

Board Approved Policy for
Grievance Redressal and Fraud Monitoring

Approved By

R. Uma Priyanka

Director



Agarwal

Principal Officer

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1. Grievance Redressal Framework

The framework for grievance redressal at Vima Insurance Brokers Private Limited will comprise of the following dimensions:

A. Definitions

- i. “Grievance/complaint” shall mean any communication that expresses dissatisfaction about an action or lack of action, about the standard of service/deficiency or service on part of the company and/or asks for remedial action.
- ii. “Inquiry” shall mean any communication from the customer for the primary purpose of requesting information about a company and/or its services.
- iii. “Request” shall mean any communication from a customer soliciting a service such as a change or modification in the policy.
- iv. “Complainant” shall mean any policyholder (including legal heirs, assigns, or legal representative) who reports a grievance to the company.

B. Registration of customer grievances at various touch points:

The touch point & mode of receipt of the customer grievance is as under:

S. No.	Touch Point	Mode of Receipt
1	Direct Customers	Block B, Tecci Park, Elcot Sez, OMR, Shollinganallur, Chennai – 600119.
	At our Office Location	Hard copy letters / Telephone calls / Letters
	Direct Grievances	Hard copy letters
	Customer support / Helpdesk	Customer may write to us at Email ID protect@vimainsurance.com
	Inbound calls	Telephone calls on our Inbound No. 9514675818
2	Insurance company	Emails / Letters / Telephone calls

C. Grievance Redressal system/procedure

Direct from Customers: The process for addressing the grievance that approaches directly to the company will be:

- All grievances will be received at Email ID protect@vimainsurance.com or at our corporate office of the Company.
- All grievances will be given a written acknowledgement within 24 hours and in extreme circumstances should not be more than 48 hours from the time of receipt.
- All grievances will be answered/acknowledged to customer by Grievance officer either through a letter, e-mail or telephonically.
- Grievance Redressal team will provide an acceptable resolution to the grievances received within 14 working days. The TAT in some exceptional cases may get extended depending upon the severity of the grievance.
- Post receipt of the grievance team will get in touch with the customer and try to understand and resolve his/her grievance in the best possible manner after looking at all the facts. In case customer is not satisfied, Grievance team will investigate the case.

- Post receiving the grievance detailed investigation to be carried out with the help of principal company and customer to furnish further details and arrive to an outcome. Final report is submitted to the concerned based on the source of grievance.
- During investigation the team will keep an eye on PIVC recording (if available) for the respective case to verify the concerns/allegations raised by customer.
- In case discrepancy is found post investigation, necessary communication will be sent to insurance company to process the case for refund. In addition, a designated plan i.e. AAP (Assertive action plan) for actions to be taken. If no discrepancy is found, necessary communication will be made to insurance company to decline the customer request for policy cancellation. PIVC recording, if available, will also be shared with the insurance company as support.

From Insurance Company: The process followed for addressing the same is as below:

- All grievances will be received at our email ID protect@vimainsurance.com
- All the grievances received will be given an acknowledgement letter through letter or Email within 24 hours and in extreme circumstances should not be more than 48 hours from the time of receipt of grievance. Grievance Redressal team will provide an acceptable resolution to the grievances received within 14 working days. The TAT in some exceptional cases may get extended depending upon the severity of the grievance.
- Post receipt of the grievance, Grievance team will get in touch with the customer and try to understand and resolve his/her grievance in the best possible manner after looking at all the facts. In case customer is not satisfied, Grievance team will investigate the case.
- Post receiving the grievance detailed investigation to be carried out with the help of principal company and customer to furnish further details and arrive to an outcome. Final report is submitted to the concerned based on the source of grievance.
- During investigation the team will keep an eye on PIVC recording (if available) for the respective case to verify the concerns/allegations raised by customer.
- In case discrepancy is found post investigation, necessary communication will be sent to insurance company to process the case for refund. In addition, a designated plan i.e. AAP (Assertive action plan) for actions to be taken. If no discrepancy is found, necessary communication will be made to insurance company to decline the customer request for policy cancellation. PIVC recording, if available, will also be shared with the insurance company as support.

D. Escalation Matrix

Escalation Matrix for Insurance Company/Policyholder:

In case the insurance company / policyholder feels that they are not getting any revert from our end within the defined TAT, following escalation matrix needs to be followed:

Level	Name	Email Id	Escalation time frame w.r.t Received date
Level 1	Grievance Support	mary@vimainsurance.com	3 days
Level 2	Grievance Officer	avinash@vimainsurance.com	6 days
Level 3	Principal Officer	anshuman.agrawal@gmail.com	10 days

We also have displayed in our office notice board with details of Bima Bharosa Portal, Insurance Ombudsman where the customer can reach out in case of further escalation.

E. Grievance Redressal Committee

The Company will also form a Grievance Redressal committee which will ensure that the company follows this policy. The committee will meet once a quarter to review the status of grievance disposal.

The responsibilities of the Grievance redressal committee shall be:

- Putting in place proper procedures and effective mechanism to address grievances and grievances of policyholders including mis-selling, forgery, and documents tampered etc.
- Ensure compliance with the statutory requirements as laid down in the regulatory framework.
- Review of the mechanism at periodic intervals.
- Provide the details of grievances at periodic intervals in such format as may be prescribed by the authority.

Composition of the Grievance Redressal Committee will be as follows:

- Manager, Grievance Team
- Grievance Officer
- Director & Principal Officer

2. Classification of Grievances

- Grievances falling under the following categories would be considered as Fraudulent Grievances
 - Offering of Bonus
 - Linkage with Previous Policies
 - One Time Investment (if it's not a one Time Investment Policy)
 - Offer of Gifts/Discounts
 - Signature Forgery
 - Offer of Mediclaim policy Any Other Mis-commitment
 - Guaranteed Returns in ULIP Plan
- Grievances falling under the following categories would be considered as Serious Grievances
 - Exaggerated Insurance Cover
 - Mode Issues
 - Does not agree with terms and conditions
 - Personal Issue (Fund Issue or Personal)
 - Plan Term Issue
 - Service Issues (Service or Document Related)
 - Pension which is not as per standard product specifications
 - Reduced Interests on Loan and Loan against a ULIP plan

- Riders – If it's not a standard feature of the Plan.
- Tie-up between two unrelated insurance Companies

3. Time frame for resolving Grievances

The company shall resolve all grievances within the time frame of 14 days or as prescribed by Regulator from time to time.

4. Proactive steps taken to reduce Grievances

The company shall initiate proactive steps to ensure reduction in the incidents leading to the customer grievances. This shall include:

- Continuous improvements of sales process by enhancing internal controls.
- Steps towards timely & accurate servicing.
- Further enhancement of the PIVC.

5. Fraud Monitoring Framework

Definitions

- i. "Insurance Fraud" (hereinafter referred to as 'Fraud') shall mean an act or omission intended to gain advantage through dishonest or unlawful means, for a party committing the fraud or for other related parties; including but not limited to:
 - ☐ Misappropriating funds;
 - ☐ Deliberately misrepresenting/concealing/not disclosing one or more material facts relevant to any decision / transaction, financial or otherwise,
 - ☐ Abusing responsibility, position of trust or a fiduciary relationship.
- ii. Red Flag Indicator or RFI means a possible warning sign, that points to a potential fraud and may require further investigation or analysis of a fact, event, statement, or claim, either alone or with other indicators.
- iii. Cyber or New Age Fraud means any insurance fraud carried out using digital or new age technologies.

Fraud Categorization

We shall follow the processes across all functions to deter, prevent, detect, report and remedy frauds; and report such frauds according to the following categories:

- i. Internal Fraud: Fraud involving internal staff, including employees and / or senior management.
- ii. Policyholder Fraud and/or Claims Fraud: Fraud involving any person(s), in obtaining coverage or payment during the purchase, servicing, or claim of an insurance policy.
- iii. External Fraud: Fraud involving external parties' / service providers / vendors etc.
- iv. Affinity Fraud or Complex Fraud: Fraud involving collusion among one or more fraud perpetrators in the above categories.

v.

Registration of Fraud at various touch points:

The touch point for an identified fraud shall be registered as under:

S. No.	Touch Point	Mode of Receipt
1	Direct Customers	Walk-in - Block B, Tecci Park, Elcot Sez, OMR, Shollinganallur, Chennai – 600119.
	At our Office Location	Hard copy letters / Telephone calls / Letters
	Fraud Committee Identification	Internal emails
	Inbound calls	Telephone calls on our Inbound Number
2	Insurance company	Emails / Letters / Telephone calls

Fraud Monitoring Committee and Unit (FMU and FMU)

A Fraud Monitoring Committee (FMC) shall be established which shall be responsible for operationalizing the Fraud risk management framework within the Company and oversee activities, as appropriate, to ensure fraud deterrence, prevention, detection, reporting and remedying.

A Fraud Monitoring Unit (FMU), independent from internal audit, to support FMC in discharging its functions and effective implementation of measures suggested by FMC.

The FMC shall recognize and understand fraud risk particular vulnerable to our organization, including potential types and impact of frauds and take steps to minimize their vulnerability to Frauds.

The FMC shall along with the Board and Senior Management shall be responsible for establishing FMU with appropriate powers under fraud risk management framework and shall have:

- Power to controls, deter, prevent, detect, report and remedy frauds.
- Follow respective regulator's policy or framework, supplemented by additional controls specific to the insurance business, if its primary business is other than insurance.
- Impart proper Education, awareness and training to employees with flow of Investigation and internal reporting structure for frauds
- Procedure for reporting Frauds to Law Enforcement Agencies (LEAs), proper coordination to meet the requirements of the LEAs and follow up with LEAs and/or court for final disposal of fraud cases
- Due diligence procedures for appointing employees /sales persons and a Whistle Blower reward.

Fraud Control system and procedure

Direct from Customers: The process for addressing the fraud related communications that approaches directly to the company will be:

- All fraud related communications will be received at Email ID protect@vimainsurance.com or at our corporate office of the Company.
- All fraud related communications will be given a written acknowledgement within 24 hours and in extreme circumstances should not be more than 48 hours from the time of receipt.
- All fraud related communications will be answered/acknowledged to customer by Fraud Control officer either through a letter, e-mail or telephonically.
- Fraud Monitoring Unit (FMU) will provide an acceptable resolution to the communication received within 14 working days. The TAT in some exceptional cases may get extended depending upon the severity of the grievance.
- Post receipt of the fraud related communications, the FMU will get in touch with the customer and try to understand and resolve his/her claim in the best possible manner after looking at all the facts. In case customer is not satisfied, fraud related communications will investigate the case.
- Post receiving the fraud related communications, a detailed investigation to be carried out with the help of principal company and customer to furnish further details and arrive to an outcome. Final report is submitted to the concerned based on the source of fraud.
- During investigation the FMU will keep an eye on PIVC recording (if available) for the respective case to verify the concerns /allegations raised by customer.
- In case discrepancy is found post investigation, necessary communication will be sent to insurance company to process the case for refund. In addition, a designated plan i.e. AAP (Assertive action plan) for actions to be taken. If no discrepancy is found, necessary communication will be made to insurance company to decline the customer request for policy cancellation. PIVC recording, if available, will also be shared with the insurance company as support.

6. Actions Taken

A committee comprising of Grievance officer, Head – HR and Principal Officer, will take appropriate action against the employees who are found to be guilty. The punishment will be decided basis severity of individual case and may vary from verbal/written warning to termination. The actions taken in this regard will be presented to Grievance redressal committee on monthly basis.

Approved By

R. Uma Priyanka

Director



A. Anand

Principal Officer

Date: 26-03-2026

Place: Chennai.

Annexure
Assertive Action Plan

- Every mis-selling of the Fraud and Very High Severity will be counted as 1 instance for the purpose of Actions to be taken.
- Every 2 mis-selling instances of the High Severity will be counted as 1 instance for the purpose of Actions to be taken.

Action to be Taken		
Designation	Instance Number	Action to be taken
Person responsible for solicitation of insurance business OR Team Coordinator / Team Leader as the case may be.	1	Verbal Warning
	2	Verbal Warning
	3	Written Warning
	4	Written Warning
	5	Written Warning
	6	Asked to Go

- Action will be taken against any Team Coordinator / Team Leader indulging in Mis-Selling.

Refer to next page for category of Mis-selling.

Annexure - 1

Assertive Action Plan for Fraud

Type of Mis-Selling	Severity Level
Bonus pitched before the actual term	Fraud
Asking customer to invest Renewal amount into new policy & Merging policies	Fraud
Offering Free Gifts to customers	Fraud
Pitching a regular premium product as a Single Premium/ one time investment product	Fraud
Linking new policy with previous policy (Merging)	Fraud
Asking the customer to source a policy and get it free looked later	Fraud
Pitching withdrawal option lower than actual term/lock-in	Fraud
Calling on Behalf of IRDA/Income Tax department.	Fraud
Pension before actual term	Fraud
Fake Verification conversation with PIVC Team.	Fraud
Cash Defalcation	Very High
Signature Forgery	Fraud
Quoting Guaranteed Returns where not a standard feature	Very High
Riders Term	High
Withdrawal of amount with bonus in endowment plans. The right thing is to say either invested amount with returns	High
Not using the word approx/performance based in non-guaranteed returns.	High
High Rider Sum Assured than can actually be offered.	High
Informing Incorrect rider features	High
Wrong Rider information given.	High
Increased Insurance Cover	High
High bonus/returns quoted	High
Informing the customer that the plan is being given on behalf of previous policy.	High
Use of Pseudo name	High
Discount on Premium	High
Impersonation of being head office, senior manager / branch manager, verification / Bonus department etc.	High
Name and number shortlisted, Forms/Schemes introduced exclusively for customers of a particular sector/age/region/company	High
Agents take commissions from premium but we invest the entire money	High
Forms/Schemes lasting for a specific period after which the benefits would not be available	High
Plan exclusively for A/AAA etc. category customers, Customers with excellent banking/credit record	High
Anniversary offer	High
Plan exclusively for senior citizens, government officials, PSU customers etc.	High
Quoting both returns and bonus where only one is the standard feature.	High

R. Uma Priyanka

Director



Aganwal

Principal Officer