.	party identities against the deceased life archive flag matches for immediate investigation test whether the insurer's own systems perform this screen at intake.	dead should be structurally impossible finding even one proves the intake defence has no memory and memory is the cheapest fraud control an insurer owns.
XF 04	Payout account convergence analysis. Objective: find bank accounts receiving multiple types of insurer outflows claims, commission, refunds, vendor payments that belong to different payees.	All outward payment files across payout types with account, IFSC and payee name party masters (XF 01 graph), using masked or hashed account keys for initial convergence analysis where feasible.	Union all payment populations group by account flag accounts receiving outflows under multiple payee identities or payout types investigate through the identity graph restrict named account outputs to confirmed exceptions and document the privacy basis for	One account harvesting claims, refunds and commission under different names is the terminus of several frauds at once the convergenc e view finds in one query what per process testing would never assemble. Because the

			the cross functional join.	test combines sensitive payee data across domains, false positives and circulation must be tightly controlled.
XF 05	Contest window composite manipulation screen. Objective: run a combined screen across the contest window backdating, advance premium, churn, FLC to quantify how much qualifying business was manufactured.	Contest windows and qualifier data (RR 01/03) NB 04 backdating flags PS 04 churn matches PS 01 FLC outcomes for window business premium receipt timing.	For each contest window, compute the share of qualifying business carrying any manipulation flag and the post window FLC/lapse decay curve of that business versus the baseline book attribute manufactured business to qualifiers and quantify rewards paid on it.	The decay curve is the proof: business manufactured for a contest dies after it putting a rupee value on rewards paid for evaporated business converts a conduct suspicion into a board grade finding.

Annexure 6
Regulations and Circulars

How to use the links: The Insurance Regulatory and Development Authority of India (IRDAI) hosts its instruments on its website (https://irdai.gov.in) under the sections 'Acts', 'Rules', 'Consolidated & Gazette Notified Regulations', 'Updated Regulations', 'Circulars' and 'Guidelines'. Individual documents on the IRDAI website carry dynamically generated document links which IRDAI may change when its website is reorganised (as has happened in the past). Accordingly: (i) where a direct document link has been verified, it is given and marked as such (ii) in all other cases, the link provided is to the stable section page of the IRDAI website, from which the instrument can be located by searching the title or the reference number given in this Annexure. The reference number and date and not the hyperlink, are the authoritative citation of each instrument.

Caution: Master circulars are stated by IRDAI to be reviewed every year and circulars, guidelines and annual obligations change more frequently than the parent regulations. This Annexure speaks as on the date of publication of this Guide. Before relying on any instrument, the internal auditor must verify from the IRDAI website (and, for non-IRDAI statutes, from India Code or the concerned regulator's website) that the instrument remains in force and must have regard to any amendment, supersession, clarification or FAQ issued subsequently. Nothing in this Annexure is a substitute for reading the instrument itself.

Master Repository of Laws, Regulations, Master Circulars and Guidelines

Ref.	Law/ Regulation/ Circular/ Guideline	Reference No./ Notification and Date	Source (official link)
I. Acts of Parliament			
A1	The Insurance Act, 1938 (Act 4 of 1938),	Act 4 of 1938	https://irdai.gov.in/acts Also available at:

	as amended from time to time (including by the Insurance Laws (Amendment) Act, 2015)		https://www.indiacode.nic.in
A2	The Insurance Regulatory and Development Authority Act, 1999 (IRDA Act)	Act 41 of 1999	https://irdai.gov.in/acts https://www.indiacode.nic.in
A3	The Insurance Laws (Amendment) Act, 2015	Act 5 of 2015	https://irdai.gov.in/acts https://www.indiacode.nic.in
A4	The Life Insurance Corporation Act, 1956	Act 31 of 1956	https://www.indiacode.nic.in
A5	The Prevention of Money laundering Act, 2002 (PMLA)	Act 15 of 2003	https://www.indiacode.nic.in
A6	The Unlawful Activities (Prevention) Act, 1967 (Section 51A – freezing of assets)	Act 37 of 1967	https://www.indiacode.nic.in
A7	The Weapons of Mass Destruction and their Delivery Systems (Prohibition of Unlawful Activities) Act, 2005 (Section 12A)	Act 21 of 2005	https://www.indiacode.nic.in

A8	The Information Technology Act, 2000 (with SPDI Rules, 2011 and IT (Intermediary Guidelines and Digital Media Ethics Code) Rules, 2021)	Act 21 of 2000	https://www.indiacode.nic.in
A9	The Digital Personal Data Protection Act, 2023 (DPDP Act) and rules notified thereunder	Act 22 of 2023	https://www.indiacode.nic.in *Also see MeitY for DPDP Rules* https://www.meity.gov.in
A10	The Companies Act, 2013	Act 18 of 2013	https://www.mca.gov.in/content/mca/global/en/acts rules/ebooks/acts.html?act=NTk2MQ==
A11	The Income tax Act, 1961 and the Income tax Act, 2025	Act 43 of 1961	https://incometaxindia.gov.in
A12	The Central Goods and Services Tax Act, 2017 and the Integrated Goods and Services Tax Act, 2017	Acts 12 and 13 of 2017	https://cbic gst.gov.in
A13	The Married Women's Property Act, 1874	Act 3 of 1874	https://www.indiacode.nic.in
A14	The Consumer Protection Act, 2019 (unfair trade	Act 35 of 2019	https://www.indiacode.nic.in

	practices, misleading advertisements)		
A15	The Aadhaar (Targeted Delivery of Financial and Other Subsidies, Benefits and Services) Act, 2016 (KYC/authentication)	Act 18 of 2016	https://www.indiacode.nic.in
II. Rules			
R1	The Insurance Rules, 1939	Notified under the Insurance Act, 1938	https://irdai.gov.in/rules
R2	The Insurance Ombudsman Rules, 2017 (as amended in 2021)	G.S.R. 413(E) dated 25 04 2017	https://irdai.gov.in/rules
R3	The Prevention of Money laundering (Maintenance of Records) Rules, 2005, as amended (including the 2023 amendments)	G.S.R. 444(E) dated 01 07 2005	https://fiuindia.gov.in https://www.indiacode.nic.in
R4	The Indian Insurance Companies (Foreign Investment) Rules, 2015, read with the FEM (Non Debt Instruments) Rules, 2019	Ministry of Finance notifications	https://egazette.gov.in *e Gazette also DFS/RBI websites*

III. IRDAI Regulations (as currently in force)			
G1	IRDAI (Insurance Products) Regulations, 2024	Notification F. No. IRDAI/Reg/8/198/2024 dated 20 03 2024	https://irdai.gov.in/consolidated gazette notified regulations *Search by title on this page*
G2	IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024	Notified 20 03 2024 effective 01 04 2024	https://irdai.gov.in/consolidated gazette notified regulations
G3	IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations, 2024	Notified 20 03 2024	https://irdai.gov.in/document detail?documentId=4589093
G4	IRDAI (Corporate Governance for Insurers) Regulations, 2024	Notified 21 03 2024	https://irdai.gov.in/consolidated gazette notified regulations
G5	IRDAI (Expenses of Management, including Commission, of Insurers) Regulations, 2024	Notified 23 01 2024	https://irdai.gov.in/consolidated gazette notified regulations
G6	IRDAI (Registration, Capital Structure, Transfer of Shares and Amalgamation of	Notified 07 03 2024	https://irdai.gov.in/consolidated gazette notified regulations

	Insurers) Regulations, 2024		
G7	IRDAI (Rural, Social Sector and Motor Third Party Obligations) Regulations, 2024	Notified 20 03 2024	https://irdai.gov.in/consolidated gazette notified regulations
G8	IRDAI (Bima Sugam – Insurance Electronic Marketplace) Regulations, 2024	Notified 20 03 2024	https://irdai.gov.in/consolidated gazette notified regulations
G9	IRDAI (Re-insurance) Regulations, 2018, as amended by the IRDAI (Re-insurance) (Amendment) Regulations, 2023	Notified 12 12 2018 amendment 2023	https://irdai.gov.in/updated regulations *See 'Updated Regulations' for consolidated text*
G10	IRDAI (Registration and Operations of Foreign Reinsurers Branches and Lloyd's India) Regulations, 2024	Notified 2024	https://irdai.gov.in/consolidated gazette notified regulations
G11	IRDA (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002, as amended	Notified 30 03 2002	https://irdai.gov.in/updated regulations

G12	IRDAI (Appointment of Insurance Agents) Regulations, 2016, as amended	Notified 2016	https://irdai.gov.in/updated regulations
G13	IRDAI (Registration of Corporate Agents) Regulations, 2015, as amended	Notified 2015	https://irdai.gov.in/updated regulations
G14	IRDAI (Insurance Brokers) Regulations, 2018, as amended	Notified 2018	https://irdai.gov.in/updated regulations
G15	IRDAI (Insurance Web Aggregators) Regulations, 2017, as amended	Notified 2017	https://irdai.gov.in/updated regulations
G16	IRDAI (Registration of Insurance Marketing Firm) Regulations, 2015, as amended	Notified 21 01 2015	https://irdai.gov.in/updated regulations
G17	IRDAI (Maintenance of Information by the Regulated Entities and Sharing of Information by the Authority) Regulations, 2025	Notified 2025	https://irdai.gov.in/consolidated gazette notified regulations
G18	SEBI (Listing Obligations and Disclosure Requirements)	SEBI notification dated 02 09 2015	https://www.sebi.gov.in

	Regulations, 2015 (for listed insurers)		
IV. IRDAI Master Circulars			
M1	Master Circular on Life Insurance Products, 2024	IRDAI/ACTL/ MSTCIR/MISC /89/6/2024 dated 12 06 2024	https://irdai.gov.in/document detail?documentId=5032913
M2	Master Circular on Protection of Policyholders' Interests, 2024	IRDAI/PP&GR /CIR/MISC/117/9/2024 dated 05 09 2024	https://irdai.gov.in/document detail?documentId=5625747
M3	Master Circular on Operations and Allied Matters of Insurers, 2024	IRDAI/PP&GR /CIR/MISC/97/ 06/2024 dated 19 06 2024	https://irdai.gov.in/circulars
M4	Master Circular on Actuarial, Finance and Investment Functions of Insurers, 2024	IRDAI/ACTL/CIR/MISC/80/05 /2024 dated 17 05 2024	https://irdai.gov.in/document detail?documentId=4907769
M5	Master Circular on Corporate Governance for Insurers, 2024	IRDAI/F&I/CIR /MISC/82/5/2024 dated 22 05 2024	https://irdai.gov.in/document detail?documentId=4916164
M6	Master Circular on Expenses of Management, including Commission, of Insurers, 2024	IRDAI/F&I/CIR /79/5/2024 dated 15 05 2024	https://irdai.gov.in/circulars

M7	Master Circular on Submission of Returns, 2024	Dated 14 06 2024	https://irdai.gov.in/document detail?documentId=5050759
M8	Master Circular on Reinsurance, 2024	Dated 31 05 2024	https://irdai.gov.in/circulars
M9	Master Circular on Rural, Social Sector and Motor Third Party Obligations, 2024	Dated 10 05 2024	https://irdai.gov.in/circulars
M10	Master Circular on Point of Sales (POS) – Life Insurance Products and Point of Sales Persons – Life Insurance (consolidating the 2016 POSP Guidelines)	Dated 03 12 2019 (consolidating IRDA/LIFE/ORD/GLD/223/11/2016)	https://irdai.gov.in/document detail?documentId=392974
V. IRDAI Guidelines and Key Circulars			
C1	Master Guidelines on Anti Money Laundering/ Counter Financing of Terrorism (AML/CFT), 2022, as amended (including amendments of 20 03 2023 and 10 10 2023)	IRDAI/IID/GDL/MISC/160/8/2022 dated 01 08 2022	https://irdai.gov.in/guidelines
C2	IRDAI Information and Cyber Security Guidelines, 2023, as	IRDAI/GA&HR/GDL/MISC/88/04/2023	https://irdai.gov.in/document detail?documentId=33147

	updated (Version 2 issued vide circular IRDAI/GA&HR/CIR/ MISC/51/4/2026 dated 06 04 2026)	dated 24 04 2023	80 *For the 2026 update, see IRDAI > Circulars*
C3	IRDAI (Insurance Fraud Monitoring Framework) Guidelines, 2025	Issued 2025 (supersedes the 2013 Fraud Monitoring Framework)	https://irdai.gov.in/guidelines
C4	Guidelines on filing of Re-insurance arrangements with the IRDAI	IRDAI/RI/GDL/ MISC/038/01/ 2020	https://irdai.gov.in/guidelines
C5	Circular on Adherence to Declared Underwriting Philosophy	Dated 22 04 2016	https://irdai.gov.in/circulars
C6	Circular on Implementation of Risk Based Supervision (RBS)	IRDAI/SDD/MISC/CIR/128/05/2026 dated 01 05 2026	https://irdai.gov.in/circulars
C7	Actuarial circulars referred to in the Guide: IRDAI/ACTL/CIR/MISC/94/05/2022 IRDAI/ACTL/CIR/MISC/115/06/2022 IRDAI/NL/CIR/MISC/169/10/2022	As per respective reference numbers	https://irdai.gov.in/circulars

	IRDAI/ACTL/CIR/MISC/05/01/2023		
C8	Circular on implementation of Ind AS 117/ IFRS 17 aligned financial reporting	IRDAI/IFRS/CIR/MISC/45/4/2026	https://irdai.gov.in/circulars
C9	CERT In Directions on information security practices, reporting of cyber incidents etc.	No. 20(3)/2022 CERT In dated 28 04 2022	https://www.cert in.org.in
C10	Government of India (MHA) Order on implementation of Section 51A of UAPA (freezing of assets)	F. No. 14014/01/2019/CFT dated 02 02 2021	https://fiuindia.gov.in
C11	Actuarial Practice Standards (APS) and Guidance Notes (GN) issued by the Institute of Actuaries of India (issued in concurrence with IRDAI)	APS 1–APS 10 and GNs, as applicable	https://www.actuariesindia.org
VI. Other Regulatory Sources and Portals			
S1	FIU IND – reporting formats and Red Flag Indicators (STR/CTR/NTR/CBWTR filing under PMLA)	Financial Intelligence Unit – India	https://fiuindia.gov.in

S2	Bima Bharosa – IRDAI's integrated grievance management system (including unclaimed amounts search)	—	https://bimabharosa.irdai.gov.in
S3	IRDAI Circulars repository (for all circulars cited by reference number in the Guide)	—	https://irdai.gov.in/circulars
S4	IRDAI Guidelines repository	—	https://irdai.gov.in/guidelines

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