



Institute of Actuaries of India

Statutory body established under an Act of Parliament

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23 October 2026

To

All Members

Dear all,

Subject: Addendum to IAN 100 Application of IFRS 17 Insurance Contracts - Non-Life Insurance

Adoption of Ind AS 117 (IFRS 17) represents a significant step change in insurance accounting in India. The actuarial profession is expected to play an important role in the implementation and the Institute of Actuaries of India (IAI) remains committed to supporting a successful transition by Indian insurers.

While extensive implementation guidance is available from the IASB, IAA, actuarial professional bodies and global accounting and consulting firms, such resources may not fully address India-specific issues and practical considerations.

The Advisory Group on IFRS 17 (Ind AS 117) of the IAI has facilitated industry discussions on key topics, including:

- Level of aggregation and measured model for motor line of business
- Treatment of crop insurance under Pradhan Mantri Fasal Bima Yojana (PMFBY) and Restructured Weather Based Crop Insurance Scheme (RWBCIS)

The deliberations arising from these industry discussions, together with the approaches considered by the Advisory Group, are available at [Magazine of the Institute of Actuaries of India](#).

The IAI has also received queries and comments from industry participants regarding the implementation of Ind AS 117. In response, a task force constituted by the Institute has considered these matters with reference to the requirements of the standard and practices across jurisdictions.

Reference has also been made to IAN 100, issued by International Actuarial Association, which is available at [IAA IAN100_31August2021.pdf](#).

This paper summarises the task force's deliberations and provides guidance on selected implementation issues to promote greater consistency in the application of Ind AS 117 within the Indian non-life insurance industry.

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Q1. Within non-life insurance, it is a common practice wherein the insurer has received premiums e.g. corporate risk renewal at 1/4 and a portfolio segment could be onerous. Even though the premiums are received - policy might not have been issued but given that 64VB clause of Insurance Act is met, the Company is liable at all times.

As per para 22, an entity shall not include contracts issued more than one year apart in the same group.

So should the contract be part of the previous year cohort or new cohort and whether the loss component needs to be recognised?

Response

Background:

Corporate risk renewals within the Indian market, typically underwritten on an annual basis and is aligned with the Indian financial year i.e. 1 April to 31 March. Operational realities of this renewal cycle include:

- Premium received by the insurers late March and before 31-March
- Policy issuance lag — formal policy documents are often issued with a short lag after 1 April

Similar renewal instances are common at 1 January for multi-national corporations etc.

From Ind AS 117 standards perspective, there is conceptual distinction between "Issued," "Recognised" and "Coverage Period" as defined below:

- Aligned with para Ind AS 117.2, the definition of contract is not limited to physical policy issuance and any agreement creating enforceable rights and obligations is a contract. Additionally, aligned with section 64VB of The Sabka Bima Sabki Raksha (Amendment of Insurance Laws) Bill, 2025 and various legal precedence, an Indian insurer become party to the contract once the premium is received by the insurance company. Thus, under Ind AS 117 a contract is issued with receipt of premium as the insurer becomes the issuer and a party to the contract.
- The period in which contracts are issued determines their inclusion in Ind AS 117, their grouping into annual cohorts, and their treatment on transition (Para 14, Para 22 and C2).
- Issuance is distinct from the date of initial recognition or coverage start (Para 25).

Thus, all such corporate risk contracts (and also retail risks) wherein there is expected to be loss components – this needs to be recognised during the current period and loss component also needs to be allowed for within the P&L for the immediate reporting period.



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Q2. How should the un-allocated premium as at the reporting date be handled?

Response

Background:

It is common for an insurer to have received premium from customer at a given reporting date but details pertaining to the risk – class of business, policy characteristics etc. aren't immediately available. The current practice is to categorize such premiums as un-allocated premium at the reporting date and this subsequently gets booked in future reporting period post internal reconciliations. With Ind AS 117, this approach creates a challenge as contract needs to be recognized and any loss components needs to be allowed for within the P&L.

Given the requirements under the standards, an insurer shall make every effort to allocate the premiums to respective Class of Business (CoB), Level of aggregation (LoA) etc. and ascertain appropriate fulfilment cash flows thereby estimating loss component, if applicable. Thus, to ensure the financial statements are fair at the reporting period insurer needs to establish appropriate system such that the quantum of unallocated premiums are minimum.

If the unallocated premiums correspond to backdated policies, auditor alignment would be required considering operational complexity. E.g. unallocated premium can be allocated to IND AS 117 cohort at the time of measurement, basis past year allocation of such premium or a separate level of aggregation can be created at each reporting period to recognize such contracts as part of Ind AS 117 liabilities.

In the event an insurer is unable to establish underlying policy level details to identify applicable risk characteristics of insurance contracts, such premium amount can be booked as part of financial liabilities subject to Ind AS 109.



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Q3. As per para 16, an entity shall divide a portfolio of insurance contracts issued into a minimum of:

- (a) a group of contracts that are onerous at initial recognition, if any;*
- (b) a group of contracts that at initial recognition have no significant possibility of becoming onerous subsequently, if any; and*
- (c) a group of the remaining contracts in the portfolio, if any.*

Across Europe, insurers have only classified contracts into only two cohorts i.e. non-onerous and Others. Is this is permissible?

Response

As per the standard, three groups are to be considered including an assessment whether contracts that are not onerous at initial recognition have no significant possibility of becoming onerous based on the likelihood of changes in assumptions which, if they occurred, would result in the contracts becoming onerous (para 18 and 19).

Additionally, BC130 clearly highlights that the proposal for not creating a grouping for contracts that have no significant possibility of becoming onerous from other contracts was rejected by the Board. They highlighted that that in the absence of such a requirement, should the likelihood of losses increase, IFRS 17 would fail to require timely recognition of contracts that become onerous.



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Q4. In case of few Crop insurance schemes, tender terms indicate an actuarial burn cost. Thus, if an insurer quotes premium rates below the actuarial burn cost - will the policy qualify as onerous contract?

Response

- **Relevance of Historical benchmarks:** The burn cost published will definitely be the starting point for onerosity testing. Historical experience assumes particular significance in the context of crop insurance, as crop business is inherently data-driven and heavily dependent on long-term weather and yield patterns, which remain among the most reliable indicators for assessing future claims experience. Under crop insurance schemes insurers have limited ability to influence the occurrence or severity of losses, as they cannot control rainfall patterns, prevent droughts, or materially mitigate catastrophe-driven losses through operational or servicing efficiencies although may possible to reduce the impact to some extent while estimating the losses. Accordingly, where insurer quotes premium rates significantly below state benchmark burning cost, it may indicate that the premium collected may not be sufficient to cover expected claims, related expenses, and risk margin and thus contract could become loss-making (onerous).
- **Assessment of Fulfilment Cash Flows vs. Historical Benchmarks:** Under the standard, the determination of whether a group of contracts is onerous at initial recognition is driven by the entity's own forward-looking, probability-weighted estimate of Fulfilment Cash Flows (FCF). An entity's forward-looking assessment may reasonably diverge from historical averages due to various factors:
- Scheme-Level and Macro Variables - prevailing meteorological outlooks (e.g., ENSO/IOD phases), technological interventions in yield estimation (e.g., YES-TECH, CROPIC), underlying yield trends, and shifts in the risk profile. However, excessive reliance on future expectations such as improved technology, enhanced yield estimation processes, favourable weather forecasts, or anticipated operational improvements, may not be sufficient unless there is objective evidence demonstrating that such factors are reasonably expected to reduce the incidence or severity of future claims.
- Entity-Specific Variables - Insurer may have better claims handling processes or fraud control mechanisms but these may have limited relevance in the context of crop insurance schemes. This is because such schemes are generally underwritten using an area approach basis, where losses are mainly driven by systemic weather-related events such as droughts, floods, pest attacks, or other natural perils. E.g. where an entire district or notified area experiences crop damage, operational efficiency alone may have limited ability to materially reduce aggregate claims exposure, as losses arise across the regions simultaneously.



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- **Structural Features and Entity-Specific Assumptions** - the structural features of certain tenders, such as risk-sharing corridors (e.g., 60:130 or 80:110 models), inherently alter the insurer's risk profile. If upside limits on cash outflows are not fully reflected in the historical burn cost calculation, the entity's expected outflows may be structurally different. Variations in entity-specific acquisition and maintenance expenses, Risk Adjustment for Non-Financial Risk, and applicable discount rates will also independently influence the final assessment of onerosity for a given premium level. For instance, even with premiums exceeding the historical burn cost, high directly attributable expenses or a significant Risk Adjustment could still lead to an onerous classification.
 - **Documentation and Governance:** Ultimately, while diverging from the published burn cost (whether bidding below or above) does not predetermine the contract's profitability classification under Ind AS 117, such pricing decisions necessitate robust internal governance. Companies are encouraged to maintain comprehensive, data-driven documentation and actuarial evidence to substantiate any material divergence between their FCF and published historical benchmarks. This ensures transparency and provides a clear rationale for statutory auditors, peer reviewers, and regulatory assessments.



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Q5. *Paragraph B37 does require consideration of “all reasonable and supportable information available at the reporting date without undue cost or effort”. Further, Information available from an entity’s own information systems is considered to be available without undue cost or effort.*

It would be easy from Auditors / Independent Actuary’s point of view to evaluate the premium rate or channel commission paid charged across each policy within Product from Premium registers. Additionally, claim experience could be easily ascertained across different cohorts using both policy / claims register.

Does this imply, that it would be imperative to measure onerosity at policy level wherever underlying data is credible?

Response

Para BC129 of Basis of Conclusion the standards clarifies this further.

The objective of the requirement [grouping of insurance contracts into profitability groups] to identify contracts that are onerous at initial recognition is to identify contracts that are onerous measured as individual contracts. An entity typically issues individual contracts and it is the characteristics of the individual contracts that determine how they should be grouped. However, the Board concluded this does not mean that the contracts must be measured individually. If an entity can determine using reasonable and supportable information that a set of contracts will all be in the same group, then the entity can measure that set to determine whether the contracts are onerous or not, because there will be no offsetting effects in the measurement of the set.

It is typical for non-life insurance companies to usually price contracts basis homogenous cohorts or model points (e.g. Make / model of car + Age of vehicle + Fuel Type + NCB + Geography in Motor or 2A2C + Age + Sum Insured + Geography in retail Health etc.) such that the cohort as a whole is expected to generate a profit margin. In many cases, the information available within the premium registers and claims registers shall qualify as reasonable and supportable information to conclude that a set of contracts will all be in the same group to complete the assessment at a higher level than the individual contracts assuming the data is credible.



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Q6. To prove a group of insurance cohorts are PAA eligible could require an insurer to undertake exhaustive testing. Can you please advise the different scenarios one need to undertake and the basis for the same to ensure that testing is exhaustive?

Response

Under Ind AS 117, insurance contracts with a coverage period of one year or less are automatically eligible for the Premium Allocation Approach (PAA). PAA eligibility testing shall be undertaken to demonstrate and document the PAA eligibility of contracts with a coverage period extending beyond one year (such as multi-year motor, long-term property, or certain Engineering All Risks policies).

An entity may test scenarios with a reasonable expectation of occurring basis historical experience, rather than impossible extremes, that could drive a material divergence between the PAA and General Measurement Model (GMM) measurements. The testing shall also include correlated shocks.

While the specific list of scenarios will vary from entity to entity and portfolio to portfolio, some common scenarios that can be considered are as follows:

- Base Case Projection - evaluating the Liability for Remaining Coverage (LRC) trajectory under expected premium receipt patterns, expected loss ratios adjusted for claims inflation and rate change, planned acquisition costs, and current discount rates.
- Claims Frequency and Severity Shocks - applying adverse shifts to the expected loss ratio due to systemic changes, change in inflation, catastrophe events basis historical experience of company and industry overall.
- Macro-Economic and Yield Curve Volatility - applying parallel upward and downward shifts to the yield curve.
- Asymmetric Risk Emergence - for portfolios where risk is not distributed evenly over time (e.g., testing and commissioning phases in EAR/CAR), testing alternate claims occurrence distributions to verify that the chosen PAA earning pattern remains an adequate proxy for the GMM cash flow release.
- Variations in Cash Flow Timing - introducing disruptions to expected premium receipt dates (e.g., delayed instalment payments) or expected claims payment patterns.

Ultimately, such analysis necessitates robust internal governance, and companies are encouraged to maintain comprehensive, data-driven documentation and actuarial evidence to substantiate the tests undertaken and the basis of scenarios considered. This ensures transparency and provides a clear rationale for statutory auditors, peer reviewers, and regulatory assessments.



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Q7. As per para 53 - PAA measurement model can be used when the entity reasonably expects that measurement of the liability for remaining coverage for the group under PAA would not differ materially from the one that would be produced applying GMM.

Does the above mean, absolute amount of LRC under PAA and GMM to be compared or any other KPIs can be used? Any guidance on the materiality thresholds an insurer should use.

Response

Aligned with Para 53(b), in case of insurance contracts with coverage longer than one year, the entity must assess whether - applying the PAA would produce an LRC that would not differ materially from the GMM LRC.

PAA eligibility is assessed at the group level by comparing the Liability for Remaining Coverage measured using the Premium Allocation Approach with the Liability for Remaining Coverage that would arise under the general measurement model i.e. absolute level of PAA LRC which is Unearned premium less insurance acquisition cash flows (unless expensed) should not be materially different from GMM LRC which is Fulfilment cash flows relating to future coverage plus Contractual Service Margin (CSM).

The comparison focuses on whether the absence of an explicit contractual service margin and discounting under the PAA would result in a material difference in the LRC at initial recognition (Para 53(b), B126–B127).

Given the standards require that differences in LRC between two measurements should not be materially different, one can establish thresholds basis discussions with auditor e.g. $x\%$ i.e. $(LRC_{GMM} - LRC_{PAA}) / LRC_{GMM} \leq +/ - x\%$. Additionally, to ensure that $\%$ threshold is not breached when the absolute LRC levels are quite small during the future run-off periods, one can potentially establish absolute threshold basis discussions with auditors e.g. INR y -crs depending on the overall profitability of the Company or $z\%$ of LOB GWP or lower of the above etc.



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Q8. Question 7.5 of IAN 100 provides a non-exhaustive list of examples where the PAA might not provide a reasonable approximation of the GMA. Few that are relevant to the Indian business are:

- Long term Motor TP: The longer the expected payout pattern is for the coverage and / or the higher the interest rate environment.
- Crop: There is a significant non-separable investment service or other non-separable non-insurance component to the contract, or there is a significant profit-sharing component.
- Home insurance (10year - 15 year): Longer duration contract generally
- Extended warranty: Coverage is deferred:

Can one conclude that these portfolio segments, PAA cannot be used?

Response

The IAN 100 does not impose any obligation on any individual actuary to promote or apply the practices described. Further, it is not a definitive statement as to what constitutes generally accepted practice in the area under discussion and the language used is not directive. Paragraph 53(a) requires a quantitative PAA Eligibility test for all groups with coverage period longer than one year. For these, the company must demonstrate reasonable expectation that PAA LRC would not differ materially from GMM LRC. Thus, one can always evaluate if PAA eligibility criteria is satisfied across each of the below product lines.

- Long term Motor TP: The Motor TP portfolio experiences longer claims reporting and settlement pattern i.e. up to 20+years. While one doesn't need to test PAA eligibility for contracts with coverage up to 12-months, in case of long-term Motor TP there is significant variations expected in case of claims settlement period, changes to underlying claims frequency and court award inflation. Further, given the high interest rate environment prevalent the changes to the interest rate structure can be quite volatile over the long duration of the contract leading to material differences in LRC between the two measurement models.
- Crop: Given multiple considerations within the Crop insurance scheme implemented by States i.e. 3-year tender terms, Surplus sharing model (80-110 / 60-130 etc.) etc. there could potentially be significant non-distinct investment component leading to material differences in LRC between the two measurement models. Further, there could be potential delays in receipt of premium receipts from State and Central governments leading to material differences in LRC.
- Home insurance (10year - 15 year): With regards to longer duration home insurance contract there is significant variations expected in case of claims incidence rates on account of catastrophic losses e.g. floods / earthquake leading to high claims volatility. Further, given the high interest rate environment prevalent the changes to the interest rate structure can be quite volatile over the long



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duration of the contract leading to material differences in LRC between the two measurement models.

- Extended warranty: With extended warranty products premium charged could be front loaded i.e. premium charged for (1+2) year coverage is at a discount to (1+1) year coverage i.e. have a significant financing component. Further, given the high interest rate environment prevalent the changes to the interest rate structure can be quite volatile over the long duration of the contract leading to material differences in LRC between the two measurement models.



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Q9. With regards to Motor TP cover, the long-term premium is at a discount as compared to sum of annual premium offered over the tenure.

Thus, does measurement of long-term Motor TP cover under PAA require an entity to adjust the carrying amount of the liability for remaining coverage to reflect the time value of money and the effect of financial risk using the discount rates at initial recognition?

Response

Background:

Motor TP premiums are tariffed in the Indian market and set by Authorities. The rating structure for Motor Third Party insurance cover is largely simplistic - flat premiums aligned with customer expectation given that insurance is mandatory in nature. With regards to new vehicles, the Motor TP cover currently are mandatorily 3-years in respect of Private Car and 5-years in respect of Two-Wheelers and the entire tenure premium is received by the insurance company upfront. Prior to introduction of long-term contracts for new private car or two wheelers, the annual premium was the same irrespective of new or old vehicles.

However, when the pricing was introduced for long-term covers for new private car and two wheelers, discount was proposed to provide benefit to the customer given that all premiums were paid upfront and it was mandatory in nature. Thus, the annualised premium for long-terms new vehicles is at a discount to the annual premium charged for non-new vehicles allowing for the investment income the insurance company is expected make on the advance receipt of premiums. This is in contrast with the long-term cover issued to old Two-wheelers wherein no discount in premiums is offered given the voluntary nature of cover. Thus, the presence of discount reflects compensation for the time value of money.

As per Ind AS 117 Para 56, LRC under PAA needs to be adjusted for the effect of time value of money and financial risk unless entity expects, at initial recognition, that the time between providing each part of the coverage and the related premium due date is no more than one year. For long-term Motor TP, the time between premium receipt and claims paid on an average is more than 1 year, and thus measurement of long-term Motor TP cover under PAA require an entity to adjust the carrying amount of the liability for remaining coverage to reflect the time value of money and the effect of financial risk using the discount rates at initial recognition.



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Q10. With regards to Health insurance cover, an insurer offers tenure-based discount when policies are issued for longer duration - both retail health and credit-linked health covers.

Thus, does measurement of such contracts under PAA require an entity to adjust the carrying amount of the liability for remaining coverage to reflect the time value of money and the effect of financial risk using the discount rates at initial recognition?

Response

A significant financing component exists if most of the following are true:

- Large multi-year premium paid significantly in advance (e.g. 3–10 years)
- Discount size closely aligns with market interest rates
- Discount explicitly compensates for early payment
- Insurer economically benefits from holding funds long before coverage
- Discount substantially disappears if premiums are paid annually

With respect to longer duration retail health and credit-linked health covers, given the current prevalent interest environment the discount explicitly compensates for early payment, and insurer is economically expected to benefit from holding funds long before coverage. Further, there are no corresponding discounts if premiums are paid annually.

As per Ind AS 117 Para 56, LRC under PAA needs to be adjusted for the effect of time value of money and financial risk unless entity expects, at initial recognition, that the time between providing each part of the coverage and the related premium due date is no more than one year. For long-term retail health and credit-linked health covers, the time between premium receipt and claims paid on an average is more than 1 year, and thus measurement of such long term contracts under PAA require an entity to adjust the carrying amount of the liability for remaining coverage to reflect the time value of money and the effect of financial risk using the discount rates at initial recognition.

Alternatively, in case of health insurance often discount could be extended for multi-year policies to reflect positive risk selection (or absence of selective lapsing). If the quantum of discount offered for multi-year reflects commensurate such benefit to the policyholder as detailed out in the pricing assumption of the products, then one can conclude that no significant financing component exists.



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Q11. With regards to Health insurance cover, an insurer offers EMI instalments without any cost to customers.

Given that the time between providing each part of the coverage and the related premium due date is no more than a year - there is no requirement to adjust the carrying amount of the liability for remaining coverage to reflect the time value of money and the effect of financial risk when contracts are measured under PAA.

Response

The EMI may reflect Time Value of Money or charge for administration or higher probability of policy lapse. The decision whether to adjust the carrying amount of the liability for remaining coverage or not largely depends on the motivation of the additional premium collected in case of instalments and the mechanism for offering such EMI facility.

When the instalments are offered for annual products, the time between providing each part of the coverage and the related premium due date is no more than one year. Thus, one can conclude that significant financing component is not applicable.

With regards to EMI instalments for long term products where premium is received in advance, it is important to consider whether an insurer is carrying the financial risk and this varies basis the below scenarios:

- **EMI as a facility:** When the EMI facility is provided by a third-party financier or service provider in respect of longer duration retail health or credit-linked health covers - insurer receives consideration upfront or shortly after inception. Typically, in such an arrangement the premium charged reflects upfront discount given that premium is received up-front then is at a discount, then insurer is economically expected to benefit from holding funds long before coverage. Accordingly, measurement of such contracts under PAA does requires an entity to adjust the carrying amount of the liability for remaining coverage to reflect the time value of money and the effect of financial risk using the discount rates at initial recognition.
- **EMI cost borne by the insurer:** Under this scenario, an Insurer itself allows deferred premium payment with no interest being charged to the customer. Aligned with Para 56 of the standards, the entity is not required to adjust the carrying amount of the liability for remaining coverage to reflect the time value of money and the effect of financial risk if, at initial recognition, the entity expects that the time between providing each part of the services and the related premium due date is no more than a year.
- **Additional EMI cost charged by the insurer:** Under this scenario, an insurer charges an additional cost (EMI charge / convenience fee) for an EMI facility and the charges could economically represents compensation for the time value of money. Aligned with Para 56 of the standards, the



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entity is not required to adjust the carrying amount of the liability for remaining coverage to reflect the time value of money and the effect of financial risk if, at initial recognition, the entity expects that the time between providing each part of the services and the related premium due date is no more than a year.



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Q12. Within non-life insurance, long-term policy GWP is account on $1/n$ basis under IGAAP. Will the same continue under Ind AS as the applicable circular hasn't been withdrawn by the Authority.

Response

Background:

As per the extant regulations, IRDAI (Actuarial, Finance and Investment Functions of Insurers), (Amendment) Regulations, 2026 and applicable Master circular, premium for a Long-Term policy if collected at the time of sale of the policy, for the entire Policy Duration or for any duration exceeding 12 months, shall be recognized on a yearly basis. In other words, the Gross Written Premium reported for any Financial Year shall be the total Gross Written Premium due for the Long-Term Policy multiplied by ' $1/n$ ', where ' n ' is the Policy Duration. The Authority had Corporate risk renewals within the Indian market, typically underwritten on an annual basis and is aligned with the Indian financial year i.e. 1 April to 31 March.

As per Para 32 and Para 33 of the Ind AS 117 standards, an entity shall include in the measurement of a group of insurance contracts all the future cash flows within the boundary of each contract in the group. In case of long term policy, the contract boundary will be at least the policy tenure of the contract issued and thus premium for the entire durations needs to be accounted for including estimate of future premium receivable under the contract allowing for an adjustment to reflect the time value of money and the financial risks related to the future cash flows, to the extent that the financial risks are not included in the estimates of the future cash flows