Claims Guideline

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CLAIMS GUIDELINE

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INTRODUCTION

1.1 The insurance sector plays an important role in indemnifying commercial entities and households against losses incurred on specified perils. Commercial and individual policyholders enter into contracts with insurers to mitigate and/or transfer risks. By these means, the policyholders protect the value of their income and assets. Insurers accept these risks in consideration for receiving a premium and, in turn, promise that a valid claim will be paid. Claims management is the process by which insurers fulfill their contractual obligations to policyholders.

1.2 The Insurance Act Chapter 84:01[1] and the Motor Vehicle (Third Party Risks) Act Chapter 48:51 set out the legal requirements for insurance companies with respect to the settlement of claims.

1.3 The purpose of this Guideline is to provide the Board of Directors and management of insurers, brokers or agents with a framework for the establishment of policies and procedures for effective claims management.

1.4 The Central Bank considers that the internal policies and procedures of insurers, brokers or agents should facilitate prompt and fair settlement of claims to policyholders. These policies and procedures should address the interaction between insurer and policyholder or claimant, as well as the insurer's ability to pay claims.

2 PURPOSE OF GUIDELINE

2.1 This Guideline seeks to promote greater fairness and transparency between policyholders and insurers. Strong market conduct ethics serve to reduce mistrust that may exist between clients and insurers, and enhanced mutual confidence improves market efficiency. Conversely, weak market conduct ethics are usually the major reason for the poor development of an insurance market.

2.2 In Trinidad and Tobago, although the majority of consumer complaints relate to motor vehicle claims, the concerns raised by consumers are not confined to this class of business. Consequently, this Guideline requires each insurer to develop, document and implement claims management policies and procedures for all of its lines of business.

[1] Section 17(1) (g) of the Insurance Act Chapter 84:01 requires that a company shall not be registered in respect of any class of insurance business unless the Central Bank is satisfied that the policy and practice of the company in dealing with claims are conducive to the efficient and speedy settlement thereof.
Section 25(5)(b) requires that the Board (of the Central Bank) may cancel the registration of a company where the Bank is satisfied that there is unreasonable delay in the settlement of claims payable under policies issued by it;
Section 25(5)(f) requires that the Board of the Central Bank may cancel the registration of a company where a final judgement obtained against the company in any court and from which no appeal is pending remains unsatisfied for at least two months.
Section 65(2) (h) requires that the powers of intervention conferred by subsection 65(1) shall be exercisable where the Governor is satisfied that there has been unreasonable delay in the settlement of claims under policies issued by the company.

2.3 This Guideline takes into consideration international standards and best practice[2] and addresses three inter-related aspects of the claims management function:

- Market conduct: the ways in which the insurer communicates and interacts with the consumer;
- Claims reserving: the primary means of ensuring that there are sufficient funds to meet claims obligations; and
- Internal controls: the means to ensure that the preceding functions work effectively.

2.4 This Guideline and the documented claims policies and procedures of an insurer will be taken into account in assessing unreasonable delay in the settlement of claims by such insurer for purposes of the Insurance Act[3]. The timelines given in this Guideline are intended for motor claims settlement. However, each insurer should include as part of its policies and procedures, settlement timelines for claims for all types of business and should ensure that these timelines reflect the principles of good market conduct.

3 DEFINITIONS

3.1 An "adjuster" means any person who receives compensation for investigating or negotiating settlement of claims arising under insurance contracts, solely on behalf of either the insurer or the policyholder but does not include:

(a) A salaried employee of an insurer while acting on behalf of such insurer in the adjustment of losses; or

(b) An agent of an insurer[4].

3.2 An "agent" means any individual, firm or company appointed by an insurer to solicit applications for insurance or negotiate insurance business on its behalf and, where authorized to do so by the insurer, to effect and countersign insurance contracts, but does not include an individual who is an employee of the insurer.

3.3 A "broker" means any individual firm, or company that receives compensation as an independent contractor in any manner for soliciting, negotiating or procuring insurance or the renewal or continuance thereof on behalf of existing or prospective policyholders.[5]

3.4 A "claimant" means one who makes a claim for an incurred loss.

3.5 An "insurer" means a company registered to carry on insurance business in Trinidad and Tobago and includes an underwriter and an association of underwriters but does

[2] See Guidance papers published by the Australian Prudential Regulation Authority (APRA), Financial Services Authority (FSA) UK, International Association of Insurance Supervisors (IAIS), Organization for Economic Cooperation and Development (OECD)

[3] Section 65(2) of the Insurance Act, chapter 84:01

[4] Definition as contained in the interpretation section of the Insurance Act Chapter 84:01.

[5] Definition as contained in the interpretation section of the Insurance Act Chapter 84:01

not include an insurance agent as such nor, where an insurance agent is also an insurer, it does not refer to that part of his business done as an insurance agent.[6]

3.6 A "policyholder" means the person who has the legal title to a policy and includes any person to whom a policy is assigned[7].

3.7 "Subrogation" means the right of an insurer, following payment of a claim, to be put in the place of the policyholder so that it can recover payment from the third party responsible for the loss. Subrogation has three elements (1) the right to proceeds of recovery; (2) the right to commence litigation; (3) the right to control the conduct of litigation.

MARKET CONDUCT

4 GENERAL REQUIREMENTS

4.1 Insurance policies, product literature, policy summary or marketing material should be clearly worded in easily understandable language and should define any words likely to be unfamiliar to the policyholder or claimant or capable of misinterpretation.

4.2 A document containing the terms and conditions of the policy should be prepared by the insurer and should be used as a basis of discussion with the prospective policyholder. A copy of the policy summary document should be given to the policyholder. As a minimum such document should also contain all exclusions or exceptions and implied conditions[8]. All the features of a product must be clearly and fairly reflected in any policy summary and marketing material in language which should be easily understandable by the policyholder or claimant.

4.3 The insurer should ensure that the claims settlement process is handled fairly, promptly and efficiently and in accordance with the terms of the insurance contract and company policy. The insurer, broker or agent should have documented internal policies and procedures for the fair, prompt and efficient handling of claims in accordance with the terms of the insurance contract and company policy. Such policies and procedures should be approved by the Board of Directors and reviewed and updated periodically. The insurer, broker or agent should ensure that staff are aware of and adhere to these procedures.

4.4 Timely and accurate information should be provided to the policyholder or claimant at all times.

[6] Definition as contained in the interpretation section of the Insurance Act Chapter 84:01
[7] Definition as contained in the interpretation section of the Insurance Act Chapter 84:01.
[8] Implied conditions are those implied by common law or implied based on an interpretation of the wording of the policy.

5 CLAIMS NOTIFICATION

5.1 The notification of a claim should be effected through a written document, the telephone, email or face to face contact and subsequently a claim form should be completed in keeping with the policy conditions.

5.2 When a policyholder or claimant reports a loss, the insurer, broker or agent should make available an appropriate claim form for the class of business, with clear instructions as to how the form should be completed. This should be done within two business days of receiving notification of a claim.

5.3 When a loss is reported, the insurer, broker or agent should inform the policyholder or claimant to co-operate in the investigation by providing the insurer with all relevant information to ensure timely processing of the transaction.

5.4 If the insurer requires specific documents from policyholders or claimants when a claim is filed, such as copies of official documents regarding the loss or any other relevant form of evidence, the insurer, broker or agent should provide a listing of these requirements with the claim form.

5.5 If a broker or agent is the initial contact for the policyholder, the broker or agent should forward the completed claim form to the insurer's claim department within three business days from the date of receipt of the completed claim form.

5.6 An insurer should respond promptly to notification of a claim. The insurance company must acknowledge receipt of the claim form within four business days.

5.7 The insurer must indicate to the policyholder or claimant the relevant department or contact person to whom all information or enquiries must be channeled. The insurer's claim department, the broker or agent should be easily accessible.

5.8 The insurer should maintain a checklist for all relevant documents needed. This should be completed and dated for all legitimate claims.

5.9 The insurer should advise the policyholder of the consequences of submitting a false or incomplete statement (which could include criminal prosecution).

5.10 If a claim involves more than one insurer on the risk, the lead insurer or broker, where applicable, should contact the other insurer(s) within two business days of the initial notification.

5.11 The insurer should inform the policyholder or claimant if an independent adjuster will be engaged to conduct a survey and/or an assessment. Where the insurer uses claims adjusters or other intermediaries, the insurer must be satisfied as to their competence and qualifications and should use only persons who are registered[9] for these purposes. The insurer should hire the adjuster within two business days from the date of receipt of the completed claim form accompanied by all relevant documentation. The adjuster should submit the assessment of damage report within five business days after receiving the instructions from the insurer.

[9] Refer to Sections 88, 90 and 91 of the Insurance Act Chap 84:01.

5.12 Within two business days of receipt of the assessment report, the insurer should notify the claimant as to when the claim will be paid.

5.13 In instances where the insurer does not engage the services of an adjuster, the insurer should conduct the investigation into the reported loss within ten business days of receipt of a claim form accompanied by all relevant documentation**.**

6 CLAIMS PROCESSING

6.1 On receipt of a claim, the insurer should establish a claim file which at a minimum should contain the following information:

- Policy number;
- Name of policyholder or claimant;
- Information on claimants;
- Description of the loss;
- Claim file number;
- Claim form;
- Checklist of all relevant documents;
- Progress report schedule;
- Opening date of the file;
- Initial value of the claim reserve and any subsequent changes;
- Reporting date;
- Request for an adjuster or investigator;
- Date on which the adjuster's report is received;
- Electronic and/or paper copy of the adjustors' and investigators' reports where applicable;
- Dates and amounts of payments;
- Date of denial, if applicable;
- Reasons for denial or reduced settlement;
- Name of broker or agent, if applicable;
- Documents recording contacts with the policyholder;
- Documented evidence of agreements or settlements;
- Claims discharge form and/or acceptance form;
- Date of file closure;
- A record of all communications whether formal or informal; and
- Any other information pertinent to the claim.

6.2 The insurer should update the claim file as necessary, and document all actions taken as part of the claims management process in order to be able to address questions that may arise concerning the handling and settlement of the claim.

6.3 If it is determined that the claim is not covered by the insurance policy or denied, the insurer should notify the policyholder or claimant in writing stating the policy provisions, conditions or exclusions on which the claim is being denied. This should be done within two business days of the date of receipt of the claim.

6.4 The insurer should not dissuade policyholders or claimants from obtaining the services of an attorney or adjuster.

6.5 The insurer should not deny a claim without reasonable and comprehensive investigation.

6.6 The insurer should keep the policyholder or claimant informed of the status of the claim and provide explanations for any delays.

6.7 The insurer should inform the policyholder or claimant when it decides to appoint an independent expert (for example, loss adjusters, solicitors, surveyors) and explain the reasons and role of these persons in the settlement of the claim.

6.8 The insurer should implement a management reporting system to track the timeliness of claims settlement and other pertinent information. Management should receive and review periodic reports which at a minimum should include:

- The aging of outstanding claims;
- Claims reported but not yet admitted;
- Claims reported but not yet paid; and
- Adequacy of claims reserving.

7 CLAIMS SETTLEMENT

7.1 When an insurer makes an offer of settlement, the insurer should disclose to the policyholder or claimant the basis used for the offer of settlement.

7.2 The insurer should not settle a claim for less than the amount to which the policyholder or claimant would be entitled to receive under the terms of the insurance contract.

7.3 After an agreement has been reached between the insurer and the policyholder or claimant on the amount of the claim, the insurer should effect the payment within three business days.

7.4 In instances where the insurer cannot settle the claim within three business days of the date of the agreement, the insurer should notify the policyholder or claimant in writing, the reasons for delay and also the earliest timeframe in which the claim will be paid.

7.5 In the case of claims settlement procedures involving other insurers, the claim should be settled with the policyholder or claimant in an appropriate time period while potential disputes with respect to subrogation between insurers are resolved.

7.6 The insurer should ensure that once an agreement has been reached and payment effected, a copy of the release signed by the policyholder or claimant should be retained on the policyholder's or claimant's file.

8 COMPLAINTS AND DISPUTE RESOLUTION

8.1 Each insurer should establish well-documented procedures for complaint and dispute management to ensure, as far as possible, that such situations are resolved promptly and fairly. As a minimum, the procedures should include:

- Acknowledgement of receipt of the complaint within an established period of time;
- Details of how the complainants will be kept informed of the status of their complaint;
- Information to complainants on how and when to access the services of the Financial Services Ombudsman as an alternative dispute resolution mechanism; and
- Establishment of the time period for sending a final response in writing to the complainant.

CLAIMS RESERVING

9 RESERVING METHODS AND DOCUMENTATION

9.1 Insurers should have appropriate claims reserving policies and procedures approved by its Board of Directors. As a minimum such policies should include the following:

- The date on which the reserve should be initiated;
- The process to be followed to adjust the initial reserve amount;
- The measurement method to be used (case estimates and or any triangulation estimate); and
- Authorization limits to adjust reserves.

9.2 The insurer should have documented methods for quantifying claim reserves[10]. The reserve should be:

- Established upon the notification of a claim;
- Updated when additional information is received to ensure that it reflects the anticipated extent of the liability; and
- Reviewed on an on-going basis.

The insurer should therefore develop a proper procedure for the coding and statistical processing of losses. This would involve the use of claims reserving methods such as case estimates and/or triangulation estimates per class of business.

[10] Section 168 of the Insurance Act Chapter 84:01 requires that with respect to a general insurance company – each company shall in respect of its outstanding unexpired policies, include in its liabilities in its annual statement deposited with the Central Bank reserves computed on such basis as the Minister on the recommendation of the Central Bank may prescribe. This basis has never been prescribed, but the methods used are subject to supervision by the Central Bank which will involve the assessment of reasonability.
Further, section 172 states (1) every company shall in addition to the reserves required to be included pursuant to section 168, provide reserves for meeting outstanding claims.(2) every company shall furnish to the Central Bank such details of the methods used in calculating the reserves to be provided under subsection (1). (3) the Central Bank may disallow any method used in calculating the reserves referred to in subsection (2) where it is satisfied that the method does not result in the provision of adequate reserves.

INTERNAL CONTROLS

10 INTERNAL CONTROLS

10.1 There should be a complete record of each claims transaction which evidences adherence to this Guideline.

10.2 The insurer should have documented internal policies and procedures for the fair, prompt and efficient handling of claims. Such policies should be approved by the Board of Directors and reviewed at periodic intervals. The insurer should ensure that staff are aware of and adhere to these procedures. An officer of the insurer should be responsible for the maintenance of the manual of policies and procedures and should ensure that additions or amendments are made when necessary.

10.3 Information to be detailed in the manual of policies and procedures should at a minimum include:

- Clearly defined levels of authority;
- Claims settlement procedures, including loss estimation and investigation procedures;
- Procedure for rejecting claims;
- Dispute resolution procedures;
- Method for monitoring compliance with claims management processes and procedures; and
- Segregation of duties in the claims department.

10.4 All staff involved in the claims handling process should possess suitable qualifications and/or experience. The insurer, broker or agent should provide training on an ongoing basis for its claims staff.

10.5 The insurer should ensure that the work programme of the internal auditor includes a review of the claims settlement process and reserving for claims.

10.6 The insurer should establish, implement and update a statistical database to track how long they take to settle claims as well as the trends in settlements and expenses. Senior management should receive periodic reports on the time taken to process claims and appropriate action taken where necessary. The Board of Directors should also receive reports on a periodic basis on claims management.

10.7 The insurer should have written internal policies and procedures for combating fraud associated with claims as considered appropriate for its level of exposure and vulnerabilities. These procedures will serve to minimize the incidence of fraudulent claims and the resulting rise in premiums.

10.8 The insurer should ensure that members of staff in their claims department are aware of and follow the company's internal policies and procedures on fraud and are adequately trained to recognize the early warning indicators.

10.9 The insurer should ensure that periodic reviews are done on the claims assessment process. This should include revisiting the valuation and assessment basis for certain types of claims on an ongoing basis and having the internal audit department conduct examinations on the process.