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NEED/IMPORTANCE OF THE STUDY

STATEMENT OF THE PROBLEM

OBJECTIVES

HYPOTHESES

RESEARCH METHODOLOGY

RESULTS & DISCUSSION

FINDINGS

RECOMMENDATIONS/SUGGESTIONS

CONCLUSIONS

SCOPE FOR FURTHER RESEARCH

ACKNOWLEDGMENTS

REFERENCES

APPENDIX/ANNEXURE

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- Garg, Bhavet (2011): Towards a New Natural Gas Policy, Political Weekly, Viewed on December 17, 2011 http://epw.in/user/viewabstract.jsp

ACCESS TO MICRO-HEALTH INSURANCE SERVICES FOR THE RURAL POOR: AN EXPLORATORY STUDY IN ANDHRA PRADESH

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ABSTRACT

There is a large potential market to micro health insurance of rural poor. The demand is strong and is indicating a potential market beyond lending loans and savings micro insurance helps is risk management of the poor in their lives. The formal linkages between insurance companies and informal agencies like MFIs and NGOs will bring greater innovation in design and delivery of micro insurance services and benefits the poor at large. For this understanding of the critical gaps in managing risks is a starting point for identifying micro insurance products for the poor. From here, the challenge becomes how to zero in on insurable risks and design products that are feasible, acceptable, and affordable. The analysis of the study revealed that the poor are vulnerable to various health related risks and they are unable to meet their high cost of health related expenditure with limited savings in their hands. The affordability analysis of premium reveals that the poor can afford to pay low premiums for their health insurance cover. The quantitive analysis on the overall satisfaction of health insurance services in rural areas reveals that majority of the poor are very much dissatisfied with the micro insurance services in rural areas. With 95 percent of the Indian population outside the non-life insurance safety net, insurers have a huge challenge and a big opportunity. Though India has experimented a lot with micro insurance, the sector is still driven by supply-led interventions. Hence, a strategic perspective towards micro insurance together with innovations in technology and assessment of client demand probably holds the key to the future of micro insurance in India.

KEYWORDS
Insurance services, Rural Poor, Andhra Pradesh.

INTRODUCTION

Microfinance in India has largely been driven by credit products of microfinance institutions (MFIs), and micro insurance has remained a secondary choice for financial inclusion. However, recently, many important developments have taken place in the Indian Micro Insurance sector. Micro-insurance is a term increasingly used to refer to '*insurance*' characterized by low premium and low caps or low coverage limits, sold as part of a typical risk-pooling and marketing arrangements, and designed to serve low-income people and businesses not served by typical social or commercial insurance schemes. The institutions or set of institutions implementing micro-insurance are commonly referred to as '*micro insurance scheme*'. With the rapid growth trajectory in recent years, India has achieved an insurance density of US$46.61* (144% over 2003) and an insurance penetration of 4.7% (36% over 2003) in 2008. However, 90%** of the Indian population, and 88%*** of the Indian workforce, the majority of whom in the unorganized sector are still excluded from any kind of insurance cover. Hence, the importance of micro insurance, both from social security and business opportunity points of view can hardly be over-emphasized.

According to Michael McCord "Micro insurance is a system of protecting poor people against specific shocks using risk pooling for regular affordable premiums proportionate to the likelihood and costs of the risk involved", He says that "appropriate delivery mechanisms, procedures, premiums and the coverage define micro insurance". The IRDA Concept Paper that preceded the publication of Micro Insurance Regulations 2005 explained that "Micro insurance refers to the protection of assets and lives against the insurable risks of the target population". The salient features are "Health insurance is sold under General Insurance Product or Life Micro Insurance Product. The Micro Insurance Regulation of 2005 was a pioneering approach by the Insurance Regulatory Development Authority (IRDA). India is among the few countries to draft and implement specific Micro Insurance Regulations. In 2002 IRDA developed rural and social sector obligation norms that mandated every insurance company to achieve percentage of polices to be sold in rural areas; and the number of lives to be covered in the social sector. A consultative group on micro insurance was set up in 2003 to look into the issues which highlighted the: non-viability of standalone micro insurance programme; apathy of insurance companies towards micro insurance; and the potential of alternative channels. In 2004, RRBs were allowed to sell insurance as "Corporate Agent", and in 2005, IRDA came up with the Micro Insurance Regulations which suggested:

1. SHGs, MFIs and NGOs were allowed to become Micro insurance Agents (MIA), a status that has simple agency clearance process and sustainable long term earning potential;
2. Stipulation of product boundaries in terms of minimum and maximum sum assured, the term of product, the allowable age group and the maximum commission to agents; and
3. Fulfillment of both rural and social sector obligation through micro insurance products.

The definition of micro insurance products according to IRDA is shown in the table below:

Type	Sum Assured (Rs. '000)	Term (Years)	Age (Years)
Term Life	5-50	5-15	18-60
Endowment	5-30	5-15	18-60
Health (individual)	5-30	1-7	Insurers' discretion
Health (family)	10-30	1-7	Insurers' discretion
Accident rider	10-50	5-15	18-60
Livestock/assets	5-30	1	NA
Accident (non-life)	10-30	1	5-70

Source: IRDA Annual Reports

* Sigma Report, Swiss Re, March 2008
** Mare Socquetl, October 2005, ILO/STEP, Microinsurance workshop, India
*** "*Pension Reforms for Unorganised Sector*", ADB, TA IND-4226, 2006

The regulation was an important accelerator for the Indian micro insurance industry. By 31st March, 2009, 7,250 MIAs were registered with IRDA. However, the regulation has certain restrictive aspects, for example exclusion of Non Banking Financial Companies and Section 25 companies from acting as MIAs; service tax on all commissions earned; lack of clarity about MIA status of Regional Rural Banks and cooperatives; and restriction of one life and one non-life partner for each MIA.

EVOLUTION OF CONCEPT OF MICRO HEALTH INSURANCE

Micro insurance has many other names. In francophone, Africa, they are usually called as "*mutuelles*" while in Anglophone Africa, they are named as "*Community Health Insurance*". The International Labor Organization prefers to call them as "*Micro Health Insurance (MHI)".* MHI is not a new phenomenon. Way back in the 19th Century, at the peak of the industrial revolution in Europe, laborers had no social security measures to protect themselves from the hardships of illness and death, these laborers instituted local *"sickness funds*" that collected money for future contingencies. Over the years, these sickness funds have federated and merged to form the large health insurance companies that exist today in European Countries. This is not limited to Europe alone, in Asia the "jyorei Scheme" in Japan has a similar history. Then there is the famous Chinese Rural Cooperative Medical System, where the farmers contributed annually to a common health fund that was used to finance the health services in the region. Many poor families in Africa, South East Asia and now in India are protected by such schemes; and a phenomenal increase particularly during the last 5 years. As per ILO estimates there are 85 such schemes covering at least 8 million people. Today in the light of governments not being able to provide adequate health care services, coupled with escalating costs in the private health sector, globally the poor have been denied access to health care. And when they do have access, the costs are so high that the family is pushed into poverty. 25-40% of the people in India have to borrow money to meet the hospitalization expenses; this is the main reason why micro-health insurance has been growing as a movement.

LIFE MICRO INSURANCE

Due to the ease of linking claim assessment, resistance to moral hazard and comfort in cross-selling, life micro insurance has been dominant worldwide. Though life, accident and disability benefits and savings and annuity liked products fall into the realm of life micro insurance, in India, credit-life insurance is dominant among life products. LIC of India, the market leader, in 2008-09 covered 14.71 million lives with a cumulative micro insurance premium of Rs.2.43 billion Though, life insurance, is a very popular savings medium in India, most of the insurance companies have not taken initiative for developing market driven and scalable savings linked micro insurance products.

POTENTIAL MARKET SIZE OF MICRO INSURANCE IN INDIA

Life	Rs.15.39 to 20.14 billion per year
Health	Rs.13.42 to 17.89 billion per year
Crop	Rs.9.76 to 13.01 billion per year
Livestock	Rs.5.86 to 8.2 billion per year
Total Microinsurance market	Rs.62.30 to 84.27 billion per year
Pension for unorganized workforce	Rs.201.3 billion (US$2.5billion) per year

Source: "Potential and Prospects of Micro insurance in India; UNDP Regional Centre of Human Development Unit 2009, "Pension Reforms for Unorganized Sector; ADB, 2006 and IIMS Data Works Survey 2008

HEALTH MICRO INSURANCE

In India health micro insurance is dominated by government subsidized schemes and localized Community Based Health Insurance (CBHI). The best known CBHI is the Yeshaswini Trust, which uses the cooperative network of Karnataka (Karnataka Milk Federation) and has reached nearly 3 million farmers. The Karuna Trust (also in Karnataka), another CBHI, has adopted Partner-Agent Model. *Uplift Mutuals* is another experiment, which aims at community managed, self sustaining health insurance across states. Government of India has conceived the "Rashtriya Swasthya Bima Yojana" (RSBY) in April, 2008, to reach 300 million poor (Below Poverty Line) by 2012*****. As on 31st May, 2010, approximately 15.729 million people have been enrolled in the programme across 21states of India**.****

RASHTRIYA SWASTHYA BIMA YOJANA

RSBY is targeted at the Below Poverty Line market. Features of the scheme include:

1. Contribution by central and state government is 75:25 and clients pay only Rs.30 for registration.
2. GTZ10 is helping governments in implementation and monitoring of the scheme.
3. It covers annual health expense up to Rs.30,000 for a family in 3,717 enrolled hospitals.
4. Biometric health cards are issued on enrolment.
5. 21 states and 11 insurance companies have enrolled

Though it has been realized that most of the low income people are willing to pay (on an average 1.35% of their annual income) for health insurance, much of this need is not converted into demand due to poor health service coverage and imperfect implementation plans. For example, the 2010 review of the National Rural Health Mission shows that only 53.1% of primary health clinics are active. The development of client centric, need based and innovative micro health insurance product is still not common.

AGRICULTURE INSURANCE

The National Agriculture Insurance Scheme, the most prominent crop insurance scheme has reached approximately 135 million farmers covering 17% of Indian farm holdings. However, high geographical concentration (7 States constitutes 80% of coverage) and a high claim ratio of 3:1 has necessitated index-based crop insurance products. Some of the new trends in crop insurance in India are:

1. A combination of weather index and remote sensing based Normalized Difference Vegetative Index (NDVI) is being developed to address the issue of basis risk,
2. Re-insurers (e.g., SwissRe) are directly partnering with MFIs and banks to provide satellite and NDVI based crop insurance.
3. Crop insurance is getting bundled with agri-inputs (e.g., Pioneer seeds) and agro advisory services (e.g. BASIX and WRMS) to create demand from farmers.
4. Index-based insurance is implemented in alternate livelihood insurance, e.g. in lac (a type of natural resin) farming, Tsar (a kind of silk) farming.

NEED OF THE STUDY

Micro health insurance is discussed after the advent of Self Help Groups (SHG) and micro finance movement in India. Lack of regulation in health care delivery, accreditation and development of clinical skills, patient informatics and standard code sets have discouraged insurers from aggressively marketing health insurance in rural areas, often resorting to short sighted strategies to fulfill mandatory norms stipulated by the Insurance Regulation and Development Authority of India (IRDA). Health insurance is not only a mechanism for financial protection of the poor to meet the high cost of health care, but also has the potential to influence the provider in various ways.

* Working Paper 2, Global Development Network, September 2009.
**Nagpal, Dr. Somi, "Micro Health Insurance in India"' 2009.

Most of the poor do not have awareness of insurance as a concept; some of them dismissing it as one of the myriad schemes with a motive to grab their hard earnings; and often get confused between the various types of insurance. The benefit of financial protection to the poor itself helps in increased access to insurance, and to overcome cost barriers for those who would not able to afford it. The health insurance mechanism thus influences accessibility, cost and affordability of quality health care. It is in this context that the need for study on Micro Insurance is identified to assess the various health related risks of the poor people. The study also made to identify the role of formal and informal institutions designing the mechanisms of delivering health insurance services.

SIGNIFICANCE

Providing insurance services to the poor who live in rural areas will be a major challenge for both public and private institutions concerned with delivering insurance services. This challenge is even more difficult because of the poor infrastructure and a nascent state of urban centric insurance industry at this point of time. This sector poses more challenges that are to be encountered and opportunities for partnership between public, private and Non-Government institutions to expand the reach and depth of rural insurance market in India. The rural market distribution and servicing are the key areas in developing rural health insurance business. The IRDA mandate on obligations of insurers to the rural and social sector, and its concept paper on micro-insurance are aimed at encouraging micro-insurance for the rural sector in India.

ACCESS TO HEALTH INSURANCE

Healthcare for the poor seems to have three central challenges: affordability, availability and quality. Effective, viable solutions will need to address all the three issues. A scalable and sustainable micro health insurance model will probably rank as the highest value intervention in addressing the issue of affordability, especially in a country like India where, according to India's National Health Accounts, an estimated 72 percent of healthcare expenditures are out-of-pocket. But the industry quickly learned that this left a large gap between what was offered and what the poor actually needed. Rural insurance can play a significant role in providing access to credit that enhances the income earning opportunities and deliver the savings that build up resources for utilization in case of emergencies.

Currently a number of private sector insurance players are working towards increasing their coverage in rural areas involving NGOs and MFIs. Till recently Indian health sector has been managed mainly by government health care facilities and other public health care systems in the traditional model of health funding and provision. But it was unable to justify the demand of over 200 million health insurable population in India mainly due to service cost and low reach to the rural population. It is estimated that people spend about 4.5% of the GDP on health care needs and this is about three-fourth of the health care expenditure. Most of it is out-of-pocket expenditure. Of all the risks facing the households of the poor, health risks pose the greatest threat to lives and livelihoods. The informal sector and the other socially challenged sections spread over the rural and urban areas of the economy and people from economically weaker sections as well as those from the backward and scheduled caste and scheduled tribe communities' account for a sizable portion of SHG membership.

MICRO INSURANCE – A MECHANISM TO COMBAT VULNERABILITY

Insurance helps the poor combat the vulnerability caused by exposure to such risks. By pooling into a risk fund to cover stipulated risks – such as illness, loss of assets, death and widowhood–poor can protect themselves from unexpected losses. Insurance of lives and livelihoods is important to the risk-prone economic life of the poor. "Like employment, health, child care, poor also need insurance to fall back on in times of financial crisis or unprecedented calamities". Micro insurance services in Andhra Pradesh largely focused on delivering insurance to the poor were found to be partnering with MFIs. This approach may not be sufficient as millions of poor people in rural and other areas live far from MFIs. There is a need for formal financial institutions like commercial banks, public and private insurance companies, NGOs, community based organizations to deliver insurance services effectively and profitably. This is not an easy task of bringing together in providing micro insurance services with right kind of products to suit to the rural population.

ROLE OF NON-GOVERNMENT ORGANISATIONS

Non Government Organizations are the most important intermediaries for rural insurance marketing. Though they are not experts in the field of insurance selling yet they play a major role in promoting "insurance" concept by educating the rural masses about what the micro insurance buying can do in their lives. They can organize public meetings by creating a movement and to encourage the habit of making insurance to protect the properties and health among the families and also to protect their future income prospects. The thinking and strategic habits of the rural poor must be changed by conducting such programs by the insurers in association with NGOs. They should jointly own the responsibility for taking care of health care initiatives in rural areas. The Confederation of NGOs of Rural India(CNRI) had extend its full cooperation and support to LIC of India with regard to implementation of the Micro Insurance – Jeevan Madhur Scheme designed to provide social security to the vast masses of rural India and also in the process provide a framework for income earning by the NGOs for strengthening their activities. On the same lines CNRI will also extend its cooperation to other public sector general insurance companies in the area of non-life products. The rural insurance market as a segment has particular system of needs, values and benefits and a particular way of responding to the stimuli that insurers provide the micro health insurance services. The values and belief systems of the rural poor who are the target market for micro health insurance products should be understood by evaluating their needs of insurance and how they are able to meet their needs with limited means. Accordingly products have to be designed keeping in mind the affordability and the benefits and costs in mind.

ROLE OF MFIs

The current state of micro-insurance identifies emerging lessons for Microfinance Institution (MFI) practitioners interested in developing their own insurance products. For insurers wishing to partner with MFIs, a clear understanding of the role of MFIs is necessary. MFIs offer risk management services in the form of loans and savings which can act as effective tools. They often work with a different business processes compared to insurers because the risk structure of credit is different from that of insurance. MFI life insurers had several thousand clients, strong information-tracking, and a stable credit or savings portfolio before they developed insurance on their own. MFIs and other local institutions are well equipped to act as agents, leveraging their existing, low-cost distribution channels and trusting relationships with low-income clients.This makes it possible to offer the benefits of insurance to low-income clients. All parties – the insurer, the MFI, and their clients - can benefit from the potential power of insurance, without destabilizing the MFI or distracting it from its core business. Insurance is a different business for MFIs, not just a different product. Those who already provide risk management savings and loan products, and still identify an effective demand from clients for insurance products, should look towards an insurance provision partnership with formal insurers. In such a relationship the insurer maintains the insurance risks and the MFI provides sales and basic servicing for the products – both doing what they do best.

CAPACITY BUILDING BY MFIs

Savings accounts are a more effective foundation for delivering insurance services than loans, because the credit-insurance link only provides coverage when the client has an outstanding loan. A savings-insurance link increases the likelihood that low-income clients with irregular income flows can access insurance. There are three groups of activities involved in providing these products they are designing the product, sale of the product and services to the beneficiaries. Increased coverage means increased complexity and increased protection generally requires greater expertise and investment to succeed. For health insurers, co-payments and mandatory reference systems are widely used. To reduce transactions costs of providing insurance, it is useful to layer insurance transactions on top of the delivery of other financial services. As the provision of insurance products gains further publicity, more MFIs will inevitably try to enter this market. There are relatively few MFIs that have reached financial sustainability, and there are even fewer that have successfully integrated a savings component into their product line. Institutions that have identified client demand for insurance products should focus on creating partnerships in which an MFI works with a

regulated insurer to provide clients with an insurance product adapted for the micro market. Such partnerships facilitate MFI provision of insurance products to clients while virtually eliminating risk to the MFI, dramatically minimizing their administrative burden, and requiring very little capacity building on the part of the MFI.

LINKAGES BETWEEN FORMAL AND INFORMAL AGENCIES

Microfinance institutions are perhaps in a unique position to provide micro insurance as they have extensive networks and are already offering financial services to poor clients. In some cases, MFIs link with formal insurance companies and act as agents for the formal insurer, although the insurer retains all of the risk. MFIs can also form joint ventures with formal insurers and share both risk and management. Some MFIs feel that while they have the networks among the poor, they are not technically proficient to provide insurance services. So, they team up with professional insurance providers who have the technical expertise in the area. Micro Finance Institutions like SEWA in India with their health and property insurance products, act as direct providers of insurance services. Credit and savings services are inadequate when households are exposed to risks which cause losses that are beyond their means. Insurance can serve as a promising response to such client needs. Today micro insurers are providing different forms of insurance for life, health, property, disability, agriculture (crop), etc. Poor households pay a small premium for limited coverage in the event of loss.

REVIEW OF LITERATURE

Several studies have been conducted previously in the area of micro insurance services. But in India it is emerging as an important area of research because access to insurance by the people living below the poverty line is the main cause of concern. In order to achieve the objective of financial inclusion by providing financial services to the poor, micro insurance is considered as one of the important services which protect the poor people from various risks like health and property. Despite regulatory bodies taking measures, the results at the ground level are not upto the mark. The literature review provides an overview of the current state of research on micro insurance. It identifies key knowledge gaps and develops a conceptual framework to inform the research agenda of the micro insurance facilities and evaluating the impact on demand and supply issues. The review also covers the supply side challenges such as product development and innovation, institutional models and delivery channels as well as technology options.

Based on their extensive survey of the literature, the authors Preker A.S. and Carrin (2004)[1] show that the main strengths of *community-financing schemes* are the extent of outreach penetration achieved through community participation, the contribution to financial protection against illness, and the increase in access to health care by low-income rural and informal sector workers. The provision of insurance to the poor has mainly been via mutual / cooperatives or *microfinance organizations using the "Partner-Agent" model.* The author R. kannan (2008)[2] says that Micro Insurance products should be designed to factor in the risks of low income households and also be as inclusive as possible with an affordable premium, and the premium payments should correspond with their cash-flow position. These products should also have clearly defined simple rules with transparent exclusions. The documentation, including claim forms, should be available in vernacular languages. The distribution channel also needs to be made more effective and banc assurance could be one route. The author also stressed the need to examine the feasibility of selling Micro Insurance products through the wide network of post offices.

The study conducted by Naveen K Shetty and Veerashekarappa (2009)[3] examines the *innovation of the MFIs in scaling up and accessing micro health insurance (Partner-Agent Model)* for the poor in India. The primary survey was conducted in 10 villages covering 106 self help groups and 318 member households in the state of Karnataka, India. The results showed that MFIs are playing a crucial role in delivering the Micro Insurance products at the door steps of the rural poor. The study also finds that the accessibility of the Micro health Insurance scheme is the poor centered and covers multi risks of the poor in rural areas.

Sneha Shukla (2008)[4] in her article "Insuring Bottom of the Pyramid" says that rural insurance can play a significant role in providing access to credit that enhances income earning opportunities, and deliver savings that build up resources for utilization in case of emergencies. While discussing the norms of rural insurance, she tries to identify various rural insurance needs like *policy holders' preferences and ability to make premium payments* taking into account the operational changes as well. It also tells about the practicing initiatives taken by the private players namely tailor made low cost term insurance products; creation of new distribution channel links and tie-ups to tap this potential rural market. The author N.Jayaseelan (2007)[5] says, that 3.19% of the total premium is accounted for by the health insurance premium. Out of the many Non-life insurance products launched during the year 2005-06, only one product was under *Micro Health Insurance* that too by a stand-alone health insurance company has been in operation. Many proactive measures like creating a database, *capacity building of stakeholders* and customized product/process designing have been suggested to take forward the sector to benefit a large number of poor households.

The authors Craig F. Churchill et., all (2003)[6] specified in their book the extensive how-to manually guide managers of microfinance institutions (MFIs) through the complexities of offering basic insurance products, either on their own or in partnership with an insurance company. The bulk of the manual is dedicated to four aspects: the fundamentals of the insurance business; the design of five recommended short-term, *credit-linked insurance policies*; outsourcing part or most of the insurance responsibilities to a formal insurance company or to skilled consultants; and the financial management and operational integration of an insurance business into a microfinance institution. A review of the existing health insurance schemes in India and select Asian and Latin American countries, such as China, Thailand, Sri Lanka, Chile, Uruguay, Colombia, Brazil, and Argentina, is undertaken with a view to drawing lessons for India.

Anil Gumber (2002)[7] in their paper examines the feasibility of providing health insurance to poor people in terms of both *willingness and capacity to pay* for such services. The paper also suggests various options available to introduce an *affordable health insurance plan* for workers in the informal sector. The authors Ramesh Bhat and Nishanth Jain (2006)[8] analyzed the *factors affecting the purchase decision of insurance* and the amount of insurance purchase in Anand district of Gujarat. The results show that the income and the *healthcare expenditure, age, coverage and knowledge about the product are the major factors in purchase decisions.* The study covered the implications of the above factors.

The author Mr.Srabanti Chakravarthi (2006)[9] attempts to highlight the possible hindrances in the *delivery system of health insurance* in India. The article raises issues of improper claim settlements, adverse selections, and information lag. Strengthening public funded facilities, improving their efficiency, quality, improved *claim settlement system*, increased promotional measures will have positive impact on the health insurance. The author also states that there is an increased need to some special health insurance policies especially for the vulnerable poor in rural areas.

The author Vinay Varma (2006)[10] says that the poor in the unorganized sector are hit on two fronts once they meet with an accident or fallen ill. The range of crisis the poor are vulnerable to include sudden accidents and hospitalization of the bread earner of the family, loss of crops and assets and live stock and above all natural calamities like floods, earthquake and draughts. This paper provides an overview of micro insurance scene in India and analyzing global practices in this area. The paper also discusses the *role of government and the regulator to improve the risk management of the poor* and suggests best marketing strategies for the poor to facilitate them with micro insurance services.

The author P.S. Gunaranjan (2007)[11] states in his article that gives an insight into the regulatory and capacity building challenges faced by micro-insurance intermediaries. Their constant interactions with insurance companies is also highlighted to further draw out these constrains and its adverse effect on scalable delivery of micro insurance. Samuel B Sekar(2009)[12] states in his research paper nearly 1.3 billion people around the world lack access to affordable healthcare, including people from India. The affordability problem has been addressed to a certain extent by the introduction of affordable insurance schemes. These schemes refute the government's assumption that impoverished families of rural India are not capable of availing healthcare services through payment of health insurance premiums. Affordable health insurance schemes have made healthcare services affordable and accessible.

A study by David Dror et., all.,(2007)[13] conducted in India in 2005, provides evidence on Willingness to pay (WTP), gathered through a unidirectional (descending) bidding game among 3024 households (HH) in seven locations where micro health insurance units are in operation. Insured persons reported slightly higher willingness to pay values than uninsured. About two-thirds of the sample agreed to pay at least 1%; about half the sample was willing to pay at least 1.35%; 30% was willing to pay about 2.0% of annual house hold income as health insurance premium. Nominal willingness to pay correlates positively with income but relative willingness to pay (expressed as percent of HH income) correlates negatively. The correlation between willingness to pay and education is secondary to

that of willingness to pay with HH income. Household composition did not affect WTP. However, HHs that experienced a high-cost health event and male respondents reported slightly higher willingness to pay. The observed nominal levels of WTP are higher than has been estimated hitherto. This paper aims to understand the role of *micro-insurance as an element of social protection.* It outlines the current status of micro-insurance provision in Ghana and Sri Lanka, two countries with very different socio-cultural backgrounds. It concludes that both countries are unlikely to extend their social security systems to the entire population in the short to medium term, making private micro-insurance initiatives essential mechanisms to help people reduce their vulnerability. In India, the out-of-pocket health expenditure by households accounts for around 70 percent of the total expenditure on health and has limited coverage.

Dilip Mavalankar and Ramesh Bhat (2000)[14] followed the areas of Economic policy context, Health financing in India, Health insurance scenario in India, Health insurance for the poor, Consumer perspective on health insurance, Models of health insurance in other countries. A number of insurance experiments are being tried out for low-income people in India. Some of these have indeed been successful while others are still struggling to become so. These experiments cover only a small percentage of the low-income population. There are several gaps in Government policies that either hinder or do not positively encourage reaching insurance to low-income people. The policy gaps can be easily identified as we discuss the various choices available to policy-makers.

James Roth et.all.,(2005)[15] looks at micro insurance from the perspective of microfinance institutions (MFIs), which are important micro insurance delivery channels. By reviewing the experiences of three Indian MFIs—SPANDANA in Andhra Pradesh, and SHEPHERD and ASA in Tamil Nadu—it seeks to answer questions about what products to offer, and how to design and deliver them. Even though these organizations operate in similar environments, they have adopted very different approaches, which presumably make sense given their experiences, degree of maturity, and intentions. Insights into the choices they made, and the reasons for making those choices, may benefit others.

Gunita Arun Chandok (2009)[16] the study is based on 3,531 households (representing 17,323 persons) and 4,316 illness episodes. The findings are that the median cost of one illness episode was INR 340. When costs were calculated as % of monthly income per person, the median value was 73% of that monthly income, and could reach as much as 780% among the 10% most exposed households. The estimated median per-capita cost of illness was 6% of annual per-capita income. The ratio of direct costs to indirect costs was 67:33. The cost of illness was lower among females in all age groups, due to lower indirect costs. 61% of total illnesses, costing 37.4% of total OOPS, were due to acute illnesses; chronic diseases represented 17.7% of illnesses but 32% of costs.

OBJECTIVES OF THE STUDY

- To study the role of the formal and informal institutions in providing rural health insurance services to the poor in Andhra Pradesh;
- To highlight the need for micro-insurance as an integral component of financial services for the poor, and
- To examine the scope for extending micro insurance services to the poor in rural health sector.

LIMITATIONS OF THE STUDY

A comprehensive study was made in order to arrive at a better understanding of Micro health insurance services for the poor in Andhra Pradesh and also to draw some generalizations. Participants to this research were chosen on random basis and according to their willingness to answer the questionnaire. The study covers the population who are living in rural areas of Andhra Pradesh is a limitation to the statistical relevance of this research. However data collected are believed to be reasonable representative of population universe in general towards the topic.

DATA SOURCES AND RESEARCH METHODOLOGY

The methodology adopted for conducting research involves the following:

PRIMARY DATA

Collection of data has been done by conducting a survey through a structured questionnaire which is administered on respondents chosen from three districts of the state of Andhra Pradesh, namely Coastal Andhra, Rayalaseema, and Telangana areas.

SECONDARY DATA

The secondary data collected is based on various journals, magazines and research studies conducted on micro insurance. An extensive review of literature on the research topic has to be done as part of collection of data from the secondary sources.

SAMPLING TECHNIQUE

Stratified Random sampling technique is used to collect the data and computer based statistical techniques will be applied for the purpose of analysis and tabulation of data. The sample design consists of respondents from the districts of Srikakulam, Chittore, and Mahabubnagar covering Coastal Andhra, Telangana and Rayalaseema regions.

SAMPLE DESIGN

In order to test the above hypothesis sampling measures are taken up. Different sampling methods are available, out of which questionnaire method is appropriate and easy to the present context of my research hypothesis. The sample design consists of respondents from various districts of Andhra Pradesh. The study is confined to population of state of Andhra Pradesh. According to 2011 census the population of Andhra Pradesh is 8.20 crores out of which rural population is about 5.0 crores. The sample so selected consists of 1500 respondents comprising 500 samples from 10 villages in each mandal in the three districts namely Srikakulam, Chittore, and Mahabubnagar with different social backgrounds The data collected is then subjected to statistical analysis using chi-square test to test the hypothesis.

RESEARCH HYPOTHESIS FOR TESTING

1. H_0-There is no relationship between monthly income and domiciliary health expenditure.
   H_1-There is a relationship between monthly income and domiciliary health expenditure.
2. H_0 - There is no relationship between monthly income and monthly savings.
   H_1 - There is a relationship between monthly income and monthly savings.
3. H_0 -There is no relationship between monthly income and affordability of premium on micro health insurance to meet high cost of health expenditure.
   H_1 - There is a relationship between monthly income and affordability of premium on micro health insurance to meet high cost of health expenditure.
4. H_0 - Majority of rural poor are not satisfied with the micro health insurance services provided in rural areas.
   H_1 - Majority of rural poor are satisfied with the micro health insurance services provided in rural areas.

TABLE NO. 1: AGE OF THE RESPONDENTS

AGE (in Years)	NUMBER OF RESPONDENTS	PERCENTAGE
25-30	480	32
30-35	525	35
35-40	335	22
40-50	160	11
50 AND ABOVE	0	0
TOTAL	**1500**	**100**

Source: Primary Data

The above table shows the age distribution of the respondents that were identified as poor. Majority of them are in the age group of 30 – 35 years which accounts for 35 percent. 32 percent of them belong to the age group of 25–30. 22 percent of the respondents belong to the age group of 35 – 40 and 11 percent of them belong to the age group of 40 – 50. A majority of the respondents are women and this provides the ample scope for insuring them at a very young age and can be easily brought under the umbrella of micro health insurance.

TABLE NO. 2: RESPONSE REGARDING LITERACY LEVEL

LITERACY LEVEL	NUMBER OF RESPONDENTS	PERCENTAGE
YES	945	63
NO	555	37
TOTAL	**1500**	**100**

Source: Primary Data

The above table analyses another personal factor considered is the educational factor of the respondents. It is identified that 63 percent said that they are literate and studied up to 5th standard and some of them told they studied up to 7th standard.37 percent of the respondents are not literate and not even have basic education. This shows wider gaps in education of the rural poor in understanding their needs for availing various benefits offered by government and other institutions providing micro insurance services. The education has helped them in understanding various schemes of micro insurance services offered by MFIs and Government.

TABLE NO. 3: RESPONSE REGARDING POSSESSION OF RAJIV AAROGYASRI CARD

RESPONSE	NUMBER OF RESPONDENTS	PERCENTAGE
YES	1434	95.60
NO	66	4.40
TOTAL	**1500**	**100**

Source: Primary Data

Responding to a question regarding possession of Rajiv Aarogyasri Card a 96 percent majority of the respondents said that they possess the card which is used to minimize the health related expenditure to a nominal amount by the entire family members. The study revealed that 4 percent of the respondents do not possess the card. This card is useful for the poor to avoid heavy health related costs when any of the family member(s) are hospitalized.

TABLE NO. 4: RESPONSE REGARDING MONTHLY INCOME

MONTHLY INCOME	NUMBER OF RESPONDENTS	PERCENTAGE
Rs.3000	843	56.20
Rs.4000	409	27.27
Rs.6000	248	16.53
TOTAL	**1500**	**100**

Source: Primary Data

To estimate the affordability of micro health insurance services the respondent's income has been analyzed. The respondent's monthly income reveals that 56 percent of the respondents are earning Rs.3,000 a month. 27 percent of the respondents are earning an income of Rs.4000. 17 percent of the respondents said that they are earning Rs.6000 per month by depending on the agriculture in the rural areas. It is observed that income level determines the status of the member in the family. Majority of the cases the male head of the family is the only earning member. A very few families have both women and men are the earning members in the family.

TABLE NO. 5: RESPONSE REGARDING MONTHLY SAVINGS

MONTHLY SAVINGS	NUMBER OF RESPONDENTS	PERCENTAGE
Rs. 500 – 800	636	42.40
Rs.800 - Rs.1000	519	34.60
Rs.1000 - Rs.1200	345	23.00
TOTAL	**1500**	**100**

Source: Primary Data

In response regarding how much do the respondents save in a month, the response received was that a mere 23 percent of them save Rs.1000 – Rs.1200 a month for meeting the future requirements of their family. 35 percent of the respondents said they save Rs.800- Rs.1000 a month. 42 percent of the respondents said they save only Rs.500 – Rs.800 a month. This clearly shows that the poor people are not in a position to meet their ends with limited means of earning and to save for the future.

TABLE NO. 6: RESPONSE REGARDING VARIOUS SOURCES OF INCOME

SOURCES OF INCOME	NUMBER OF RESPONDENTS	PERCENTAGE
EMPLOYMENT	139	9.26
BUSINESS	20	1.34
AGRICULTURE	791	52.73
LABOUR	550	36.67
TOTAL	**1500**	**100**

Source: Primary Data

The respondents in the rural areas are mainly dependent on agriculture and a majority of them are agriculture labor. The above table represents the various sources of income of the respondents. 53 percent of the poor people are dependent on agriculture with small land holdings at their disposal. 37 percent of the

respondents are daily agriculture labour working on daily wage basis. 9 percent of the respondents are employees in village and cottage industries in rural area. A mere 1 percent of the respondents are having small business at home to sustain their living in rural areas.

TABLE NO.7: RESPONSE REGARDING EXPENDITURE ON HEALTH

EXPENDITURE ON HEALTH	NUMBER OF RESPONDENTS	PERCENTAGE
Rs.500-Rs.1000	807	53.80
Rs.1000 - Rs.5000	396	26.40
Rs.5000 - Rs.10000	201	13.40
Above Rs.10000	96	6.40
TOTAL	**1500**	**100**

Source: Primary Data

In responding to the question on health expenditure by the respondents, 54 percent of the respondents said that they spend Rs.500 – Rs.1,000 on health related problems. 26 percent of the respondents reacted and said they use to spend Rs.1000 – Rs.5000 on their health. 14 percent of the respondents said they spend Rs. 5000 – Rs.10000 on their health. 7 percent of the respondents said that they spent Rs. 10000 towards protecting them from health related problems. The general perception of the respondents is that they are unable to meet the growing cost of the health and facing lot of problems in meeting the expenditure towards health.

TABLE NO. 8: SOURCES OF FUNDS FOR MEETING HEALTH EXPENSES

SOURCE OF FUNDS	NUMBER OF RESPONDENTS	PERCENTAGE
Own Sources	882	58.80
Mortgage of Assets	348	23.20
Loan from Money Lenders	57	3.80
Loan from Relatives	213	14.20
TOTAL	**1500**	**100**

Source: Primary Data

The above table shows the various sources of funds available to the respondents in meeting their health related costs. 59 per cent of the majority said that they are meeting the health expenses from their own savings as a major source. Whereas 23 percent of the respondents said they mortgage their personal assets for meeting the health related expenses. 4 percent of the respondents said they depend on village money lenders for meeting health related expenses in case of urgency and 14 percent of the respondents said they take loan from their relatives and friends for meeting emergency health related expenses.

TABLE NO. 9: AFFORDABILITY OF PREMIUM PER MONTH TOWARDS MICRO HEALTH INSURANCE

PREMIUM PER MONTH	NUMBER OF RESPONDENTS	PERCENTAGE
Rs.10 - Rs.25	76	5.06
Rs.25 - Rs.50	80	5.34
Rs.50 - Rs.75	597	39.80
Rs.75 - Rs.100	747	49.80
TOTAL	**1500**	**100**

Source: Primary Data

The above table shows the affordability of premium of health insurance by the poor people in rural areas. The lower level of income of the respondents is not able to support them for affording health insurance premium. 5% of the respondents said they can afford Rs10 – Rs.25 where as another 5% of the poor said they can afford Rs.25 – Rs. 50 per month. 40 percent of the respondents are affordable to pay Rs.50 – Rs.75 and 50 percent of the respondents said their income levels are just sufficient to afford Rs. 75 – Rs 100 per month towards health insurance premium.

TABLE NO. 10: RESPONSE REGARDING OVERALL SATISFACTION ON MICRO INSURANCE SERVICES FOR THE POOR IN RURAL AREAS

DEGREE OF SATISFACTION	NUMBER OF RESPONDENTS	PERCENTAGE
HIGHLY SATISFIED	66	4.40
MODERATELY SATISFIED	45	3.00
LOW SATISFACTION	423	28.20
NOT SATISFIED	966	64.40
TOTAL	**1500**	**100.00**

Source: Primary Data

On an analysis of overall satisfaction of respondents on various parameters like access and affordability of micro insurance services, 66 respondents said that they are highly satisfied. 45 respondents said they are moderately satisfied with the micro insurance schemes.423 respondents have low satisfaction due to the fact that they did not derive any benefit from the scheme. 966 respondents have replied that they are not satisfied with regard to access to insurance for the poor by the government and criticized the government for not taking steps to provide insurance to them to improve their well being and to protect their health.

HYPOTHESIS TESTING – CHI-SQUARE TEST

1. RELATIONSHIP BETWEEN MONTHLY INCOME AND MONTHLY SAVINGS

OBSERVED FREQUENCIES

	Monthly Savings				
Monthly Income		Rs. 500 – 800	Rs. 800 - 1000	Rs.1000 - 1200	**Total**
	3000/-	406	233	204	843
	4000/-	129	217	63	409
	6000/-	101	69	78	248
	Total	**636**	**519**	**345**	**1500**

HYPOTHESIS:

H_0: There is no relation between monthly income and monthly savings

H_1: There is a relation between monthly income and monthly savings

Therefore χ^2 = 92.1823

Tabulated value of χ^2 for 4 degrees of freedom at 5% level of significance is 9.49

There is no relationship between monthly income and monthly savings. Since the calculated value of χ^2 is greater than the tabulated value of χ^2 for 6 degrees of freedom at 5% level of significance, hypothesis is rejected. Hence we can conclude that there is a relationship between monthly income and monthly savings.

HYPOTHESIS TESTING – ANOVA

ANOVA: TWO-FACTOR WITHOUT REPLICATION

SUMMARY	*Count*	*Sum*	*Average*	*Variance*
3000/-	3	843	281	11929
4000/-	3	409	136.3333	5969.333
6000/-	3	248	82.66667	272.3333
Rs. 500-800	3	636	212	28423
Rs.800-1000	3	519	173	8176
Rs.1000-1200	3	345	115	5997

ANOVA						
Source of Variation	***SS***	***df***	***MS***	***F***	***P-value***	***F crit***
Rows	63144.67	2	31572.33	5.7281	0.066975	6.944272
Columns	14294	2	7147	1.296665	0.368053	6.944272
Error	22047.33	4	5511.833			
Total	99486	8				

Since p > 0.05 the monthly savings of the respondents is **not** significant. We accept the Null hypothesis. Hence It can be concluded that the savings are homogeneous among the respondents

2. RELATION BETWEEN MONTHLY INCOME AND DOMICILIARY EXPENDITURE ON HEALTH

OBSERVED FREQUENCIES

	Domiciliary Expenses on Health					
Monthly Income		Rs.500-1000	Rs.1000-5000	Rs5000-10000	More than Rs.10000	**Total**
	3000/-	458	221	113	51	843
	4000/-	222	101	59	27	409
	6000/-	127	74	29	18	248
	Total	**807**	**396**	**201**	**96**	**1500**

HYPOTHESIS:

H_0: There is no relation between monthly income and domiciliary expenses on health.

H_1: There is a relation between monthly income and spent on domiciliary expenses on health during last year.

Therefore χ^2 = 3.2753

Tabulated value of χ^2 for 6 degrees of freedom at 5% level of significance is 12.6

There is no relationship between monthly income and domiciliary expenditure on health. Since the calculated value of χ^2 is less the tabulated value of χ^2 for 6 degrees of freedom at 5% level of significance, hypothesis is accepted. Hence we can conclude that there is a relationship between monthly income and domiciliary expenditure on health.

HYPOTHESIS TESTING – ANOVA

ANOVA: TWO-FACTOR WITHOUT REPLICATION

SUMMARY	*Count*	*Sum*	*Average*	*Variance*
Monthly Income	4	843	210.75	32104.25
Monthly Income	4	409	102.25	7291.583
Monthly Income	4	248	62	2464.667
Health Expenses	3	807	269	29047
Health Expenses	3	396	132	6123
Health Expenses	3	201	67	1812
Health Expenses	3	96	32	291

ANOVA						
Source of Variation	***SS***	***Df***	***MS***	***F***	***P-value***	***F crit***
Monthly Income	47358.5	2	23679.25	5.225766	0.04851	5.143253
Health Expenses	98394	3	32798	7.238179	0.020308	4.757063
Error	27187.5	6	4531.25			
Total	172940	11				

Since P < 0.05 the domestic health expenditure is significant. We reject the Null hypothesis. Hence it can be concluded that the domestic health expenditure is NOT homogeneous among the respondents

3. RELATIONSHIP BETWEEN MONTHLY INCOME AND AMOUNT OF PREMIUM AFFORDABLE TO PAY FOR MICRO HEALTH INSURANCE

OBSERVED FREQUENCIES

	Amount of premium affordable to pay for health insurance to meet high cost of health related expenses					
Monthly Income	**Rs.**	**Rs. 10 - 25**	**Rs. 25-50**	**Rs.50-75**	**Rs. 75-100**	**Total**
	3000/-	33	38	328	444	843
	4000/-	30	29	170	180	409
	6000/-	13	13	99	123	248
	Total	**76**	**80**	**597**	**747**	**1500**

HYPOTHESIS

H_0: There is no a relation between monthly income and amount of premium affordable to pay for health insurance to meet high cost of health related expenses.

H_1: There is a relation between monthly income and amount of premium affordable to pay for health insurance to meet high cost of health related expenses.

Therefore χ^2=14.4633, Tabulated value of χ^2 for 6 degrees of freedom at 5% level of significance is 12.6

There is no relationship between monthly income and affordability of premium on micro health insurance to meet high cost of health expenditure. Since the calculated value of χ^2 is greater than the tabulated value of χ^2 for 6 degrees of freedom at 5% level of significance, the hypothesis is rejected. Hence we can conclude that there is a relationship between monthly income and amount of premium the poor can afford to pay for health insurance to meet high cost of health related expenses.

HYPOTHESIS TESTING – ANOVA

ANOVA: TWO-FACTOR WITHOUT REPLICATION

SUMMARY	*Count*	*Sum*	*Average*	*Variance*
Monthly Income	4	843	210.75	43196.92
Monthly Income	4	409	102.25	7073.583
Monthly Income	4	248	62	3297.333
Premium	3	76	25.33333	116.3333
Premium	3	80	26.66667	160.3333
Premium	3	597	199	13741
Premium	3	747	249	29331

ANOVA						
Source of Variation	***SS***	***df***	***MS***	***F***	***P-value***	***F crit***
Rows	47358.5	2	23679.25	3.611584	0.093422	5.143253
Columns	121364.7	3	40454.89	6.170222	0.028981	4.757063
Error	39338.83	6	6556.472			
Total	208062	11				

Since p < 0.05, the premium affordable to pay for the health insurance is significant. We reject the Null hypothesis Hence it can be concluded that the amoaunt of affordable premium paid by the respondents is NOT homogeneous

4. RELATION BETWEEN AMOUNT OF SUM ASSURED FOR HEALTH INSURANCE AND OPINION ON MICRO HEALTH INSURANCE SERVICES FOR THE POOR

OBSERVED FREQUENCIES

	Opinion on Micro Health Insurance Services					
The amount of Sum assured for health insurance	**Sum Assured**	**High Satisfied**	**Moderately Satisfied**	**Low Satisfaction**	**No Satisfaction**	**Total**
	30000	60	147	42	30	279
	50000	597	474	15	15	1101
	75000	48	12	0	0	60
	100000	45	15	0	0	60
	150000	0	0	0	0	0
	Total	**750**	**648**	**57**	**45**	**1500**

HYPOTHESIS

H_0: There is no relation between amount of sum assured and opinion on micro health insurance services for the poor.

H_1: There is a relation between amount of sum assured and opinion on micro health insurance services for the poor.

Therefore χ^2=269.5299

Tabulated value of χ^2 for 9 degrees of freedom at 5% level of significance is 16.9

Majority of the rural poor are not satisfied with the micro insurance services provided in rural areas. Since the calculated value of χ^2 is greater than the tabulated value of χ^2 and found significant at 5% level of significance, the hypothesis is rejected. Hence we can conclude that there is a relationship between the amount of sum assured and opinion on micro health insurance services for the poor.

TABLE NO. 10: RESPONSE REGARDING OVERALL SATISFACTION ON MICRO INSURANCE SERVICES FOR THE POOR IN RURAL AREAS

DEGREE OF SATISFACTION	NO. OF RESPONDENTS (f)	WEIGHT (W)	WEIGHTED SCORE (W*f)	$x-\bar{x}$	$(x-\bar{x})^2$	$f(x-\bar{x})^2$
1	**2**	**3**	**4**	**5**	**6**	**7**
HIGHLY SATISFIED	66	5	330	5 – 2.09 = **2.91**	8.4681	**558.89**
MODERATELY SATISFIED	45	4	180	4 – 2.09 = **1.91**	3.6481	**164.16**
LOW SATISFACTION	423	3	1269	3 – 2.09 = **0.91**	0.8281	**350.29**
NOT SATISFIED	387	2	774	2 – 2.09 = **- 0.09**	0.0081	**3.130**
HIGHLY DISSATISFIED	579	1	579	1. – 2.09 = **- 1.09**	1.1881	**687.91**
TOTAL	**f=1500**		**3132**			**1764.38**

The weighted mean score = 2.09 ; f = 1500 ; mid point = 3.0 $\sum$ w. f = 3132

$\sum = \sqrt{f(x-\bar{x})^2/N} = \sqrt{1764.38/1500} = \sqrt{1.1763} = 1.085$

$\bar{x}$ +/- $\sum$ = 2.09 +/- 1.085 = 3.175 and 1.005 with mid point = 3.0 deviations from the midpoint 1.175 and -1.995

Sum of the deviations = -0.82 hence the conclusion is negative.

CONCLUSION

There is a large potential market to micro health insurance of rural poor. The demand is strong and is indicating a potential market beyond lending loans and savings micro insurance helps is risk management of the poor in their lives. The formal linkages between insurance companies and informal agencies like MFIs and NGOs will bring greater innovation in design and delivery of micro insurance services and benefits the poor at large. For this understanding of the critical gaps in managing risks is a starting point for identifying micro insurance products for the poor. From here, the challenge becomes how to zero in on insurable risks and design products that are feasible, acceptable, and affordable. The analysis of the study revealed that the poor are vulnerable to various health related

risks and they are unable to meet their high cost of health related expenditure with limited savings in their hands. The affordability analysis of premium reveals that the poor can afford to pay low premiums for their health insurance cover. The quantitive analysis on the overall satisfaction of health insurance services in rural areas reveals that majority of the poor are very much dissatisfied with the micro insurance services in rural areas. With 95 percent of the Indian population outside the non-life insurance safety net, insurers have a huge challenge and a big opportunity. Though India has experimented a lot with micro insurance, the sector is still driven by supply-led interventions. Hence, a strategic perspective towards micro insurance together with innovations in technology and assessment of client demand probably holds the key to the future of micro insurance in India.

SUGGESTIONS

The study analyzed various factors contributing to the growth of micro health insurance services. A clear understanding of the micro insurance scenario in India in terms of access, affordability and quality in terms of satisfaction of the poor requires lot of efforts from the formal and informal agencies contributing to the social goals besides profit making. An important alternative option to fulfill the economic as well as the social goals can be by offering subsidies in risk coverage rather than premium through some form of risk adjustment within the insurance industry. There is a need to provide after sale service for extension of insurance market to serve the large number of poor population living in rural areas.

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ANNEXURE

LIST OF MICRO INSURANCE PRODUCTS WITH UIN'S

Financial Year	Name of the Product	Product UIN No.	From (opening date)
2007-08	Bajaj Allianz Jana Vikas Yojana	116N047V01	4-Apr-07
2007-08	Bajaj Allianz Saral Suraksha Yojana	116N048V01	4-Apr-07
2007-08	Bajaj Allianz Alp Nivesh Yojana	116N049V01	4-Apr-07
2007-08	Grameen Suraksha	122N039V01	16-Mar-07
2007-08	Birla Sun Life Insurance Bima Suraksha Super	109N032V01	13-Aug-07
2007-08	Birla Sun Life Insurance Bima Dhan Sanchay	109N033V01	13-Aug-07
2008-09	ICICI Pru Sarv Jana Suraksha	105N081V01	2-Jun-08
2007-08	ING Vysya Saral Suraksha	114N032V01	3-Sep-07
2006-07	LIC's Jeevan Madhur	512N240V01	14-Sep-06
2009-10	LIC's Jeevan Mangal	512N257V01	4-May-09
2008-09	Met Vishwas	117N042V01	2-Jun-08
2007-08	SBI Life Grameen Shakti	111N038V01	6-Sep-07
2007-08	SBI Life Grameen Super Suraksha	111N039V01	6-Sep-07
2006-07	Ayushman Yojana	110N042V01	30-May-06
2006-07	Navkalyan Yojana	110N043V01	30-May-06
2006-07	Sampoorn Bima Yojana	110N044V01	2-Jun-06
2008-09	Tata AIG Sumangal Bima Yojana	110N061V01	3-Jun-08
2006-07	Sahara Sahayog (Micro Endowment Insurance without profit plan)	127N010V01	21-Apr-2006
2007-08	Shri Sahay	128N011V01	7-Feb-07
2007-08	Sri Sahay (AP)	128N012V01	24-Apr-07
2008-09	IDBI Fortis Group Microsurance Plan	135N004V01	5-Nov-08
2008-09	DLF Pramerica Sarv Suraksha	140N007V01	16-Mar-09
2008-09	SUD Life Paraspar Suraksha Plan	142N009V01	17-Mar-09

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With sincere regards

Thanking you profoundly

Academically yours

Sd/-

Co-ordinator