SYLLABUS


Claim Management – Concept & Classification of Claim, Essential elements of Claim, Claim procedure, Role of insured & insurer in claim management, Claim settlement & its significance, Nature of claim for various classes of insurance, Dispute, Litigation & Arbitration.

Trends in claim, Role of IT in claim settlement, Customer service, Quality aspect, Insurance business & claim management in other countries.

Suggested Reading:

2. Risk Management & Insurance- Scott Harington.
3. Risk Management & Insurance- C. Arthur Willams
UNDERWRITING MANAGEMENT- MEANING AND FUNDAMENTAL OF UNDERWRITING

Insurance company assumes billions of dollars in financial risk annually, risk that is transferred to them from individuals or businesses via insurance transaction. For an insurance company the overall profitability depends significantly upon the quality of underwriting. Insurance underwriter using various underwriting tools and process are employed by insurers to asses both their new and existing business.

Insurance underwriting is defined as the process of choosing who and what the insurance company decides to insure. This is based on a risk assessment. It is pretty much the "behind the scenes" work in an insurance company where they determine who is insured and how much in insurance premiums they will charge the insured person. Insurance underwriting also involves choosing who the insurance company will not insure.

Underwriting can also be defined as A financial professional that evaluates the risks of insuring a particular person or asset and uses that information to set premium pricing for insurance policies. Insurance underwriters are employed by insurance companies to help price life insurance, health insurance, property/casualty insurance and homeowners insurance, among others. Underwriters use computer programs and actuarial data to determine the likelihood and magnitude of a payout over the life of the policy. Higher-risk individuals and assets will have to pay more in premiums to receive the same level of protection as a (perceived) lower-risk person or asset.

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and assets will have to pay more in premiums to receive the same level of protection as a (perceived) lower-risk person or asset.

There are multiple purposes of underwriting. The main predominant purpose is to develop and maintain profitable book of businesses for the insurer. Underwriting is crucial for insurer’s success. Underwriting goal follow directly from insurer’s corporate strategies and objectives. Underwriting is common in all forms of insurance, not just health insurance. For example, an automobile insurer will charge higher rates to young, unmarried males, or it may refuse coverage to drivers with a history of accidents. Fire insurers may inspect properties, offer reduced premiums for safety features such as sprinkler systems, and so on.

Two key considerations govern an insurer’s behavior:

- People are more likely to buy insurance if they have reason to believe they will incur high costs in the near future. This phenomenon is known as “adverse selection.” Non group health insurers must be aware that people may wait until they are sick before they start shopping for coverage.
- A small proportion of the insured population accounts for a very large share of total claims costs.

Basically, underwriting consists of two components; risk assessment and pricing. Successful underwriting requires a system of risk selection to obtain a group in which loss results will be reasonably predictable by means of the law of averages. To accomplish this goal there must be a balance between obtaining volume and obtaining homogeneous risks. If an insurance company issuing individual life policies, for instance, adopted such strict standards that it would only accept individuals who were practically perfect physically, ideal from a moral standpoint, and in risk-free occupations, there would be only a very small group from which to choose. Such a group would be very homogeneous, with all the risk units--in this case the individual lives--subject to about the same chance of loss. But the mass or volume of risk units would be very small, and thus the predictability of loss might be adversely affected. Another element entering in to make selection of such a group impractical would be that selection procedures necessary to obtain this near-perfect set of individuals. The expense involved would more than offset the savings from the mortality rate of the group. In
underwriting, selection expense is a factor to be considered. There has to be a balance between the strictness of selection standards and the necessity of having a large volume of risk units to be insured.

To achieve profitability, the underwriting function serves additional purposes:

- Guarding against adverse selection
- Ensuring adequate policy holder
- Enforcing underwriting guidelines.

The objective of underwriting is to produce a pool of insured’s, by categories, whose actual loss experience will closely approximate the expected loss experience of a given hypothetical pool of insured’s. That is, if an underwriter is told that a pool of exposures with specified characteristics (e.g., a pool of brick buildings located no more than 5 miles from a fire station) will produce a specified loss rate of, say, 1% of the value of the insured property, then the underwriter should try to place in this pool all the exposures whose characteristics match the specifications.

**Underwriting Policy**

When evaluating applicants, underwriters determine whether insurance on the applicant will be:

- rejected;
- issued on a substandard basis;
- issued on a standard basis; or
- issued on a preferred basis.

**Rejecting Applicants**

Insurers reject applications for insurance when they find that the applicant represents a risk that falls outside of the underwriting standards established by the insurance company. These underwriting standards take into consideration many items, such as regulations that require the insurer to establish adequate rates, laws that mandate that certain factors cannot be used to reject an application, insurance principles such as insurability and indemnity, the marketplace in which the insurer sells its products and the profit the insurer hopes to make on its business.
**Issuing Policies on a Substandard Basis**

The decision to issue a policy on a substandard basis occurs when a risk is not deemed to be Outside underwriting standards, but is considered to be of high risk within those standards. The insurer generally has three basic options when it offers a substandard policy issue to an Applicant. It may:

- a. issue the policy with a higher premium than would be required for a standard policy
- b. issue the policy with limited benefits
- c. issue the policy with certain exclusions

**Higher Premium**

The insurer may charge a higher premium to applicants deemed to be of higher risk than those who would be considered a standard risk as long as those higher rates fall within certain Parameters. First, if the insurance policy is one that requires that rates be filed with the state in which the policy is issued, the rate must be approved by the state. Secondly, the rate may not be discriminatory. The insurer must charge every insured with the same characteristics the same rate. Thirdly, in some states higher premium may not be charged based on certain items as defined in state statutes. The insurer must of course comply with such statutes in determining whether to charge higher premium rates.

**Limit Policy Benefits**

Insurers may also respond to substandard applicants by offering a policy with limited policy benefits. Again, whether the insurer may limit benefits is regulated by state law. For example, under long-term care policies, some states require that policies offer a minimum home health care benefit limit as a certain ratio of the nursing home benefit limit. Therefore, a long-term care insurer could not limit the home health benefit on a policy in a manner that would not comply with such a law. Assuming state regulations are followed, an insurer could offer lower policy limits on certain coverage to a substandard applicant, or could offer lower policy limits for all coverage to such an
applicant. Dealing with substandard applicants by limiting policy benefits is most common in commercial coverage’s.

**Excluding Certain Provisions from Coverage**

Another option an insurer may have is to offer an substandard applicant a policy that excludes coverage for certain property, insured’s or operations that are deemed too high a risk for the insurer to cover. As with the other options discussed, such exclusions must be allowable under state regulations. This type of exclusion is most common in commercial property and liability coverage’s. For example, an insurer may cover all the property owned by a business, except that within a building whose operations have been discontinued. Or, an insurer may offer to provide liability coverage for all business operations except for that portion that has potential pollution liability that is too high for the insurer to cover.

**Issuing Policies on a Standard Basis**

Underwriters base their determination that a policy should be issued on a standard basis on an analysis of the characteristics of the risk represented by the applicant. Applicants who are issued policies with standard rates fall within the normal boundaries of underwriting standards for that type of policy.

**Issuing Policies on a Preferred Basis**

If an application falls within the lowest risk boundaries of the underwriting standards, the policy is issued on a preferred basis. Preferred rates represent the lowest rates offered by an insurer for its coverage. Rates offered on a preferred basis must adhere to the insurance regulations applicable to them, just as rates offered on a substandard and standard basis must. Insurance regulators do not want insurers to offer rates that are so low that the insurer cannot meet its contractual obligations to pay covered claims.

**Formulating Underwriting Policy**

Staff underwriters try to formulate an underwriting policy that effectively translates the goals of an insurer's owners and management into rules and procedures that guide individual and aggregate underwriting decisions. Underwriting policy determines the
composition of the insurer's book of business. Goals for an insurer's book of business might be established by types of insurance and classes of business to be written; territories to be developed; or forms, insurance rates, and rating plans to be used.

An insurer's underwriting policy is influenced by management's desired position in the insurance marketplace. Most insurers see their role as standard insurers—that is, they seek better-than-average accounts. Some insurers, however, see an opportunity to offer coverage in areas that are underserved by the standard market. These nonstandard or specialty insurers might use loss control, more restrictive coverage forms, or higher prices to make a profit insuring accounts considered marginal or unacceptable in the standard market. Underwriting policy is always being reviewed and it is subject to these limitations:

1. Financial capacity
2. Regulation
3. Personnel and physical resources
4. Reinsurance

**Terms at Policy Issue**

Besides setting specified rates, the applicant may be required to meet underwriting requirements in order for insurance to be issued or remain in force. For example, a business may be required to install a sprinkler system, a homeowner may be required to add railing to a deck, and an individual with a valuable coin collection may be required to place it in a safety deposit box in order for the insurance to apply.

**SOURCES OF UNDERWRITING INFORMATION**

Many resources are used during the underwriting process. The most important of these resources is the application. In this section, we will review the basic components of applications for various lines of insurance, along with the other resources used in underwriting, including reports, site inspections, insurance maps, insurance company files and industry statistical reports and data.
Insurance Applications

The insurance application is a critical underwriting resource. From it, the underwriter finds most of the basic information needed to determine whether to issue a policy, and if so, at what premium and terms.

Life Insurance Applications

Each life application generally requires the following type of information:

- Applicant and insured name, address and other general information
- Medical information
- Agent’s statement
- Selection of riders or optional features
- Signatures

General Information

The general information section of life insurance applications generally asks for the name, address, birth date, social security number and gender of the insured and owner. The relationship of the owner to the insured is also needed. The name or names of beneficiaries is also requested, along with the percentage for each beneficiary or other beneficiary designation, and the relationship of each beneficiary to the owner. Some applications also require the beneficiary’s social security number. This is to aid the insurer in identifying the proper beneficiary, if necessary.

Medical Information

Medical questions include asking whether tobacco or nicotine products have been used, and if the insured had been diagnosed, treated or hospitalized for:

- Cancer;
- Heart attack;
- Stroke;
- Diabetes;
- Kidney disorders;
· Alzheimer’s disease;
· Liver disorder;
· Organ transplant;
· Alcohol or drug use treatments;
· AIDS or HIV;
· Irregular heart beat;
· High blood pressure;
· Fainting spells;
· Emphysema or other chronic lung or respiratory disorder;
· Inability to work for more than a week in the past six months or year; and
· Other similar questions.

If there is a “yes” response to the medical questions asked, the application will generally ask for more details. Once the application reaches the home office, medical reports or an attending physician statement may also be requested. Or, the insurer may have issued underwriting guidelines to the agent, who requests such reports through his or her agency office. These reports will be discussed later in this chapter.

Replacement

Each application also asks whether this proposed insurance will replace or change any existing or pending insurance. If the applicant answers “yes” to this question, the agent may be required by state regulations to complete state replacement forms with the applicant. State replacement forms generally include comparative information for the applicant to read regarding the proposed insurance and the policy to be replaced. They may also include disclosure statements for the applicant to sign indicating that the applicant understands that there may be surrender charges involved in canceling the existing policy, that the new policy generally includes commission loads and that a new surrender charge period may apply to the new policy. An insurance company required “1035 Exchange” or “Absolute Assignment” form must also be completed in a replacement situation.
CLASSES OF BUSINESS

Refers to an industry classification according to the perils insured and the exposure the purpose is to group homogeneous risk for the purposes of rate development Insurance coverage is available for every conceivable risk your business might face. Cost and amount of coverage of policies vary among insurers. You should discuss your specific business risks and the types of insurance available with your insurance agent or broker. Your agency can advise you on the exact types of insurance you should consider purchasing.

General Liability Insurance

A standard insurance policy issued to business organizations to protect them against liability claims for bodily injury (BI) and property damage (PD) arising out of premises, operations, products, and completed operations; and advertising and personal injury (PI) liability. The CGL policy was introduced in 1986 and replaced the "comprehensive" general liability policy.

General liability insurance (GL) is coverage that can protect you from a variety of claims including bodily injury, property damage, personal injury and others that can arise from your business operations. General liability insurance is often combined with property insurance in a Business Owners Policy (BOP), but general liability insurance also is available to many contractors as standalone coverage through the Progressive Commercial Advantage SM program.

Business owners purchase general liability insurance to cover legal hassles due to accident, injuries and claims of negligence. These policies protect against payments as the result of bodily injury, property damage, medical expenses, libel, slander, the cost of defending lawsuits, and settlement bonds or judgments required during an appeal procedure.

As a contractor or small business owner, one need some form of general liability insurance to safeguard your livelihood.
A single accident could result in a lawsuit that you might not be able to handle. A great way to protect against this type of situation is to make sure you carry enough general liability insurance. Some employers might also require you to carry a certain amount of general liability insurance before you can work for them.

Commercial General Liability Insurance protects small-business owners from claims of injury, property damage, and negligence related to their business activities. The indemnity provided by a liability insurance policy helps your business owner cover the costs associated with mounting a legal defense.

In addition, many small-business owners find that their clients require them to have General Liability Insurance (sometimes referred to Commercial General Liability, or CGL, insurance) before they’ll sign a contract. This means that having the right coverage in place can make a significant difference in a business owner’s ability to land clients and bring in revenue.

In simple terms, a Commercial General Liability Insurance policy protects your business by providing the financial resources necessary to keep it operational when unexpected events (such as a client injury that leads to a lawsuit) throw a wrench in your plans. Read on for the specific costs your CGL policy covers.

A general liability insurance policy provides financial protection from the risks that any business owner, no matter how careful, might incur. A typical policy covers the following expenses:

- The costs of defending or investigating a suit or claim against you, including court costs, witness fees, attorney's fees, and police report costs
- Reasonable expenses incurred when the insurance company asks you to assist in your defense (e.g., income lost while spending a day in court)
- Judgments or settlements resulting from covered suits, including interest required on the judgment and the injured party’s medical expenses, if your defense is unsuccessful
- The premium on a court-mandated bond connected with a liability suit

A general liability policy insurance policy covers you, of course, but it also covers many of the other people involved in your business:
• If you have a joint venture or partnership, all of your partners, members, and their spouses are protected if they are sued for something they do in an official capacity related to your business.

• If your business is a corporation, your policy covers all of your business’s executive officers, stockholders and directors while they are acting in their official capacities.

• If you have subsidiaries, your policy’s liability coverage extends to any subsidiary where you own at least 50 percent of the stock.

• Your policy protects your employees from claims that result from actions they take in their capacity as employees.

• If you have a written agreement to indemnify a person or organization, such as a vendor, that person or organization would be protected against liability claims for property damage or bodily injury as a result of selling or distributing your products.

• During the first 90 days after you acquire a new business, it is automatically covered by this policy. After that time frame, you would need to update your policy to continue this protection for the new part of your business.

• People legally associated with your business, including volunteers working under your direction, are covered for liabilities that result from the work they do for you, and for the use or maintenance of your property that is in their care.

• If you’ve read this far, you deserve a pat on the back, or in this case, a free t-shirt. Click here and we’ll send you one.

**Specific Coverage Offered by General Liability Insurance**

**Bodily Injury**

It may be difficult to imagine how your business could cause another person serious harm or even death. But it’s good to know that if you are ever held responsible for someone else’s sickness, injury, or disease, your general liability insurance policy would pay for:

• Medical care costs
• Loss of services
• Court-awarded compensation for deaths that result from an injury

**Property Damage**

Even if you’re careful and take precautions, it’s still possible that something your business does – or something it doesn't do – could damage another person’s property. It’s also possible that your actions might prevent the property’s owner from being able to use it. In such cases, your business liability insurance coverage compensates for:

• Physical damage to the property, or
• Loss of use of the property

It is important to note that property damage liability coverage often does not cover damage caused to client property you are working on or have in your possession.

**Products-Completed Operations**

Commercial general liability insurance policies generally include liability protection for services or products completed by your company. So if something your company manufactures or a service your company provides causes an injury, your policy would pay for any resulting legal expenses, as well as damages up to your policy's limit.

**Contractual Liability**

Your commercial liability insurance coverage would cover liability you might take on when you enter into various contracts, such as:

• Easement-of-license agreements
• Building leases
• Elevator maintenance agreements
• Agreements to indemnify a municipality, if required by ordinance

**Liquor Liability**

If you do not manufacture, distribute, sell, serve, or furnish alcoholic beverages as a business, your general liability insurance policy will cover you if are held liable for a liquor-related accident. If you distribute alcoholic beverages occasionally, such as at a
company picnic or office holiday party, you’d also be covered - as long as you don't charge money for the alcohol.

**Employee Injuries**

It’s important to know that if an employee should sue you over an injury on the job, your commercial general liability insurance policy would not cover the damages. For this type of coverage, you need a workers' compensation policy.

**Fire, Explosion, or Lightning Damage**

The property insurance portion of your general liability insurance covers damage you may cause to other people’s property as a result of fire, lightning, or explosion, whether you own your business property or rent it. This coverage even applies to other areas in your building that may be damaged as a result of negligence on your part. Let’s say a fire in your office on the building’s second floor causes damage to another company’s offices below. Your liability policy will pay for the damage to the downstairs office space.

**Hired Auto and Non-owned Auto**

Most businesses add an option to their general liability policy called “hired auto and non-owned auto” insurance. If you don’t have any vehicles in your company’s name, this option meets the requirements of any contract that requires you to have commercial auto coverage.

This coverage also allows you to save money on at least part of the insurance that rental car companies recommend whenever you pick up their cars. When you rent the car in your company’s name, this insurance applies to the liability part of the rental car contract. You’ll still need to purchase damage insurance from the car rental agency if you want to be fully protected, however, as this option doesn’t cover physical damage to the rented vehicle.

Additionally, if you or an employee is driving a personally owned vehicle on company business, and you have an auto accident, non-owned auto coverage protects you should the company be sued. However, the policy will not cover a suit against you or your employee personally – that would be covered by a personal auto policy.
Legal Defense Expenses

Even if your company is not found liable for a claim, the process of mounting a defense is expensive without insurance. A business liability insurance policy will generally pay for:

- The cost to defend or investigate a suit or claim against you, including court costs, witness fees, attorney's fees, and police report costs
- If the insurance company asks you to assist in your defense against a claim, it will pay your reasonable expenses, such as the loss of your income for a day in court
- It will pay the judgments or settlements resulting from covered suits, including interest required on the judgment and the injured party’s medical expenses, if your defense is unsuccessful
- When a court requires you to post a bond to ensure you can pay a potential judgment in a liability suit, this insurance will pay the premium for the bond

Medical Payments

If a person should be injured, either directly by you or at your place of business, your commercial liability insurance coverage would pay for funeral and medical expenses incurred within a year of the accident. For example, if one of your clients slips and falls at your office and requires medical treatment, your policy would cover the cost of that treatment. Of course, policy limits apply.

Personal Injury

Personal injury is the part of the commercial general liability policy that protects you should someone claim that your business caused damage that isn’t physical. In the following examples, most liability policies would protect you against any lawsuits related to:

- Publishing, in writing or verbally, false information that libels or slanders an organization or person
- Publishing material that violates someone’s privacy rights
- Falsely detaining, arresting or imprisoning someone
- Maliciously prosecuting someone
- Evicting someone wrongfully

**Advertising Injury**

Should you ever be sued over something that happens while advertising your company's products or services, your business liability insurance protection will cover the claim. Advertising injuries can arise from:

- Publishing, verbally or in writing, false information that libels or slanders a person or organization
- Publishing material that violates an individual’s privacy rights
- Copying another company's style of doing business, or advertising concepts
- Infringing on another business’s title, copyright or slogan

**General Liability Insurance & the Business Owner’s Policy (BOP)**

For some business owners, general liability insurance can be simplified through an insurance package known as a business owner’s policy, or BOP. In order to qualify for a BOP, which offers the kinds of insurance business owners most commonly need in one pre-packaged policy, a business must meet certain criteria.

**Product Liability Insurance**

Companies that manufacture, wholesale, distribute, and retail a product may be liable for its safety. Product liability insurance protects against financial loss as a result of a defect product that causes injury or bodily harm. The amount of insurance you should purchase depends on the products you sell or manufacture. A clothing store would have far less risk than a small appliance store, for example.

Product liability insurance protects the business from claims related to the manufacture or sale of products, food, medicines or other goods to the public. It covers the manufacturer's or seller's liability for losses or injuries to a buyer, user or bystander caused by a defect or malfunction of the product, and, in some instances, a defective
design or a failure to warn. When it is part of a commercial general liability policy, the coverage is sometimes called products-completed operations insurance.

To understand the need for this coverage it is critical to understand the potential liability. There are generally three types of products "claims" a company may face:

- **Manufacturing or Production Flaws**- A claim that some part of the production process created an unreasonably unsafe defect in the resulting product. Recent claims against Chinese manufacturers regarding the presence of dangerous chemicals in their products are an example of this type of claim.

- **Design Defect**- A claim that the design of the product is inherently unsafe. The most memorable example is the series of Pinto car cases against Ford in the 1970's.

- **Defective Warnings or Instructions**- The claim that the product was not properly labeled or had insufficient warnings for the consumer to understand the risk. The McDonald's "coffee case" is an example.

The damages awarded in these claims include medical costs, compensatory damages, economic damages, and, in some instances, attorneys' fees, costs and punitive damages. Product liability claims can and do put businesses out of business - just ask any of the officers from any asbestos manufacturer.

All too often, resellers, gray market commercial sellers, and retailers fail to secure this coverage. The logic is that, since they did not "manufacture" anything, the coverage is not necessary. However, manufacturers are not the only ones subject to product liability exposure, retailers and wholesalers are often brought into a lawsuit for alleged negligence by the consumer. Most states follow the "stream of commerce" model of liability. This means that if your company participated in placing the product into the "stream of commerce," it can be held liable for damages to the end user.

If your company provides any products to the consuming public, then your company needs product liability or completed-operations coverage. In most cases, some form of
this coverage will be present in the standard commercial general liability or business owners' policy. You will need to confirm this with your insurance professional. You will want to have a clear understanding of what is covered (for example, some policies will cover economic damages, but not punitive or statutory damages).

Finally, the premiums on such policies are based upon the type of product, volume of sales, and the role of the insured in the process. Thus, underreporting the volume of sales may seem like a good way to lower premiums or the idea may be to insure only a part of the sales. Don't under report or try to insure less than the actual amount of sales. This is because there are usually substantial underinsurance penalties applied when the insured underinsures. On the other hand, you will want to make absolutely sure that your products are properly identified. For example, if you supply step stools, you do not want them categorized as ladders. Ladders will have a much higher premium because of the risk potential.

**Professional Liability Insurance**

Business owners providing services should consider having professional liability insurance (also known as **errors and omissions insurance**). This type of liability coverage protects your business against malpractice, errors, and negligence in provision of services to your customers. Depending on your profession, you may be required by your state government to carry such a policy. For example, physicians are required to purchase malpractice insurance as a condition of practicing in certain states.

Professional liability insurance protects your business assets from claims that may result from advice, expertise or professional services you provide. If your business engages in these activities, you could be at risk for being sued by a customer, client or other party who claims he or she lost money or was harmed in some way due to a negligent act, error or omission.

Professional liability insurance may take on different forms and names depending on the profession. For example, in reference to medical professions it is called **malpractice insurance**, while **errors and omissions (E&O) insurance** is used by consultants, brokers and lawyers.[1] Other professions that commonly purchase professional liability insurance include accounting and financial services, construction and maintenance (general contractors, plumbers, etc., many of
whom are also surety bonded), and transport. Some charities and other nonprofits/NGOs are also professional-liability insured.

Any individual in a profession that provides advice, expertise, recommendations or a professional service to customers, clients or another party would benefit from professional liability insurance. Professionals are expected to have extensive knowledge or training in their area of expertise. Additionally, they are expected to perform the services for which they were hired, according to the standards of conduct in their profession. If they fail to use the degree of skill expected, they can be held legally responsible for any harm or financial loss that they cause to another person or business. Professional liability insurance protects you in cases of faulty service (errors) or failure to provide a service altogether (omission). This type of insurance coverage pays the cost of your defense and any damages awarded (up to policy limits). Insurance companies have developed many specialized policy forms that respond to the individual risks of particular professions and services. Professional liability insurance coverage is specialty coverage and is generally not included under homeowners insurance, in-home business policies or business owners policies.

The primary reason for professional liability coverage is that a typical general liability insurance policy will only respond to a bodily injury, property damage, personal injury or advertising injury claim. Other forms of insurance cover are employers, public and product liability. But various professional services and products can give rise to legal claims without causing any of the specific types of harm covered by such policies. Common claims that professional liability insurance covers are negligence, misrepresentation, violation of good faith and fair dealing, and inaccurate advice. Examples:

- If a software product fails to perform properly, it may not cause physical, personal, or advertising damages, therefore the general liability policy would not be triggered; it may, however, directly cause financial losses which could potentially be attributed to the software developer's misrepresentation of the product capabilities.

- If a custom-designed product fails without causing damage to person or property other than to the subject product itself, a product liability policy may cover consequential damages such as losses from business interruption, but will generally
not cover the cost to redesign, repair or replace the failed product itself. Claims for these losses against the manufacturer may be covered by a professional liability policy.

**Commercial Property Insurance**

Property insurance covers everything related to the loss and damage of company property due to a wide-variety of events such as fire, smoke, wind and hail storms, civil disobedience and vandalism. The definition of "property" is broad, and includes lost income, business interruption, buildings, computers, company papers and money.

Property insurance policies come in two basic forms: (1) **all-risk policies** covering a wide-range of incidents and perils except those noted in the policy; (2) **peril-specific policies** that cover losses from only those perils listed in the policy. Examples of peril-specific policies include fire, flood, crime and **business interruption insurance**. All-risk policies generally cover risks faced by the average small business, while peril-specific policies are usually purchased when there is high risk of peril in a certain area. Consult your insurance agent or broker about the type of business property insurance best suited for your small business.

Commercial property insurance helps businesses, including farms and ranches, pay to repair or replace buildings and other property damaged or destroyed because of fire, storm, or other things covered by your policy. It also pays to replace stolen or lost property. Business owners can buy commercial property insurance regardless of whether they own, rent, or lease a building.

If you rent or lease a building, consider tenant coverage that will insure your on-premises property, including machinery, furniture, and merchandise. A building owner’s policy doesn’t usually cover the contents of the building that belong to you. The cost of tenant coverage is usually less than building coverage because the policy only covers contents.

You can buy a single policy to cover a business with more than one location, unless they have different functions and different risk profiles. This could be the case if your business has an administrative office and a separate factory. If your business has operations at multiple locations, ask your agent if you need separate policies.
There are three types of commercial property policies in Texas. The policies protect against different causes of damage, commonly called “risks.” These include fires, lightning storms, windstorms, or damage caused by vehicles and civil commotion.

Read your policy carefully. You may need to buy additional coverage or specialized policies -- such as flood, windstorm, or crime coverage -- to fully protect your business.

- **Basic form policies** usually cover common risks.
- **Broad form policies** usually cover the common risks in addition to water damage, structural collapse, sprinkler leakage, and damage caused by ice, sleet, or weight of snow.
- **Special form policies** cover all types of risks except those the policy specifically excludes. Common exclusions include damages from flood, earth movement, war, terrorism, nuclear disaster, wear and tear, and insects and vermin.

Commercial property policies provide either replacement cost coverage, actual cash value coverage, or a combination of both.

- **Replacement cost coverage** will pay to rebuild or repair your property, based on current construction costs. Replacement cost is different from market value and doesn’t include the value of your land.
- **Actual cash value coverage** will pay to rebuild or replace your property minus depreciation. Depreciation is a decrease in value due to wear and tear or age. If your business is destroyed and you only have actual cash value coverage, you may not be able to completely rebuild.

Following are some typical commercial property coverage:

- **Building occupied by the insured coverage** insures a building that you regularly use but don’t own. This coverage can be important if you lease or borrow a building.
- **Newly acquired or constructed buildings coverage** insures a new building if you add it to your policy within a certain amount of time. If you don’t tell your insurance company within the time period – usually 30 days – your policy won’t cover the new building. Commercial property policies usually only cover buildings named in the policy.
• **Employees’ personal property coverage** insures your employees’ personal property if the property is on your premises. Generally, you must buy this coverage as an endorsement if you need more than a limited amount.

• **Off-premises property coverage** covers your property located off site. Some policies might not cover off-premises property or may provide only limited coverage. You can usually buy an endorsement to cover off-premises property. If you can’t buy an endorsement, you may have to buy a separate policy.

• **Business interruption coverage** pays for the income you’d lose if your business is damaged and you can’t perform your normal business operations.

• **Extra expense coverage** pays any additional costs to return your business to normal after it’s damaged.

• **Valuable papers coverage** provides limited coverage for your business records and other valuable papers. You may be able to buy an endorsement to increase this coverage.

• **Ordinance or law coverage** pays additional costs to repair or rebuild a facility to current building codes after it’s damaged. Many policies provide limited ordinance coverage, but you can increase it with an endorsement.

• **Boiler and machinery coverage** covers boilers, air conditioning units, compressors, steam cookers, electric water heaters, and similar machinery. Coverage is usually only for machinery listed in the policy and to any subsequent losses, such as when a boiler explosion or water heater leak causes damage to other property. You can usually buy this coverage as an endorsement or a separate policy.

• **Inland marine coverage** insures goods in transit by land, air, or inland waterways. It also covers projects under construction and transportation and communications structures, such as bridges, tunnels, and communications towers.

**Home-Based Business Insurance**

Contrary to popular belief, homeowners’ insurance policies do not generally cover home-based business losses. Depending on risks to your business, you may add riders to your homeowners’ policy to cover normal business risks such as property damage. However,
homeowners' policies only go so far in covering home-based businesses and you may need to purchase additional policies to cover other risks, such as general and professional liability.

**There are three broad types of business insurance:**

- Assets & revenue insurance
- People insurance
- Liability insurance

**Assets & revenue insurance**

To protect your assets and your livelihood, you should consider these insurance types:

**Compulsory Insurance**

The following types of insurance are compulsory for all applicable businesses:

**Motor vehicles and fleets**

It is compulsory to insure all company or business vehicles for third party injury liability. Many different types of policies are available, so make sure you understand the options before making a decision. There are four basic options:

- **Compulsory third party (injury)**
  
  This policy covers you for claims made against you for personal injuries and legal costs arising from the use of your car. You must obtain this insurance to register your car.

- **Third party property damage**
  
  This policy covers your liability for damage to another person or to the property of others and your legal costs. It doesn’t include repairs to your own car if you caused an accident.

- **Third party, fire and theft**
  
  This policy covers you against the events covered above, as well as fire and theft. It also insures against damage caused if your car was stolen.

- **Comprehensive**
  
  This policy covers you for all of the above plus damage caused to your own car by you in an accident. If you're buying a car on an installment basis, financiers will usually insist on this cover.

**Other Insurance:**
The following types of insurance aren't compulsory, though it is recommended that you consider all options:

- **Building and contents**
  This covers the building, contents and stock of your business against fire and other perils such as earthquake, lightning, storms, floods, impact, malicious damage and explosion.

- **Burglary**
  Insures your business assets against burglary, and is most important for a retailer or business that has a property that is not always attended.

- **Business interruption or loss of profits**
  Such Insurance covers you if your business is interrupted through damage to property by fire or other insured perils. Ensures your ongoing expenses are met and profit is maintained through a provision of cash flow.

- **Deterioration of stock**
  This covers your business for the deterioration of chilled, refrigerated or frozen stock following the breakdown of the refrigerator or freezer they were kept in.

- **Electronic equipment**
  This covers your electronic equipment for theft, destruction or damage.

- **Employee dishonesty**
  This is Key Employee Insurance which covers losses resulting from employee theft or embezzlement.

- **Farm insurance**
  This category Insurance plan is for farms covering things such as crops, livestock, buildings, and machinery.

- **Goods in transit**
Covers loss of, or damage to, the goods you buy, sell or use in your business when they are in transit by ship, air, post, rail or road.

- **Machinery breakdown**

  This insurance protects your business when mechanical and electrical plant and machinery at the worksite break down.

- **Tax Audit**

  This covers you for the cost of professional fees in the event of a tax audit or investigation into your business.

- **Property in transit**

  Covers theft or damage of items you use for business purposes that travel with you, such as tools and equipment.

**People Insurance**

Insuring yourself and your employees in the event of a workplace accident or illness is essential for protecting your business against costly compensation claims. Consider the following workplace insurance obligations:

**Workers Compensation**

You must provide accident and sickness insurance for your employees - workers compensation - through an approved insurer. Workers compensation is covered by separate state and territory legislation.

**Personal accident and illness**

If you are self employed you won’t be covered by workers compensation, so it's recommended by law that you cover yourself for accident and sickness insurance through a private insurer. This policy will compensate you for loss of revenue while you or your employee(s) recover.

As a business owner, you may also wish to consider personal life insurance. There are several types of life insurance available. Some are investment-type funds where you
contribute over a certain time and get back your investment plus interest earnings at the maturity date. Others are designed to cover things that could happen to you, such as:

- **Income protection or disability insurance** - covers part of your normal income if you are prevented from working through sickness or accident.
- **Trauma insurance** - provides a lump sum when you are diagnosed with one of several specified life threatening illnesses.
- **Term life insurance or whole of life cover** - provides your dependents with a lump sum if you die.
- **Total and permanent disability insurance** - provides a lump sum only if you are totally and permanently disabled before retirement.

**Liability Insurance**

There are many different types of insurance policies available, but liability insurance is one of the most popular because it costs much less than many other options. For example, in regard to auto insurance policies, liability insurance costs far less than full coverage. The reason for this is because full coverage insurance must pay for both your vehicle and any other vehicle involved in a collision, as well as property damage and medical expenses due to injuries to you or another party.

On the other hand, liability insurance is only responsible for the other party's losses. Your person and your property are unprotected, but liability insurance protects you from being held responsible for the other party's damages.

If you own a business, you may be liable for damages or injuries to another person or property. Though liability insurance is optional in most cases, it is strongly recommended for businesses in all industries as the likelihood of being sued for negligence is unpredictable and potentially very costly. Types of liability insurance you may need to consider include:

**Public Liability**

Public liability insurance protects you and your business against the financial risk of being found liable to a third party for death or injury, loss or damage of property or economic loss resulting from your negligence.
**Professional Indemnity**

Professional indemnity insurance protects advice-based businesses from legal action taken for losses incurred as a result of professional negligence. It provides indemnity cover if your client suffers a loss - material, financial or physical - directly attributed to negligent acts, errors or omissions.

**Product Liability**

If you sell, supply or deliver goods, even in the form of repair or service, you may need cover against claims of goods causing injury, death or damage. Product liability insurance covers you if any of these events happen to another business or person by the failure of your product or the product you are selling.

**PRODUCT DESIGN**

1. Insurance product design is the process of creating a new and or enhancing an existing insurance product to be sold by an insurer/intermediary to its customers.

2. An insurer should take into consideration among others the following aspects when designing an insurance product;

   a) Setting a business case for new or enhanced product;
   b) Market testing and analysis;
   c) Cost/benefit analysis;
   d) Risk identification, assessment and mitigation;
   e) An implementation plan for the product, including milestones;
   f) Clearly defined and appropriate levels of delegation for approval of all material aspects of product design;
   g) Post-implementation review; and
   h) Methods for monitoring compliance with product design policies and procedures.

One main issue in the liberalized scenario of the insurance sector is in the area of developing new products. Constant activity in this area is very important for determining the overall profitability, and growth of any insurance company. The main reason for the
liberalization of the insurance sector is that it the public sector was not practical in the process of developing products that satisfied the needs of the customer.

Product development process is an important process for an insurance company. Developing insurance products include the following steps:

- **Customer requirement analysis** - In the first step, the customer requirements are analysed. In this phase, the information on the amount to be insured, total income, client biometrics such as age and family size, current purchasing habits, and so on are analysed.

- **Business analysis** - In the business analysis stage of product development, different departments of the insurance company have the following responsibilities.
  1. Marketing department has to perform the market analysis to know the customer needs, and make a forecast for sales.
  2. Underwriting department has to prepare the manuals.
  3. Customer service department assesses the procedural requirements of the new products.
  4. Actuarial department develops the specifications of the product, and the resulting impact on product portfolios.
  5. Accounting department reports the financial requirements of the new product.
  6. Information systems department checks whether the insurer has enough operating systems to accommodate the new product or not.
  7. Investment department along with the actuarial department determines the investment needs for the new product.

- **Prototype development** - In this step, a prototype of the product is designed and testing is carried out.

- **Pricing the product** - The pricing of the insurance products plays an important role in the design and development of the product. The price of the product should include the risk premium that the insurance company needs for accepting the
policy, and the cost for distributing and administering the product to the client. The policy price that is charged to the client includes the risk premium and the cost of the distributor.

- **Product release** - This stage is called as the ‘technical design stage’. It involves creation of drafts for policy documents, commission structure, underwriting, forms and procedures and issue specifications. Before the product is released to the market the insurance companies have to take care of the following:
  1. Arrangement of training material.
  2. Designing promotional materials for the products.
  3. Releasing all the information that is needed to understand the product.
  4. Administration of the product after release.
  5. Complete policy filing, the process by which the organisation obtains all the regulatory approvals from all the applicable authorities that are needed to release the product.
  6. Educating and training the staff and the sales agents on administrative procedures and forms that are needed to sell administer and service the product.

The environment in which the insurer functions inspires its product development. This comprises of the legal framework which the insurance industry has to follow and social and economic factors. Any stage of product development has to be carried out in accordance with the customer’s interest. Thus, since 1973, the Indian Insurance sector has directed the product development towards meeting this goal. In the last three decades, the General Insurance Company (GIC) together with its four subsidiaries has developed 150 new products, and has met its customer requirements. To control poverty and provide employment in the rural areas, the insurance sector developed the Integrated Rural Development Program (IRDP).

**Business Challenges in Product Design:**

Across various economies and geographic regions, “hard and soft” insurance market cycle conditions cause competitive challenges and shifts in strategic business imperatives
for insurers and producers, especially in general insurance lines of business. Premium pricing strength erodes during soft market conditions, pushing carriers to seek more profitable niche growth through finer risk segmentation and tailored product and service offerings. To respond quickly to these dynamic market conditions, carriers must have the ability to either price-down in soft markets or price-up during hard cycles at the right risk levels. Most carriers’ legacy platforms respond to pricing and underwriting change controls in 90–180 days on average — often missing starting and ending cycle rhythms. Policy renewals are particularly vulnerable during these cycles. Risk reevaluation and pricing periods typically are susceptible to competitive predators. Renewal pricing often is left either to inefficient manual processes as guesswork or to mass re-pricing applied across the board without insight into risk-ratio tolerances or customer loyalty.

**Inability to Identify and Capitalize on New Product Opportunities with Risk Selection and Pricing Accuracy**

Insurance carriers typically move across all or a subset of seven key business process management steps when responding to market cycle challenges. The steps, in sequence, are research, design, development, analysis, filing, maintenance and deployment. Not all product updates require carriers to move through the entire sequence of steps. For the situations that do use all seven steps, such as new product portfolio and branding, the bulk of the workload and duration lies within the “design, develop and analyze” steps, depending on the degree of product complexity for launch or modification. However, in North America, filing, along with regulatory and compliance, takes the most time because of the time required to work with all 50 states’ insurance commissioners. Whether products have to go through all seven steps or only a few of the steps, ultimately, carriers want several product development work streams and launches done simultaneously and issued to production on a specific date. Another issue brokers deal with is the need for instant risk evaluation, rating, pricing and product modification to close business quickly. This type of design capability is invaluable when a broker is negotiating underwriting details for a multimillion-dollar deal with a major customer, such as a global hotel chain in Europe or more than 1,000 commercial delivery vehicles
across China. Real-time responsiveness and collaboration with a broker during these timely negotiation situations are priceless in winning against the competition.

**Rigid, Existing Policy Administration Systems**

Insurers struggle with the imperative to grow business with limited resources and budgets. Many insurers are hampered by inflexible legacy systems that stymie their efforts to grow, through 20- to 30-year-old technology platforms that hold critical data assets captive. It is not uncommon for an aged policy administration system to possess old, impossible-to-maintain, hard-coded information that holds carriers back. This often is known as the “spaghetti code” of policy systems. The legacy systems are difficult to maintain, change and teach to new IT staff. Carriers are looking for ways to use new, best-of-breed technology to make their systems more agile so they can support improved processes, including shortened PD&D configuration cycles. Gartner’s Kimberly Harris-Ferrante says, “Some insurers want to extend the life of their legacy systems and leverage past investments by modifying policy solutions. Using this approach, established systems are modified to comply with standards or to support new initiatives. Policy system modification projects might include using new technologies, such as Web services and XML, to expose trapped legacy data to other systems and applications.” Moreover, continues Harris-Ferrante although custom development has been preferred in the past, the trend has reversed during the past three to four years. Instead, insurers today have shifted to purchasing packages or maintaining their systems.

**UNDERWRITING OF LIFE INSURANCE:**

Life Insurance Underwriting is the process of accepting the proposal of the customer based on the guidelines formulated by the insurance company. The insurance companies codify a set of procedures which must be followed before accepting any new business. When a new proposal comes to the insurance company its underwriting department scrutinizes the proposal whether or not it fulfills the criteria laid down by the company. If they find any lacunae they ask the agent to get it corrected. It is not that one can get whatever cover one wants. The issue of policy depends on income of the insured and whether he has the capacity to pay the premium over the years. Once the underwriters are
satisfied that all the conditions have been fulfilled they go ahead to accept the premium and issue the policy. Underwriting can be defined as the decision making process during which the company decides whether to insure or not and if yes at what rate.

**LIFE INSURANCE IN OPERATION - FROM PROPOSAL TO POLICY**

Since life insurance is a financial contract, and a long-term contract and that a contract which may come to be executed when one of the parties to the contract may not exist and may be called up to a court of law in case of dispute in future, it is essential that all the terms and conditions of the contract must be clearly understood and put in writing legibly. Looking at the importance of the contract combined with the raised expectation of a benefit which is still in the womb of a promise, unstinted trust should be created in the mind of the insured so that he remains confident of its benefit and continues to perform his part of the duty during the continuance of the contract. The proposal form, as prescribed by the insurer for the type of insurance that the prospect has agreed to buy, must be appropriately selected. The proposer, must go through the proposal column by column, appreciate the meaning and importance of each information sought and fill it up legibly and completely. Hyphens and oblique, dittos and blanks should be avoided as they are likely to be misunderstood or can be misused. An incomplete proposal leads to further queries and in the process a lot of valuable time and effort is wasted. While different insurance companies will have different formats for the proposal from the points on which information is sought, are substantially the same.

Wherever medical report is required, the medical examiner is required to endorse the answers to the questions relating to personal history and personal health as stated in this form. If no medical report is required, the life proposed has to give additional information about his physical measurements as required. However, most insurers insist upon medical reports only in cases where either the sum assured is very high, or the life proposed is beyond certain age limit or the plan of insurance carries a lot of risk element. We shall discuss these points later on in this chapter. However it is sufficient to state here that a
medical report has to be given by a company approved medical examiner. Medical examination has to be conducted at a well-equipped clinic. A lady life has to be examined by a lady doctor only. The medical examiner should not be related to the life proposed and the report should be submitted confidentially to the insurer who pays for the medical examination. However, if the prospect decides ultimately not to go ahead with the completion of the proposal, he bears the cost of the medical examination and the initial deposit is refunded less this cost. Every insurance company has its own policy as to the need for the medical report and therefore company rules must be consulted before taking the life proposed to the doctor. The insurer may also ask for special reports like X-ray, ECG, Blood Sugar Test etc. after examining the proposal. There are also standard rules for obtaining these reports depending upon age at entry, sum under consideration or personal history of illness etc. These circumstances are provided in the company manual. The cost of these special reports is initially paid by the prospect but it is reimbursable by the insurer, after the proposal is completed. The rates of payment for these reports are fixed by the insurers in advance and these reports are confidential and are the property of the insurer irrespective of who ultimately pays for those reports.

**Personal statement regarding health declaration**

This statement is required at the time of revival of a policy either with or without a medical report depending upon the duration of policy-lapses and physical condition of the life assured. However if there is a delay in completing the proposal say 3 months to one year, the insurer may ask for a statement in the prescribed form.

**Queries regarding occupation**

This statement gives a complete picture regarding the extent of hazard, if the life to be assured is engaged in any hazardous occupation like electrical industry or mining or chemical industry etc. If a policy is to be taken under Married Women’s Property Act 1874, to secure the policy money against all other claimants to the estate, prescribed forms are used depending upon the number of beneficiaries and trustees. For the revival of a children’s policy, a separate health declaration is required. Special statements are required, if the proposal has to be financed by a HUF for the benefit of one of its
members. If the insurance is to be taken on the life of a key functionary in a company - what is called Keymans’ policy, a separate questionnaire is to be filled in by an authorized person of the company.

**SELECTION OF PLAN AND TERM**

The plan should be carefully selected taking into consideration the special need of the life to be insured. A plan well selected generates lot of goodwill for the company which means a lot more business, a lot more income. Term of course means the period of the plan after which it matures for payment. Here again the need of the proposer alone is to be considered. Term also determines the rate of commission to the agent, but this is of no consideration while canvassing insurance plan and term.

**OBJECTS OF INSURANCE**

Objects of insurance can be family provision or old age provision etc. Irrespective of what is stated here, the payment of claim money is decided by the nature of the plan of insurance purchased. There are plans specially designed to provide for the marriage of the female child, maintenance of a handicapped child, a child’s insurance to give him the benefits of lower premium etc. Therefore the object stated must match the plan selected.

An endowment plan benefits the family in case of early death of the insured, when the claim money is paid in a lump sum. In case of maturity also, the money is paid in lump sum. However, it is also possible to opt for instalment payment of the lump sum money, in the shape of a pension if option is so exercised in good time, say one year in advance. It is called “settlement option”.

A danger inherent in lump sum settlements is though it is most flexible in the hands of the receiver, that the money may be mismanaged, poorly invested or spent foolishly. The Surviving beneficiaries of the family need a guaranteed income rather than cash. Of course it is possible to purchase an annuity policy with the cash amount available, even if no such advance arrangement has been made.

**SUM PROPOSED**
This is the amount insured and is paid as claim money either on death or maturity along with bonus or guaranteed addition etc. as per the conditions of the policy. As stated earlier, life insurance is not a contract of indemnity and therefore, the claim amount is not related to the financial status of the life assured. It is therefore, advised, while deciding the sum proposed, a proper estimate on lines of Human Life Value theory should be made. In case, the prospect finds it difficult to pay the required premium for a certain sum assured, who is proper, the agent can select a plan, which permits high sum assured with a low premium like a convertible whole life policy. Alternatively he may keep in continuous contact with the life insured to sell him additional insurance, whenever, his financial situation improves.

In any case, everybody needs a review of his insurance cover from time to time at least for two reasons - One - the income goes up along with the liability in course of time. Two-the continuous inflation in the market, reduces the money value of the insurance over time and therefore additional insurance has to be purchased, at least every five years, to maintain the value of sum assured, at the original rate planned for.

For example, the sum assured of one lakh taken today may find it worth only if compared in terms of its purchasing power ten years from now. The problem is, that as people pay more for goods and services and as their income and wages rise, they often do not increase the life insurance protection to compensate for the other changes. An agent would do well to appreciate this for continuous business.

**ACCIDENT BENEFIT**

This part refers to the double accident and permanent disability benefit and for this a small extra premium is charged. We will discuss this benefit a little later. But first let it be known that there is a normal provision for disability benefit allowed in all policies for free and the benefit relates to the waiving of all future premium after the total permanent Disability has been caused due to an accident as defined hereafter within stipulated period of the accident and provided the policy is in force. The Double Accident and Permanent Disability benefit has two parts - one relating to death due to accident and second permanent disability suffered due to such accident. The benefit payable on the death of the life assured is an additional sum equal to the sum assured, provided the
policy was in force at the time of accident and the bodily injury has been sustained directly due to an accident caused by an outward, violent and visible means and the death has been caused solely, directly and independent of all other intervening causes, within the stipulated period, due to the bodily injury. Thus the above definition of accident excludes self injury, attempted suicide, insanity, immorality or when the life assured is under the influence of any liquor, drug etc. The injury suffered by a person while flying in any capacity other than as a passenger without any duty on board is also excluded. So also injury caused during riots, civil commotion, war, mountaineering etc. or while the life assured is committing any breach of law or while in the employment of the armed forces or navigation.

As a general rule, whenever an extra premium is charged due to the hazardous nature of occupation this benefit is excluded, in case the death or disability occurs due to such occupation. So also life assured with physical impairment. The children, male or female are not granted such benefit. Normally an exclusion clause is inserted in the policy document in all such cases. The permanent disability benefit is the payment of a sum equal to the sum assured, in monthly installments spread over a period of years. However, if the policy becomes a claim either due to death or maturity, before the expiry of specified years, the balance installments are paid with the claim. The second benefit in case of permanent disability in the way of waiving the payment of future premium to the extent of a sum assured specified.

To be eligible for the aforesaid benefit the disability must be the consequence of an accident as defined above and must be total and permanent. In other words the disability must completely disable the life assured from following any occupation or profession in order to earn his livelihood. The insurer must be informed about the happening of this disability with such proof as required and the insurer has a right to examine the disabled person through a medical examiner. However any wrong payment on this count is recoverable by the insurer.

**MODE OF PAYMENT OF PREMIUM**
This is an important aspect of selling life insurance because the immediate sacrifice of cost burden to the policyholder can be regulated by selecting carefully the mode of installment payment. In the prospectus, the insurer prints only annual premiums and if the mode of payment is chosen yearly, a rebate in premium is allowed. In case the mode selected is half-yearly lesser rebate is allowed. Quarterly rate is exactly one fourth of the published annual rate. Monthly installments invite 5% extra. The reason is the higher administrative cost to account for more frequent payments.

Many prospects may find it difficult to pay annual premium in one go. Resistance to sale becomes less, if payment amount can be divided in a number of installments’. However, there is a danger of forgetting such frequent payment causing policy to lapse. It is in the interest of the agent and of the policyholder to ensure that the policy does not lapse due to non-payment of premium.

Modes of payment like payment by bank on a scheduled date or loan from P.F. A/C is other alternatives. For those who are in secured jobs with reputed companies including government, payment of premium through salary savings scheme is possible. In such a case the insurer and the employer enter into an agreement whereby the employer agrees to deduct the premium from the salary of the insured employee who accordingly authorizes the employer for the deduction and the employer remits a consolidated amount with a demand note to the insurer. However this mode of premium payment is not free of its complications. The employer as a third party is involved in payment of premium and thereby keeping the policy in force. If for some reason which may be anything from non-payment of salary to negligence or misappropriation or financial problem of the employer the installment of premium does not reach the insurer and the claim arises there is a real problem leading to misery and litigation.

DECLARATIONS

At the end of the proposal, the proposer makes three declarations which make the answers in the proposal the basis of the insurance contract:
1. The proposer guarantees as to the truthfulness of the information so far it is within his knowledge. Thus the foundation of the basic principle of “utmost good faith” is laid and the breach of it makes the contract void.

2. The proposer authorizes the doctor to divulge all information known to him about the health and habit to the insurer whenever necessary. Thus a doctor giving such information to the insurer at any time, either at the time of proposal or at the time of claim, cannot be held guilty of divulging any confidential information.

3. The third declaration relates to a period between the date of signing the proposal and acceptance of the risk by the insurer. This is a period during which the underwriter has not yet seen the proposal and has, therefore, not undertaken any risk. Any unfavorable incident during this period shall, therefore, materially affect the decision.

The proposal is to be signed in the presence of a witness because that is the legal requirement to enter into a contract. Normally agent should sign as a witness as that is the proper way. If the proposer has signed in a language other than the one in which the questions have been asked in the proposal form, he must declare that he has understood the questions and has answered in his own language. The person who has explained the questions must also endorse for having done so. However, if the proposer is illiterate and puts his thumb impression, similar declaration is required both by the proposer and the person who has explained the questions. Under no circumstance, the agent should write the answers in the proposal form in his own hand. It is prohibited in the Agents Regulation, 2000. Section 41 of the Insurance Act states that offer or acceptance of any rebate other than what is permitted in the company prospectus is an offence. However we hope, this provision of law becomes really effective.

Whenever the proposer has to be medically examined by an authorized doctor, the doctor signs the proposal as a proof of having read the proposal form duly filled in. The life proposed signs to establish his identity. The proposal form duly filled in is the basis of contract and no amount of care taken to fill it up is too much. It is rightly compared with the rituals which a couple goes through at the time of marriage. An elaborate ritual is necessary to realize the importance of the relationship. Insurance, establishes a lifetime relationship.
Underwriting of General Insurance

For a general insurance company, underwriting business is the basic core activity. All other activities, in fact, emanate from this core activity only. Not much attention was being paid to this core activity in the nationalized set-up under tariff era. Underwriting was reduced to referring to the pages of tariff. There was no application of mind. Any innovation was out of question. The customer has to tailor his needs according to the available products rather than it being other way. In an environment like this the underwriting skill and expertise development saw a decline. Then came the liberalization of insurance sector and gradual withdrawal of tariff with the ultimate aim of ushering in a fully tariff free regime. Suddenly underwriting became all important. The environment became very competitive. Profit and solvency concern forced insurance companies to relook at their underwriting operation under IRDA regulation on “File & Use” system. This meant amongst other, all insurance company must have - An underwriting policy duly approved by the board

- The pricing has to be actuarially evaluated and if it is subsidized, this has to be spelt out.
- The concept of appointed actuary in general insurance company has come.
- Nominated underwriters & issues connected with that.
- Marketing & underwriting delinked.

Then there are regulations to protect policy holders interests and certification of outstanding claims provisioning by Appointed Actuary. These regulations have their own bearing on underwriting and pricing, which cannot be ignored now. There is now talk of risk perception based effective underwriting. Risk management and related issues are increasingly becoming crucial and important which is the way it should always be.
Pursuit of premium for obvious reasons is the goal of all general insurance companies. But this premium underwritten must be quality premium and must generate profit. The excellence and the quality of underwriting will determine the long term survival of general insurance companies. This realization is now coming. Then there are whole lot of other issues (e.g. marketing, claims settlement, investment operation, etc.) which are dependent upon the underwriting operation of the company.

The underwriting issues therefore cannot be seen in isolation and there is a need to Re look at things in the present day context. Let’s now examine what does underwriting entail, how is the underwriting philosophy /policy of a company is formulated and how this policy is monitored for effective implementation. But before that let us discuss the corporate goal of a general insurance company because policies in other areas of operation must fit in and help achieve the corporate goal.

In today’s world most of the organizations have vision and mission statements. Insurance companies are no exception. These statements provide the broad frame work within which the corporate goals / objectives of the insurance companies are set. The corporate objectives provide the business direction for medium and long term goals. This involves understanding as to where the organization stands now, its core capabilities, strength and weakness and the environment (business, social and economic, regulatory / legal etc,) in which it operates. Bases on these understandings, the road map to achieve the goal is set. Corporate objectives cover whole range of the organizations activities including the underwriting goal. The underwriting policy of the company must therefore be capable of delivering the required results and accordingly must be subject to continue review for its effectiveness. Underwriting basically refers to the process of evaluating a proposal that comes for insurance. Based on the evaluation done a decision is to be taken as to the acceptance of proposal or otherwise If it is to be accepted, at what price and on what terms, conditions and coverage’s. This process ends with the issue of policy documents. For a routine kind of simple proposal, the entire procedure is very simple. Generally insurance companies have internal guide rates and standard policy documents, for these routine risks which are typically High frequency, low severity risk and do not require much of an underwriting expertise & skill.
For simple risk, the evaluation is done through the information contained in the proposal form. For big and complex, industrial risk, the evaluation is done through risk inspection carried out by specialist trained engineers of the insurance company. Individual risk peculiarities will vary and the report of the risk engineer comprehensively examines the physical hazard aspects in relation to the perils covered. Depending upon the class of business, additional questions may be asked through a questionnaire. For medical insurance, medical checkup and diagnostic test may be insisted upon. Moral hazard aspects are difficult to assess. But for big corporate clients, it is worthwhile to examine their corporate governance, risk management philosophy, safety and investigation mechanism and above all the quality, skill and experience of manpower in handling and minimizing loss. All said, insurance companies are always exposed to “adverse selection.” Whether it is proposal form, questionnaire or risk inspective, the idea is to get all relevant information for an informed underwriting. Insurance companies have to be on their guard for adverse selection and moral hazard aspect.

After having decided to accept the proposal after due evaluation, the next step is to decide about the pricing and this involves matching of risk to price (via experience and modeling) as also limiting of potential loss exposure through some mechanism. Insurance is an intangible product and pricing intangible product is difficult for it cannot be based on deterministic model traditionally used for tangible goods / products. The uncertainty about frequency and severity of claims makes the pricing task of insurance product very difficult. We have to make use of stochastic models which are based on theory of probability. Based on the past data (experience), these model help us in making prediction about the likely number of claims that are expected to be reported as also about the average claims size. The expected claims cost is worked out by multiplying the two. The claims cost must also take into account the provision for IBNR & IBNER claims. Inflation must also be factored in pricing. For any policy issued today, the claims if it arises will be on some future date. Claims cost is the most dominant cost and most difficult to determine. The other costs are the management cost and cost of business acquisition which are to be factored in the pricing along with a reasonable margin of profit.
The pricing will also depend on the terms, conditions, special warranties, scope of coverage, etc. Higher deductible, reduced coverage, etc. would obviously attract lesser premium. Pricing should also be sensitive to the business, regulatory, economic and social environment. Balancing has to be done to make the price competitive on the one hand and actuarially adequate (alignment of risk with price) i.e. economic price on the other hand. Reducing claim cost and other costs of operation is therefore such a big issue. Price adequacy is a regulatory concern also. Modern day computers have enabled storage and analysis of huge volume of data. Since actuarial modeling is based on past claim data and simulation, the insurance company, must have a system of capturing good quality relevant data. Repetitive underwriting decision can then become a rule in the underwriting manual or better still the system supported e-risk analysis and pricing There is no other way except leveraging IT.

After having fixed the price, the next issue is to examine the acceptance in relation to the underwriting capacity and also if so warranted how to increase this capacity and the cost of the same. Underwriting capacity refers to the maximum premium that an insurance company can go for against the specified level of capital because of regulatory requirements and also dictated by prudence therefore; generating volume of business is linked to underwriting capacity of the company which in turn is linked to the capital and free reserve of the company. This means that if you want to increase the underwriting capacity you have to bring more of capital and more of free reserve. The other option is to hire the capital through reinsurance arrangement. Depending upon the underwriting capacity, business plan, size and volatility of portfolio, etc, a decision is to be taken as to how much exposure to retain on a big single risk or on an aggregate exposure from a group of risk. This retention is kept on companies own account and the balance is reinsured through a well thought out comprehensive reinsurance programmed. Reinsurance incidentally narrows down the range of variability of the insurers result. The capacity of underwriting being limited, profit has to be generated from this limited volume of business. The skill and judgment of underwriter therefore becomes very important to make use of the available capacity to maximize profit.

The other underwriting objective could be:
- Leadership of a selective business class e.g. health insurance
- Underwriting profitability
- Brand leader
- Company of choice for businessman / common man
- Aggressive underwriting for volume
- Developing balanced portfolio by spreading the risk geographically and class wise.

There is therefore a need to have an underwriting policy which should define the underwriting objective of the company, the underwriting structure and authority approach to key underwriting issues, portfolio goals (volume and mix), marketing strategy, R & D, response time for proposal acceptance, etc. This involves a proper understanding of organizational strengths and weakness, the challenges ahead, the changing business and regulatory environment, etc. The strategy to overcome the weakness and the preparedness to meet the future challenges should form part of the underwriting policy. The underwriting capacity and reinsurance support arranged should be factored while formulating underwriting policy. The training of underwriting people is also an area which is to be addressed through this policy. As part of this policy underwriting manuals and guide rates should be developed to provide underwriting direction and decision. The underwriting authority should be clearly defined. The underwriting goal and the road map to achieve the same should be clear to one and all in the organization. The underwriting policy helps in translating goals into strategies which in turn will be reflected in the business that the underwriter accepts.

The underwriting challenges that the insurance company will face in near future may include
- Terrorism cover
- Environmental and pollution issues
- High tech/ high value project
- Coverage’s for intellectual property right
- Cyber security / liability
- Insurance as a comprehensive solution under one umbrella.
- Credit risk
- Performance guarantee
- Contingent business interruption
- Long term insurance cover e.g. latent defect insurance (high rise building) Insurers have to make use of the advances being made in science and technology to better analyze the risk and have better pricing capability. For example in health sector the advances made in genetics and the ability to make prediction about disease based on genetic testing can be a powerful tool for life and health insurance underwriting.

The company which will first develop the underwriting capability of future generation risk will be the company that will rule. R & D, innovation and futuristic view of things are important. Insurance companies should understand and realize, if they are not able to meet the new demands of market, some non-insurance player may step in. Globalization and its impact on insurance, liberalization of insurance sector, the proposed changes in Insurance Act of 1938, intensified competition, electronic commerce, emergence of new risk, local factors affecting the insurance market, the financial meltdown and recession, etc. are the factors which will deeply affect the insurance business and will bring challenges of new kind before the underwriting community. Are we prepared to face the new challenges? The insurance companies must gear themselves to be the true underwriter of the future risk.
UNDERWRITING & PRICING OF PRODUCT

INTRODUCTION

Underwriting is the process by which the lender decides whether an applicant is creditworthy and should receive a loan. An effective underwriting and loan approval process is a key predecessor to favorable portfolio quality, and a main task of the function is to avoid as many undue risks as possible. When credit card loans are underwritten with sensible, well-defined credit principals, sound credit quality is much more likely to prevail.

Many actuaries believe that rate indications should be based only on anticipated costs. Stable actuarial rates ensure adequate returns for insurers, and they mitigate the price variations that anger consumers. Carriers may be tempted by the marketing benefits of rate cutting, but actuaries should not encourage such follies.

TYPES OF UNDERWRITING:

An insurance company may issue policies for many different types of insurance. However, most underwriters perform their responsibilities as specialists. An underwriter may underwrite just property policies, just casualty policies, just personal property policies, just professional liability policies, and so on.

Securities underwriting:
Securities **underwriting** refers to the process by which investment banks raise investment capital from investors on behalf of corporations and governments that are issuing securities (both equity and debt capital). The services of an underwriter are typically used during a public offering.

**Bank Underwriting:**

It is the detailed credit analysis preceding the granting of a loan, based on credit information furnished by the borrower; such underwriting falls into several areas:

(a) Consumer loan underwriting includes the verification of such items as employment history, salary and financial statements; publicly available information, such as the borrower's credit history, which is detailed in a credit report; and the lender's evaluation of the borrower's credit needs and ability to pay. Examples include mortgage underwriting.

(b) Commercial (or business) underwriting consists of the evaluation of financial information provided by small businesses including analysis of the business balance sheet including tangible net worth, the ratio of debt to worth (leverage) and available liquidity (current ratio). Analysis of the income statement typically includes revenue trends, gross margin, profitability, and debt service coverage (see Debt Service Coverage Ratio).

**Insurance underwriting:**

Insurance underwriters evaluate the risk and exposures of potential clients. They decide how much coverage the client should receive, how much they should pay for it, or whether even to accept the risk and insure them. Underwriting involves measuring risk exposure and determining the premium that needs to be charged to insure that risk. The function of the underwriter is to protect the company's book of business from risks that they feel will make a loss and issue insurance policies at a premium that is commensurate with the exposure presented by a risk. Each insurance company has its own set of underwriting guidelines to help the underwriter determine whether or not the company should accept the risk.

**Other forms of underwriting**
Real estate underwriting

In evaluation of a real estate loan, in addition to assessing the borrower, the property itself is scrutinized. Underwriters use the debt service coverage ratio to figure out whether the property is capable of redeeming its own value or not.

Forensic underwriting

Forensic underwriting is the "after-the-fact" process used by lenders to determine what went wrong with a mortgage. Forensic underwriting refers to a borrower's ability to work out a modification scenario with their current lien holder, not to qualify them for a new loan or a refinance. This is typically done by an underwriter staffed with a team of people who are experienced in every aspect of the real estate field.

Sponsorship underwriting

Underwriting may also refer to financial sponsorship of a venture, and is also used as a term within public broadcasting (both public television and radio) to describe funding given by a company or organization for the operations of the service, in exchange for a mention of their product or service within the station's programming.

Property and Casualty Underwriters

Within the property and casualty field, underwriters often specialize in a particular type of property or casualty coverage. Within this field there may be fire underwriters, homeowners underwriters, automobile insurance underwriters, inland marine underwriters, commercial property underwriters, personal property underwriters, commercial general liability underwriters, professional liability underwriters and Workers Compensation underwriters, for example. These underwriters, whether they perform underwriting tasks for one line of insurance or for many lines, must understand the risks involved with each line of insurance for which they underwrite and the available and practical methods of dealing with these risks. They must also be able to gather and understand the various resources used to evaluate each application and determine whether the applicant meets company underwriting standards. Such resources may include site
inspection reports, business or personal financial statements and reports, and if a business is being insured, statistical reports generated by the industry in which the business falls, as well as statistical reports from the property and casualty insurance industry that are applicable to the risk.

**Personal Line and Commercial Lines**

A further distinction among property and casualty underwriters is whether they underwriter personal lines or commercial lines. Although both individuals and businesses need property and liability coverage’s, the insurance needs of an individual are very different from the needs of a business. In addition, there are many, many types of businesses and therefore many different sorts of risks associated with these varying business types. Therefore, within the commercial lines area, there may be many specialized underwriting functions.

If an underwriter works with commercial lines applicants, the underwriter is generally familiar with risk management principles and methods as they apply to the type of business being insured. Such underwriters also are knowledgeable regarding the type and scope of risks associated with various business occupancies. They understand that the risks related to running a supermarket are different from those that exist when operating a manufacturing plant. Depending on the insurer, a commercial property and casualty underwriter may even specialize in underwriting specific types of businesses. For example, if an insurer markets to those needing boilers and machinery insurance and also to those with extensive data processing facilities, one set of underwriters may work with the boilers and machinery applicants and another set work with those with data processing protection needs. If a property and casualty underwriter works with personal lines applicants, the underwriter will have a deep understanding of the specific risks facing individuals, such as homeowners or drivers. A home owner insurance underwriter will understand differences in home construction materials, the safety impact of various security systems, and other factors that determine the rates and insurability of a homeowners applicant. A personal automobile insurance underwriter will be an expert in
understanding the various safety features in all makes of cars, what types of drivers are statistically found to be safe drivers, and so on. An underwriter working with highly valuable personal property owned by an individual will be familiar with appraisal reports and appropriate security measures that should be taken to protect the property.

**Life and Health Underwriters**

Another area of specialty for underwriters is life and health insurance. A life and health insurance underwriter is familiar with things such as the impact of medical history and other health issues on insurability. The health or life underwriter is able to read and understand medical reports such as the attending physician statement and data gathered from the Medical Information Bureau. Due to the extensive regulatory environment surrounding health insurance, health insurance underwriters are also very familiar with state and federal regulations regarding health coverage.

**Liability Underwriters**

Liability insurance underwriters must be familiar with the liability risks found inherently in commercial businesses, professionals or individuals. They must also be able to evaluate past losses, judgments and settlements in terms of the likelihood of reoccurrence in order to determine relative future risk. They must also be familiar with current trends in court judgments and with liability laws in order to properly evaluate high-risk applicants.

**Group Underwriters**

Many types of insurance are written on a group basis, and health insurance is often written in this manner. Group insurance is handled somewhat differently than individual policies for underwriting purposes. Generally in life and health insurance group programs, a rate is established that applies to the entire group to be insured. This rate is established by analyzing the characteristics of the group as a whole, as well as individuals within the group. This rate is generally reviewed and revised on an annual basis. Under
some types of group underwriting, individual rates are assigned to individuals within the group, but a discounted rate is applied because the individual is part of the group, so the insurer’s marketing costs are reduced on a per coverage basis. A group offering automobile coverage to its members may have rates assigned in this way. Some forms of group insurance, especially when offered as part of an employer’s benefit package, are subject to special federal and state regulations. Because group underwriting differs in operations and regulation from individual underwriting, an insurer may use specialized underwriters for group insurance.

GENERAL UNDERWRITING CONSIDERATIONS

Management essentially launches the underwriting process when it identifies its strategic plan and subsequently establishes the credit criteria and the general exclusion criteria for consumer solicitations. Procedures for eliminating prospects from solicitation lists and certain screening processes could also be considered initial stages of the underwriting and loan approval process in that they assist in weeding out consumers that may be non-creditworthy in relation to the bank’s risk tolerance level, identified target market, or product type(s) offered.

For a general insurance company, underwriting business is the basic core activity. All other activities, in fact, emanate from this core activity only. Not much attention was being paid to this core activity in the nationalized set-up under tariff era. Underwriting was reduced to referring to the pages of tariff. There was no application of mind. Any innovation was out of question. The customer has to tailor his needs according to the available products rather than it being other way. In an environment like this the Underwriting skill and expertise development saw a decline. Then came the liberalization of insurance sector and gradual withdrawal of tariff with the ultimate aim of ushering in a fully tariff free regime. Suddenly underwriting became all important. The environment became very competitive. Profit and solvency concern forced insurance companies to relook at their underwriting operation under IRDA regulation on “File & Use” system. This meant amongst other, all insurance company must have
- An underwriting policy duly approved by the board
- The pricing has to be actuarially evaluated and if it is subsidized, this has to be 
  spelt out.
- The concept of appointed actuary in general insurance company has come.
- Nominated underwriters & issues connected with that.
- Marketing & underwriting delinked.

Underwriting basically refers to the process of evaluating a proposal that comes for 
insurance. Based on the evaluation done a decision is to be taken as to the acceptance of 
proposal or otherwise. If it is to be accepted, at what price and on what terms and 
conditions and coverage’s. This process ends with the issue of policy documents. For a 
routine kind of simple proposal, the entire procedure is very simple. Generally insurance 
companies have internal guide rates and standard policy documents, for these routine 
risks which are typically “High frequency, low severity risk” and do not require much of 
an underwriting expertise & skill. But the aggregate of simple risk across the company, 
and the likely financial consequences needs monitoring. 
However, typically for “low frequency high severity risk” e.g. liability, aviation, etc. or 
unusual risk, or risk with every high sum insured, etc. the underwriting process becomes 
more complex and whole lot of other issues having bearing on acceptance of such risk 
come in the picture. These include:-
- Underwriting capacity and retention on own account and solvency concern
- Reinsurance arrangement and cost associated with that
- Availability of technical expertise for underwriting big and complex risk in the 
  company.
- The authority to accept such risks and the underwriting policy of the company.
For simple risk, the evaluation is done through the information contained in the proposal 
form. For big and complex, industrial risk, the evaluation is done through risk inspection 
carried out by specialist trained engineers of the insurance company.
Individual risk peculiarities will vary and the report of the risk engineer comprehensively 
examines the physical hazard aspects in relation to the perils covered. Depending upon 
the class of business, additional questions may be asked through a questionnaire. For 
medical insurance, medical checkup and diagnostic test may be insisted upon. Moral
hazard aspects are difficult to assess. But for big corporate clients, it is worthwhile to examine their corporate governance, risk management philosophy, safety and investigation mechanism and above all the quality, skill and experience of manpower in handling and minimizing loss. All said, insurance companies are always exposed to “adverse selection.” Whether it is proposal form, questionnaire or risk inspective, the idea is to get all relevant information for an informed underwriting. Insurance companies have to be on their guard for adverse selection and moral hazard aspect.

After having decided to accept the proposal after due evaluation, the next step is to decide about the pricing and this involves matching of risk to price (via experience and modeling) as also limiting of potential loss exposure through some mechanism. Insurance is an intangible product and pricing intangible product is difficult for it cannot be based on deterministic model traditionally used for tangible goods / products. The uncertainty about frequency and severity of claims makes the pricing task of insurance product very difficult. We have to make use of stochastic models which are based on theory of probability. Based on the past data (experience), these model help us in making prediction about the likely number of claims that are expected to be reported as also about the average claims size. The expected claims cost is worked out by multiplying the two. The claims cost must also take into account the provision for IBNR & IBNER claims. Inflation must also be factored in pricing. For any policy issued today, the claims if it arises will be on some future date. Claims cost is the most dominant cost and most difficult to determine. The other costs are the management cost and cost of business acquisition which are to be factored in the pricing along with a reasonable margin of profit.

**PRICING:**

Pricing is not simply assessing whether future losses will be greater or less than past losses – it should be about assessing the probability of losses for the exposures being covered during the prospective coverage period. As underwriters, we must pay more attention to future exposures rather than past losses. While experience rating will likely continue, in part, to be the basis for the estimation of future losses, the resulting estimates
should be subject to an “exposure underwriting” framework. The pure loss cost component (one of three components: loss cost, risk and expense loads) of the premium should be based on a frequency, a severity and a catastrophic loss component. In most years, the severity and the catastrophic components of the loss will be zero for any individual risk and thus not indicative of the potential for losses based on exposure. The property risks that does not have a large fire loss or is not impacted by a natural catastrophe such as an earthquake is obvious examples. Since the large fire and/or earthquake have not occurred, their impact is not contemplated in the loss cost calculation, but these are real exposures and should be contemplated in the underwriting and pricing of the risk.

The first question we have to ask – do we think past losses are predictive of future losses? In econometric terms, is it appropriate to use adaptive expectations – or simple extrapolations of the past? Adaptive expectations are averages of recent observations. In many parts of the world, simple burning cost calculations are the common rating approach. The approach assumes a three- or five-year time horizon is appropriate. But the approach ignores prospective changes in exposure and changes in the environment. The approach, however, is simple, and with the exception of a future trend assumption, relatively easy to get consensus with the insured, assuming the quality of the information is good and that adequate case loss reserves had been established.

It is when we attempt to “exposure underwrite” (i.e., predict future losses based on future exposures) that the importance and the complexity of the underwriting thought process and the information necessary increases significantly. We use ever more sophisticated pricing models to better estimate future loss costs for a specific class, peril or individual risk. For example, in the underwriting of property risks today, it is common to use complex probabilistic models to estimate natural hazard exposures and to calculate expected annual loss costs. The models are based on many assumptions about the periods/hazards (both frequency and intensity) and the damageability to different construction or occupancy classes. Underwriting focused on future exposures versus past losses requires a thorough discussion about the models used, the critical assumptions made and our confidence in the resulting estimate.
Increasingly, automobile premiums are based on credit variables, future usage estimates and in some cases actual miles driven. In reinsurance, an example is the excess of loss exposure pricing model used to calculate the portion of the expected ground up loss by layer. Exposure pricing tools are based on industry loss experience and statistics by class. The expected loss ratio (estimated for the coverage period) and the distribution of loss to layer are critical assumptions that need to be discussed in the exposure underwriting process. In all of these examples, the model expectations form the basis for reviewing, and ultimately understanding how actual losses/results compare with the estimated/expected losses. This feedback loop or mechanism enhances the underwriter’s ability to be more forward-looking in his/her underwriting and pricing assessments.

After having decided to accept the proposal after due evaluation, the next step is to decide about the **pricing** and this involves matching of risk to price (via experience and modeling) as also limiting of potential loss exposure through some mechanism. Insurance is an intangible product and pricing intangible product is difficult for it cannot be based on deterministic model traditionally used for tangible goods / products. The uncertainty about frequency and severity of claims makes the pricing task of insurance product very difficult. One has to make use of stochastic models which are based on theory of probability. Based on the past data (experience), these model help in making prediction about the likely number of claims that are expected to be reported as also about the average claims size. The expected claims cost is worked out by multiplying the two. The claims cost must also take into account the provision for IBNR & IBNER claims.

**Inflation** must also be factored in pricing. For any policy issued today, the claims if it arises will be on some future date. Claims cost is the most dominant cost and most difficult to determine. The other costs are the management cost and cost of business acquisition which are to be factored in the pricing along with a reasonable margin of profit.
The pricing will also depend on the terms, **conditions, special warranties, scope of coverage**, etc. Higher deductible, reduced coverage, etc. would obviously attract lesser premium.

Pricing should also be sensitive to **the business, regulatory, economic and social environment**. Balancing has to be done to make the price competitive on the one hand and actuarially adequate (alignment of risk with price) i.e. economic price on the other hand. Reducing claim cost and other costs of operation is therefore such a big issue.

Price adequacy is a regulatory concern also. Modern day computers have enabled storage and analysis of huge volume of data. Since actuarial modeling is based on past claim data and simulation, the insurance company, must have a system of capturing good quality relevant data.

Repetitive underwriting decision can then become a rule in the underwriting manual or better still the system supported e-risk analysis and pricing. There is no other way except leveraging IT. Yet another pricing aspect is, the pricing philosophy should be based on system of loading and discount depending upon how the policy performs. It must encourage loss control. The price must also factor “margin for adverse deviation.” The pricing philosophy must address the regulatory concern of rating adequacy, non-discriminatory and non-excessive pricing. The price should be stable over a period of time. While talking about pricing, it should be appreciated that rates are ultimately quoted by companies based on the competitive environment, the reality of risk / loss exposures are same for all.

**Assessment & Management of Exposure**

Ensuring that risk is estimated appropriately is nothing new, but in a competitive world, insurers need to do so as quickly and accurately as possibly. Those with the greatest insight into their customers and associated risk profiles will always derive a competitive advantage, whatever happens in future with the right data integration services and technology platforms, insurance companies can get to grips with location intelligence and data to use these as a tool to recognizing patterns and trends, make more informed
decisions and support their marketing. This creates the opportunity for a more pro-active strategy that delivers real differentiation in the marketplace, greater productivity and the opportunity to develop new business models and opportunities.

The age of intuition based underwriting is ending and the underwriting role is changing at an exponential rate. The growth in large amounts of data has initiated a more predictive risk management environment, which is driving a demand for a cultural shift within the traditional underwriting approach. Underwriters are being asked to change the manner in which they assess risk, manage their books, and market their products. The optimal execution in the underwriting process will soon require the development of new skill sets in order to meet the demands of the evolving underwriting model. Few steps in assessment and management are:

**Managing the collection of data**

The insurance industry has a long history of maintaining data for underwriting transactions either in paper files or legacy systems. Legacy systems had been designed more to connect workflow than to harvest the information surrounding the underwriting transaction, making accessibility to the underwriting data manual and onerous. With improvements in technology, there are many new ways to extract data. As the capability to extract data has progressed, there is a counterweighing and maturing thought that not all of the historical data that can be recovered is precisely relevant to what insurers need or want. With the developing maturity in understanding data, there are shifts in attitudes regarding the power of alternatively sourced information. As the industry pursues more effective collection of its data to drive better business results, the issue of getting information into the underwriting process comes across as a challenge. Despite improvement in data collection and consumption practices, in many cases transactional underwriting decisions remain reliant upon an underwriter’s intuition. We find that many insurers can improve their ability to efficiently integrate critical and timely insights into the underwriting process. With this going on, we are observing a trend in the number of insurance organizations that are engaged in some form of automated data collection. This activity has the effect of growing data sets at an exponential rate with the larger data sets
creating opportunities to derive additional insights. Additionally, the resident knowledge already held within an insurance carrier and the challenge becomes how to disseminate the collective insights (current and in development). In some examples, insurers are looking to leverage the experience and knowledge of experienced underwriters by capturing their information in a consumable format to be shared and integrated with the underwriting process.

**Integrating data insights into the underwriting process**

Gaps in the alignment of data and the underwriting process occur when data is not linked real time to underwriting activities. Insurers need to improve their strategic underwriting domain by aligning their data with their business strategy, by delivering in a timely manner, and by leveraging both across the enterprise. As an example, we see actuarial insight that may have application into multiple areas of a company’s underwriting but is often integrated narrowly as it is applied to only one process or risk classification. Even innovative best practice underwriting solutions offered by one business unit may not be available or immediately consumable by others with similar risks and opportunities. As a result, we are seeing more emphasis by companies to understand and then element these insights more quickly into a greater spectrum of underwriting activities and across a broader range of functions.

Insurance companies recognize that the drivers for healthy performance are to expand and grow beyond simple calculations into the realms of business intelligence and analytics. The traditional examination and explanation aspects of underwriting coupled with the dynamics of a data rich environment yield further capabilities in the use of predictive analytics that are transforming the insurance business today. The growth in large amounts of data has begun to result in a more predictive risk management environment. This is driving a demand for more proactive products but also necessitates a cultural change within the traditional underwriting approach. Significantly, underwriters will be asked to change the manner in which they assess risk, manage their book, and market their products.

Ultimately, data integration with the underwriting process will require the development of new skill sets in order to meet the demands of the new underwriting model. For
example, companies are evaluating the benefits of analyzing the entire book of business, not just statistically sampling from the population. Re-underwriting the entire book is now not only possible, but reasonable as a way to better understand changes in insights, decisions, or risk profiles.

To address the challenge of integrated data insights into the underwriting process, insurers should begin by understanding the various dynamics of their data, the analytical environment and the organization itself. This understanding must include such aspects as a detailed structure of the data, its sources, how fast it is created, its real quality and its breadth of applicability. All of these attributes must then be placed in context to the growing skill set that must be available to leverage a data rich and analytic environment. Companies must be prepared to objectively study the structure and functioning of their underwriting processes and organization. This then allows them to realign it to move from merely collecting, validating and simplistically using data to a much more active structure that allows for more of the insights to be obtained and acted upon in as broad a manner as possible.

**Data and innovation in the underwriting process**

We have found that many companies believe they possess a level of innovative uniqueness, either in terms of their distribution channel, or more notably in their underwriting expertise (in a particular segment or sub-segment of the market). Historically, niche underwriting expertise has provided a competitive advantage that was difficult to replicate but with the emerging era of big data, such advantages have begun to erode. Facing this reality, insurance industry leaders are now taking increased strategic risks to get to the forefront of product innovation and are employing technological experimentation to drive better results with their data. Pointedly, innovative experimentation of technology and data are accelerating the evolution of the concept of risk. While most risk can be placed into classic operational, financial, and market categories, the growth of data sets is increasing awareness of both the complexity as well as the interrelationships. The dynamic and evolving nature of risk is making historically biased planning processes less useful in guiding companies. Companies that are moving to a more robust analysis of risk attributes and applying a more dynamic approach to their
evaluations are gaining insights that allow them to be aware of the changing aspects of risk ahead of the market. While there still remains the challenge of translating the insights into action, these insights provide them with market making advantages. Delivering the insights to the underwriting process has become a new success metric for leading insurers. Instead of a vertically delivered and reactive approach on risk and exposure trends, these companies are providing real time access to developing exposure concentrations, new risk insights, and dynamic profitability model equations.

Insurance companies are faced with increasing competition in the space they previously held an advantage—their underwriting expertise. Big data and data analytics are creating the opportunity for a more level playing field. Getting to innovative approaches in capturing and integrating data within the underwriting process will reward the early adopters. To get to innovative applications of data, insurers need to develop a culture of educated exploration. Insurers first need to assess the ease, level and timeliness of getting the ‘right’ data to the underwriting process. They should then employ proof of concept, and iterative pilots to test and learn approaches. Data maturity comes through experience and rewards those who are willing to take the risk.

**Funding underwriting process improvements**

The continuing financial crisis has forced the insurance industry to re-evaluate budgets and re-prioritize both planned and in-flight initiatives. As market capacity normalizes, many property and casualty (P&C) insurance companies place underwriting transformation at or near the top of their list of strategic initiatives. Yet, companies are faced with maintaining legacy systems that consume most of the available funding. While challenged by funding issues, insurance organizations are committed to making significant investments to create more efficient underwriting processes. They are looking for tools and technology packages that provide the ability to support aggressive growth plans while reducing costs. There are two paths that insurers can take to address the challenge of funding. The first is to streamline and reduce redundancies in the underwriting process and operations to identify cost savings. This can be accomplished through the use of leading edge underwriting workstation technologies. These tools support the underwriting process by assessing completeness of submissions, enabling the
clearance process, preliminary determination of risk eligibility and smart routing of submissions to the underwriter. The tools provide the opportunity to eliminate much of the low-value add work that many underwriters still perform. The second path is to take a component-based approach. Core activities are identified, differentiators are determined and business priorities are assessed. This helps determine the focus areas for funding. Current influencers include data integration and the ability to perform “smart” underwriting. These should function as the drivers of underwriting process improvement funding.

The import facility in Exposure allows you to overlay the outline or shape file of an event onto the map to enable your exposure to be calculated. The event library comprises a wide range of event types, including hurricanes, earthquakes, floods and wildfires. It also contains a library of historical events that you can add to your analyses to facilitate comparisons. When an event occurs, Exposure enables you to respond quickly and address some key questions throughout the duration of the event:

- What customers have been already affected? Which customers are likely to be affected?
- What potential claims may be made? What claims have already been filed?
- What is my total exposure?

Effective systems and processes have the following features:

- Material and reasonably foreseeable accumulations are considered and the resultant loss potential assessed.
- The relevant data to assess and model exposure in different classes of business is identified and obtained when risks are underwritten and input into the relevant system shortly thereafter.
- Where models are employed, more than one model is used (whether internally developed or externally sourced) to determine exposure.
- The modeling is carried out by appropriately skilled and experienced personnel.
- The output is challenged and tested independently of the underwriting function by individuals who have sufficient knowledge, experience and status.

Below the main features of assessing and managing of exposure:
Ownership and exposure capture

Ownership

It is expected that the managing agent’s board will approve the approaches being used for exposure management, including loss modeling and will incorporate the modeled outputs within their overall business planning and review process.

Expected features for exposure capture

- 100% of all relevant risks (policies) have been captured in an appropriate manner.
- Each new risk is added to the data being modeled as soon as possible.

Structured approach to exposure management

The managing agent has effective systems and processes to record, monitor and assess its underwriting exposures.

Principle

The managing agent has effective systems and processes to record, monitor and assess its underwriting exposures.

Minimum standards

The managing agent can demonstrate that it has effective systems and processes for:

- Assessing and modeling exposure for each managed syndicate.
- Validating the output from those processes and systems.
- Integrating the output within annual business plans, underwriting controls and the capital setting process.
- Regular reporting of exposures to the board and to Lloyd's to comply with Lloyd's exposure reporting requirements.

Effective systems and processes have the following features:

- Material and reasonably foreseeable accumulations are considered and the resultant loss potential assessed.
The relevant data to assess and model exposure in different classes of business is identified and obtained when risks are underwritten and input into the relevant system shortly thereafter.

Where models are employed, more than one model is used (whether internally developed or externally sourced) to determine exposure.

The modeling is carried out by appropriately skilled and experienced personnel.

The output is challenged and tested independently of the underwriting function by individuals who have sufficient knowledge, experience and status.

Once risks have been identified, they must then be assessed as to their potential severity of impact (generally a negative impact, such as damage or loss) and to the probability of occurrence. These quantities can be either simple to measure, in the case of the value of a lost building, or impossible to know for sure in the case of the probability of an unlikely event occurring. Therefore, in the assessment process it is critical to make the best educated decisions in order to properly prioritize the implementation of the risk management plan.

Even a short-term positive improvement can have long-term negative impacts. Take the "turnpike" example. A highway is widened to allow more traffic. More traffic capacity leads to greater development in the areas surrounding the improved traffic capacity. Over time, traffic thereby increases to fill available capacity. Turnpikes thereby need to be expanded in a seemingly endless cycles. There are many other engineering examples where expanded capacity (to do any function) is soon filled by increased demand. Since expansion comes at a cost, the resulting growth could become unsustainable without forecasting and management.

The fundamental difficulty in risk assessment is determining the rate of occurrence since statistical information is not available on all kinds of past incidents. Furthermore, evaluating the severity of the consequences (impact) is often quite difficult for intangible assets. Asset valuation is another question that needs to be addressed. Thus, best educated opinions and available statistics are the primary sources of information. Nevertheless, risk assessment should produce such information for the management of the organization that the primary risks are easy to understand and that the risk management decisions may be prioritized. Thus, there have been several theories and attempts to quantify risks.
Numerous different risk formulae exist, but perhaps the most widely accepted formula for risk quantification is:

Rate (or probability) of occurrence multiplied by the impact of the event equals risk magnitude

**What constitutes a ‘material and reasonably foreseeable accumulation’?**

As a minimum it is expected that managing agents will put in place a structured process for recording exposure and monitoring accumulations where accumulations represent 10% or more of syndicate capacity (gross of reinsurance). It is important to note here that the Realistic Disaster Scenarios (RDS) do not necessarily represent the full range of accumulations to be monitored. Each managing agent is expected to form an independent view of the risks it faces and should manage those risks accordingly.

**Choosing the right approach**

Amongst managing agents’ considerations will be:

- Effective tools used generally in market sectors
- The capability of in house staff to create appropriate tools and analyse accumulations of exposure.

**Importance of loss modeling**

At its core is the importance for managing agents to understand their potential for loss, ensure that this is in line with their intended risk appetite and ensure that exposures are managed accordingly. Understanding loss potential should be one element within an integrated approach to managing the business. Significant changes in exposure should be under continuous review and management.
Modeling encompasses a variety of possible methodologies

The requirement for assessing and modeling exposure needs to be interpreted taking account of the individual business’s scale and risk profile:

- There is no one approach to the modeling of loss potential, as the methods must suit the class of business. Neither is there a requirement to use external models over those developed by skilled personnel within managing agents - some modeling processes will not involve bespoke computer programmers’.

- Dependent upon the nature of the risk accumulations a range of modelling solutions, from the very simple to the highly complex, may be necessary.

- in addition to considering what constitutes an effective model, it is necessary to be clear about how the outputs from such models should be used.

- it is for the managing agent to demonstrate that their choice of modelling approach is appropriate, that the outputs are accurate, relevant and that outputs are used effectively.

A robust process

the modeling process (es) should be documented (including information inputs and use of outputs), the owner(s) specified and the personnel running them should be suitably experienced. The robustness of the process should be audited by suitably experienced personnel. These aspects apply to modeling processes developed ‘in house’ and to processes sourced externally.

Validating loss modeling outputs

Outputs are expected to be validated (regardless of ‘custom & practice’ or historical effectiveness) and this can be done in various ways, dependent upon the nature of risks involved:

- Peer review by suitably experienced personnel.
• Checked against the outputs from one or more different modeling approaches – where two approaches generate significantly different results managing agents should establish what is creating the variance.

• Following a material event, managing agents should review their existing model’s underlying assumptions and should recalibrate their models if necessary, as soon as practicable.

• **Consistency of approach**
  The inputs and outputs should be entirely aligned with other management processes, as well as being used consistently. Any inconsistency between output from exposure modeling and input to ICA calculations will need to be understood.

**PERIL**

In Insurance the term “peril” is:

- The cause of an injury,
- The reason something is damaged or destroyed,
- The way something was lost or is no longer in your possession.

Insurance companies generally label a particular risk as a “peril” which may cause a loss or damage. A peril may include such things as fire, **earthquake**, windstorm, **flood**, or theft to name just a few.

- **Named Peril** coverage sometimes known as **Specified Peril Insurance**. These policies cover losses for only a named peril specifically stated in the policy. For example, a Standard Fire Policy will cover the two specifically named perils of fire and lightning. Other perils can be added by endorsement, such as theft and vandalism, or malicious mischief. Additional coverage for **Earthquake** might be considered, or obtaining **Flood Insurance** may be needed if the risk flood is high. Named peril policies specify the perils, causes of damage or loss, and states the policy limits. These policies generally offer the lowest premium and the fewest risks of loss will be covered.

- **All-Risk** insurance or **open peril** coverage is generally more expensive however, an all-risk policy will cover losses and pay claims for damages to personal property when the peril is direct, sudden and accidental and isn’t excluded in the policy.
“All-risk” policies cover all perils that are not specifically listed as excluded the policy contract. Often, the terms “comprehensive” or “open peril” are used to define all-risk coverage.

With an all-risk policy the premium is generally higher, and the coverage is broad. However, careful review of the “excluded” causes of loss should be made. Even the most comprehensive homeowner policy for example doesn’t cover losses caused by flooding, and may not include earthquake without an endorsement.

“Open Perils” and “Named Perils” Coverage

A peril, as referred to in an insurance policy, is a cause of loss, such as fire or theft. Coverage can be provided on an “all perils” basis, or a “named perils” basis. Named Perils policies list exactly what is covered by the policy, while Open Perils (or All Perils) policies will list what is excluded from coverage. Named Perils policies are generally more restrictive. A dwelling policy usually provides coverage for both the dwelling and contents on a named perils basis, while a home owners policy usually provides coverage for the dwelling on an all perils basis, and for the contents on a named perils basis.

Package versus Peril-Specific Coverage

A package policy provides coverage for multiple, but usually not all perils. A home owners policy, for example, is a package policy typically providing coverage for the perils of fire, lightning, and extended coverage. Extended coverage includes coverage for the perils of windstorm, hail, explosion, riot, civil commotion, aircraft, vehicles, smoke, vandalism, malicious mischief, theft, and breakage of glass. Some policies, such as earthquake or flood policies, provide coverage for specific perils that are often excluded in package policies. Fire and sprinkler leakage damage as a result of an earthquake may be covered by a standard home owners policy. To purchase the most appropriate insurance, it is important for you to consider what additional perils you may face. And, you should always verify what is covered in your specific policy.

Any risk that can be quantified can potentially be insured. Specific kinds of risk that may give rise to claims are known as perils. An insurance policy will set out in detail which perils are covered by the policy and which is not. Below are non-exhaustive lists of the
many different types of insurance that exist. A single policy may cover risks in one or more of the categories set out below. For example, vehicle insurance would typically cover both the property risk (theft or damage to the vehicle) and the liability risk (legal claims arising from an accident). A home insurance policy in the US typically includes coverage for damage to the home and the owner's belongings, certain legal claims against the owner, and even a small amount of coverage for medical expenses of guests who are injured on the owner's property.

Business insurance can take a number of different forms, such as the various kinds of professional liability insurance, also called professional indemnity (PI), which are discussed below under that name; and the business owner's policy (BOP), which packages into one policy many of the kinds of coverage that a business owner needs, in a way analogous to how homeowners' insurance packages the coverage that a homeowner needs.

At the most basic level, initial ratemaking involves looking at the frequency and severity of insured perils and the expected average payout resulting from these perils. Thereafter an insurance company will collect historical loss data, bring the loss data to present value, and compare these prior losses to the premium collected in order to assess rate adequacy. Loss ratios and expense loads are also used. Rating for different risk characteristics involves at the most basic level comparing the losses with "loss relativities"—a policy with twice as many losses would therefore be charged twice as much. More complex multivariate analyses are sometimes used when multiple characteristics are involved and a univariate analysis could produce confounded results. Other statistical methods may be used in assessing the probability of future losses.

Upon termination of a given policy, the amount of premium collected minus the amount paid out in claims is the insurer's underwriting profit on that policy. Underwriting performance is measured by something called the "combined ratio" which is the ratio of expenses/losses to premiums. A combined ratio of less than 100 percent indicates an underwriting profit, while anything over 100 indicates an underwriting loss. A company with a combined ratio over 100% may nevertheless remain profitable due to investment earnings.
Insurance companies earn investment profits on "float". Float, or available reserve, is the amount of money on hand at any given moment that an insurer has collected in insurance premiums but has not paid out in claims. Insurers start investing insurance premiums as soon as they are collected and continue to earn interest or other income on them until claims are paid out. The Association of British Insurers (gathering 400 insurance companies and 94% of UK insurance services) has almost 20% of the investments in the London Stock Exchange.

In the United States, the underwriting loss of property and casualty insurance companies was $142.3 billion in the five years ending 2003. But overall profit for the same period was $68.4 billion, as the result of float. Some insurance industry insiders, most notably Hank Greenberg, do not believe that it is forever possible to sustain a profit from float without an underwriting profit as well, but this opinion is not universally held. Naturally, the float method is difficult to carry out in an economically depressed period. Bear markets do cause insurers to shift away from investments and to toughen up their underwriting standards, so a poor economy generally means high insurance premiums. This tendency to swing between profitable and unprofitable periods over time is commonly known as the underwriting, or insurance, cycle.

**Perils & Clause of Insurance Policies**

**PERILS COVERED**

The major perils covered in a fire policy can be grouped as:-

**Fire Perils**

- Fire.
- Explosion / implosion.
- Aircraft damage.
- AOG perils.
- Lightning. Storm, cyclone, tempest, hurricane, tornado & flood.
- Subsidence & landslide including rock slide.

**Social Perils**
- Riot, strike, malicious damage.
- Terrorism (the optional cover).

Other perils
- Impact damage.
- Bursting or overflowing of water tanks & pipes.
- Bush fire.

Fire Perils

Fire - actual ignition by accident means, and does not include the following:
- Property undergoing drying / heating process.
- Burning by order of public authority.
- Spontaneous combustion.

EXPLOSION / IMPLOSION

Explosion due to domestic boilers is covered, but explosion due to industrial boilers are covered under “Boiler Pressure plant Machinery”. Explosion by centrifugal forces are not covered.

AIRCRAFT DAMAGE

Aerial devices, space craft causing direct physical impact damage are covered. Damage by falling objects are also covered. Shattering of wall due to sonic boom is not covered.

AOG PERILS

LIGHTNING

Lightning means visual discharge of atmospheric electricity. Only direct effects are covered and indirect effects like voltage surge are not covered.

SCOTTTHF

Storm, cyclone, tempest, typhoon, tornado, hurricane, flood and inundation.
Wind as per Beaufort Index of wind velocity and location. Based on the wind speed and velocity it is classified and is called differently in different places.
Flood

- Water coming out of its natural confines ex: Drainage overflows, water tank overflows is also considered as flooding.
- Inundation entry of floodwater into the property.
- Landslide / Subsidence Gradual sinking or settling in of soft sub soil.

SOCIAL PERILS

RSMD

- Riot - unlawful assembly of 4 or more persons.
- Strike - revolt against established authority.

Malicious Damage

- Damage caused due to personal grouse or ill will.
  All acts of commission are covered and Acts of omission are not covered.
  Eg: During strike employees may cause physical damage. This is an act of commission. This is covered.
- Failure to switch off fan and consequential damage caused due to this is not covered. This Is an act of omission and is not covered.
- Prevention of access is not covered. Burglary and theft during RSMD is covered.

OTHER PERILS

- Impact damage - damage due to collision with third party. Impact damage from insured's own vehicle or vehicle of his employees is not covered.
- Missile testing - exposure to this risk is mainly present along the Indian East coast near Gopalpura region. Any damage due to wrong firing of missiles is covered.
- Inadvertent leakage from sprinklers other than defects and repairs are covered.
- Bush Fire - fire from foliage other than forest fire is covered.

EXCLUSIONS
• War and war group of perils.
• Nuclear group of perils.
• Earthquake / volcanic eruption.
• Theft / burglary except during strike.
• Electrical fire due to short circuit, arcing, excess of voltage.

**Excluded Property**

• Bullion, curios, plans and drawings beyond Rs 10,000.00.
• Loss or damage to machinery when removed to another place for repair for a period beyond 60 days.

**Excluded Losses**

• Consequential losses.
• Damage by spoilage due to interruption of any process.
• Damage to stocks in cold storage premises.

**RULES AND REGULATIONS UNDER TARIFF**

**One Industry One Rate**

As per the new guidelines, the principle of One Industry One Rate should be followed. It is important to classify the industry as per the correct risk code.

**No selection of Property**

All property has to be covered and selection of property is not allowed in Fire Insurance.

**BLOCKWISE SUM INSURED**

• Building.
• Plant and machinery.
• Stock.
• Stock in process.
• Furniture.
• Fittings.
RISKS ARE COVERED IN TWO MAJOR HEAD

Non Industrial Risks

Includes dwellings, shops, hotels, schools, colleges, clubs, office premises etc.

Industrial Risks

Eg: Chemical, textile, rubber, cement, sugar etc.

PERILS PARTICULAR TO PARTICULAR INDUSTRY

There are certain perils which are not common across the board, but are specific to certain industries only like:-

- Spontaneous Combustion - coal.
- Material Spoilage - breweries.

These can be added on as optional to the standard policy.

SPECIAL STOCK INSURANCE POLICY

FLOATING POLICIES

Floating policies are policies which are taken to insure the risk at a number of locations under one policy. Floating policies can be issued in respect of immovable property. It is permissible to issue a policy covering stock in one account in more than one specified building or in open within the limit of one city / town / village.

DECLARATION POLICIES

Declaration policies are policies which are issued in case there is a fluctuating stock balance throughout the year. These policies are issued for the highest sum insured throughout the year & the unused balance is refunded against declarations.

BASIS OF VALUATION POLICY

Reinstatement value policies are taken for covering a risk for the value of it’s reconstruction / replacement / reinstatement in case of a loss. This basis of valuation is
followed while taking up the insurance policy to ensure that the insured is adequately covered in case of a loss. Reinstatement value insurance may be granted on buildings, machinery, furniture, fixture & fittings only.

SPECIAL / RATED RISKS

Certain industries can be given special confessional rate which has to be granted by the Tariff Advisory Committee only.

SPECIAL CLAUSE

Escalation Clause

An increase in the sum insured throughout the period of the policy can be opted by the insured in return for an additional premium to be paid in advance.

INSURANCE OF ADDITIONAL EXPENSES OF RENT FOR AN ALTERNATIVE ACCOMMODATION

Additional expense of rent for an alternative accommodation in respect of non-manufacturing risks may be covered under Fire Material Damage policy only on the following basis:

- The cover may be granted for non-manufacturing premises only.
- The rate should be same as applicable to the existing premises under occupation.
- The additional expense recoverable under the policy may be additional rent actually paid i.e., the difference between the new and the original rent only.
- Insurance should be granted against RSMTD and earthquake & other extraneous perils.
- The cover may be limited to building f superior and class I construction.

LOSS OF RENT CLAUSE

Where loss of rent caused by insured perils is covered, the rate chargeable for the above cover is the rate applicable to the particular building or premises concerned.
OMISSION TO INSURE ADDITIONS, ALTERATION OR EXTENSIONS CLAUSE

The insurance by this policy extends to cover buildings and / or machinery, plant and other contents as defined in columns here of which the insured may erect or acquire or for which they may become responsible:

- At the within described premises.
- For use as factories.

RATING CALCULATION OF PREMIUM

The tariff Advisory Committee vide its circular dated 04.12.06 has withdraw the rates applicable under the fire Tariff w.e.f.01.01.07.

Now company would have to file fresh rates with the TAC under the new file and use guidelines.

AVERAGE

By applying the Principle of average, the adequacy of Sum insured is checked. Under insurance is penalized. Claims are settled on the following basis:

Claim Amount = Loss x Sum insured value

CONTRIBUTION

In case of multiple insurers then the loss will be borne by them as per their ratios and proportions.

SUBROGATION

Any claim is to be settled by the person who perpetuated the loss. After indemnifying the insured, the insurer steps into the shoes of the insured. Subrogation is the transfer of rights and remedies of the insured against the Third party to the insurer.
RE-INSTATEMENT OF SUM INSURED

Sum insured is per policy limit. Any claim settled will reduce the Sum insured by the claim amount. Sum insured will be re-instated by payment of additional premium for the un-expired period from date of loss.

Case of Shri Ram Insurance:

Clauses

Following clauses may be attached to the Policy by adjusting or providing additional Sum Insured where applicable.

i. Agreed Bank Clause
ii. Architects', Surveyors' and Consulting Engineers' Fees Clause
iii. Designation of Property Clause
iv. Escalation clause
v. Omission to Insure Additions, Alterations or Extensions Clause
vi. Temporary Removal of Stocks Clause

Section I - Material Damage

In consideration of the insured paying to the Company, the premium shown in the schedule, the Company agrees (subject to the terms, conditions and exclusions contained herein or endorsed or otherwise expressed hereon which shall so far as the nature of them respectively will permit be deemed to be conditions precedent to the right of the Insured to recover hereunder) that if after payment of the premium any of the property insured be accidentally physically lost destroyed or damaged other than by an excluded cause during the period of insurance or any subsequent period in respect of which the insured shall have paid and the Insurer shall have accepted the premium required for the renewal of this policy, the Insurer will pay to the Insured the value of the property at the time of the happening of its accidental physical loss or destruction or damage (being hereinafter termed Damage) or at its option reinstate or replace such property or any part thereof.
Provided that the liability of the Insurer in respect of any one loss or in the aggregate in any one period of insurance shall in no case exceed a. As regards buildings, plants and machinery, furniture, fixture, fittings etc. the cost of replacement or reinstatement on the date of replacement or reinstatement subject to the maximum liability being restricted to the sum insured in respect of that category of the item under the policy. As regards stocks the market value of the same not exceeding the sum insured in respect of that category of item under the policy.

EXCLUSIONS

A. EXCLUDED CAUSES

1) This policy does not cover damage to the property insured caused by:
   a) i) faulty or defective design materials or workmanship inherent vice latent defect gradual deterioration deformation or distortion or wear and tear
   ii) Interruption of the water supply gas electricity or fuel systems or failure of the effluent disposal systems to and from the premises. Unless Damage by a cause not excluded in the policy ensues and then the Insurer shall be liable only for such ensuing Damage.
   b) i) collapse or cracking of buildings
   ii) corrosion rust extremes or changes in temperature dampness dryness wet or dry rot fungus shrinkage evaporation loss of weight pollution contamination change in color flavor texture or finish action of light vermin insects marring or scratching Unless such loss is caused directly by Damage to the property insured or to premises containing such property by a cause not excluded in the policy
   c) i) larceny
   ii) acts of fraud or dishonesty
   iii) Disappearance unexplained or inventory shortage misfiling or misplacing of information shortage in supply or delivery of materials or shortage due to clerical or accounting error
   d) i) coastal or river erosion
   ii) Normal settlement or bedding down of new structures.
2) Damage caused by or arising from :-
a) any willful act or willful negligence on the part of the Insured or any person acting on his behalf b) cessation of work delay or loss of market or any other consequential or indirect loss of any kind or description whatsoever 3) Damage occasioned directly or indirectly by or through or in consequence of any of the following occurrences, namely:-
a) war invasion act of foreign enemy hostilities or warlike operations (whether war be declared or not) civil war
b) Mutiny civil commotion assuming the proportions of or amounting to a popular rising military rising insurrection rebellion revolution military or usurped power
4) i) permanent or temporary dispossession resulting from nationalisation commandeering or requisition by any lawfully constituted authority
ii) permanent or temporary dispossession of any building resulting from the unlawful occupation of such building by any person provided that the Insurers are not relieved of any liability to the Insured in respect of Damage to the property insured occurring before dispossession or during temporary dispossession which is otherwise insured by this Policy
iii) the destruction of property by order of any public authority In any action, suit or other proceeding where the Insurer alleges that by reason of the provisions of Exclusions A3 (a) and (b) above any loss destruction or damage is not covered by this insurance the burden of proving that such loss destruction or damage is covered shall be upon the Insured.
5) Damage directly or indirectly caused by or arising from or in consequence of or contributed confiscation to by:-
a) Nuclear weapons material
b) Ionizing radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. Solely for the purpose of this Exclusion Combustion shall include any self-sustaining process of nuclear fission.

B. EXCLUDED PROPERTY

This Policy does not cover:
1) Money cheques stamps bonds credit cards securities of any description jewellery precious stones precious metals bullion furs curiosities rare books or works of art unless specifically mentioned as insured by this policy.

2) Unless specifically mentioned as insured by this Policy goods held in trust or on commission documents manuscripts business books computer systems records patterns models moulds plans designs explosives

3) a) vehicles licensed for road use (including accessories thereon) caravans trailers railway locomotives or rolling stock watercraft aircraft spacecraft or the like b) property in transit other than within the premises specified in the Schedule c) property or structures in course of demolition construction or erection and materials or supplies in connection therewith d) land (including top-soil back-fill drainage or culverts) driveways pavements roads runways railway lines dams reservoirs canals rigs wells pipelines tunnels bridges docks piers jetties excavations wharves mining property underground off-shore property unless specifically covered. e) livestock growing crops or trees f) property damaged as a result of its undergoing any process g) property undergoing alteration repair testing installation or servicing including materials and supplies therefore if directly attributable to the operations of work being performed thereon unless Damage by a cause not otherwise excluded ensues and then the Insurer will be liable only for such ensuing loss

h) Property more specifically insured

i) property insured if removed to any building or place other than in which it is herein stated to be insured, except machinery and equipments temporarily removed for repairs, cleaning, renovation or other similar purpose for a period not exceeding 60 days.

j) damage to property which at the time of the happening of such damage is insured by or would for the existence of this policy be insured by any marine policy or policies except in respect of any excess beyond the amount which would have been payable under the marine policy or policies had this insurance not been effected.

Section II - Business Interruption

The Insurers agree that if during the period of insurance the business carried on by the insured at all the premises specified & listed in the Schedule is interrupted or interfered
with in consequence of loss destruction or damage indemnifiable under Section I, then the Insurers shall indemnify the Insured for the amount of loss as hereinafter defined resulting from such interruption or interference provided that the liability of the Insurers in no case exceeds the total sum insured or such other sum as may hereinafter be substituted therefor by Endorsement signed by or on behalf of the insurers Special.

Exclusions to Section II:

1. This Policy does not cover loss resulting from interruption of or interference with the business directly or indirectly attributable to
1.1. Any restrictions on reconstruction or operation imposed by any public authority
1.2. The Insured's lack of sufficient capital for timely restoration or replacement of property lost destroyed or damaged
1.3. Loss of business due to causes such as suspension lapse or cancellation of a lease license or order etc. which occurs after the date when the items lost destroyed or damaged are again in operating condition and the business could have been resumed, if said lease license order etc. had not lapsed or had not been suspended or cancelled.
1.4. Damage to boilers economizers turbines or other vessels machinery or apparatus in which pressure is used or their contents resulting from their explosion or rupture.
1.5. Electronic installations, computers and data processing equipment.
1.6. Damage resulting from:
a) Deliberate erasure loss distortion or corruption of information on computer systems or other records programs or software.
b) Other erasure loss distortion or corruption of information on computer systems or other records programs of software unless resulting from fire lightning explosion aircraft, impact by any road vehicle or animals earthquake, hurricane, windstorm flood, bursting overflowing discharging or leaking of water tanks apparatus or pipes in so far as it is not otherwise excluded unless caused by Damage to the machine or apparatus in which the records are mounted.
1.7. Mechanical or electrical breakdown or derangement of machinery or equipment.
2. This Policy does not cover the deductible stated in the Schedule to be borne by the Insured.

OPERATIONAL CONTROL

The managing agent has effective systems and controls over each managed syndicate's underwriting.

Principle

The managing agent has effective systems and controls over each managed syndicate's underwriting.

Minimum standards

The managing agent's board should ensure that there are effective underwriting systems and controls in place. See below for guidance on effective systems and controls. Effective systems and controls have the following features: They ensure that underwriting takes into account:

- The syndicate's annual business plan and underwriting policy
- The underwriter's terms of reference and authorities pricing policy
- Exposure management information
- The syndicate's reinsurance arrangements
- Requirements to achieve Pre-Bind Quality Assurance (PBQA), including Contract Certainty.
- External regulatory requirements

They ensure that the managing agent keeps (or has the right to access) all relevant information in respect of each risk underwritten by the syndicate including the slip and the placing documentation. They ensure that a representative range of risks underwritten by the syndicate is reviewed and assessed regularly by an appropriately qualified individual who is independent of the underwriter of those risks.

They ensure that underwriting decisions are the subject of an appropriate peer review process. They require the referral of risks or underwriting decisions which are outside an underwriter's agreed levels of authority.
Effective systems and controls - Overview

Effective systems and controls are essential for the delivery of the managing agent's strategic and business plans. To facilitate this it is expected that the managing agent's board will nominate one director to be responsible for the managing agent's underwriting systems and controls and ensure that the nominated director and supporting staff have the requisite skills, experience and available time to manage and execute the controls effectively.

Reference to 'Effective systems and controls' should be interpreted as widely as necessary for the effective management of each syndicate. Controls are seen broadly to sit under two headings:

- Prevention controls - These include, for example, written authorisation and proactive management of each individual's underwriting authority and the proactive management of any variances to prescribe procedures/authorities.
- Detection controls - These include, for example, internal audit reviews, peer review processes and independent reviews.

Managing agents' controls would normally reflect the levels of value and the degree of risk within their underwriting activities. It is expected that managing agents will have their systems and controls for the effective management of each syndicate set out in writing.

Case for operation checklist for Underwriting:

“Insurance underwriting risk” is the risk that an insurance company will suffer losses because the economic situations or the occurring rate of incidents have changed contrary to the forecast made at the time when a premium rate was set. Inspectors will verify and inspect the insurance underwriting risk of insurance companies using “Risk Management Systems Checklists (Common Items)”, and “Insurance Underwriting Risk Checklist”. They will also inspect responsibility reserve fund and liability reserves by using ”Responsibility reserve fund, etc.” and ”Liability reserve Inspection Manual”. Inspections on solvency margin ratio, etc. will be performed by using the “(Attachment) Inspections concerning Solvency Margin Ratio, etc.” of the “Real Estate Investment Risk
Checklist” on the basis of the checklists and manuals for “Asset Investment Risk”, “Market Risk”, “Credit Risk”, “Real Estate Investment Risk” as well as this checklist and manual.

In this checklist and manual, “Responsibility reserve fund” refers to the responsibility reserve fund set forth in Article 116 of the Insurance Business Law (hereinafter to be called “Law”), “Responsibility reserve fund, etc.” refers to responsibility reserve fund, reserves for dividends to policyholders and equal deposit of dividends to policyholders as stipulated in Article 28 of the Implementing Regulation of the Insurance Business Law (hereinafter to be called “Regulation”) and life insurance companies’ reserves for dividends to policyholders as stipulated in Article 64 of the Regulation. “Liability reserves” refers to the liability reserves as stipulated in Article 117 of the Law.

This checklist and manual apply to all insurance companies, including the foreign offices of Japanese insurance companies (foreign branch, foreign subsidiaries, and offices of the overseas workers, etc., though whether to include these offices in the inspection by this checklist and manual will be determined in light of applicable laws and ordinances, including applicable foreign-country laws and ordinances) and the Japan offices of foreign insurance companies.

It is expected that, as part of the efforts to ensure sound and proper operations and in accordance with the principle of self-responsibility, individual insurance companies will fully exercise their creativity and innovation to voluntarily create their own detailed manuals. These insurance company manuals should make note of the content of this manual and be adapted to the size and nature of the insurance company.

The check points in this manual represent standard to be used by inspectors in evaluating the risk management systems of insurance companies. They do not constitute direct statutory obligations to be achieved by insurance companies. Care must be taken that the manual is not adopted by rote and uniformly. If there may be cases in which the checklist description has not been fulfilled literally, by insurance company, in the light of ensuring the soundness and appropriateness of its operation only the time that the measures by insurance company are equivalent in their effects to the descriptions for the check point or are sufficient given the size and nature of the insurance company, these measures
would not be deemed inappropriate. Inspectors will therefore need to fully dialogue relevant points with insurance companies during on-site inspections.

Note: Explanation of check points

① Unless explicitly stated otherwise, items expressed in the question form such as “does the insurance company” or “is the insurance company” are minimum standards that are expected of all insurance companies. Inspectors, as they go through their checklists, need to fully verify the effectiveness of these items.

② Unless explicitly stated otherwise, items worded in the form of “it would be desirable that” constitute “best practice(sound practice)” for all insurance companies. Inspectors need only confirm these items.

Note: Distinction between “board of directors” and “board of directors, etc.”

① Items that are defined as roles of the “board of directors” are items for which the board of directors itself needs to determine all essential matters. This does not, however, preclude the board of directors from delegating consideration of draft documents to the management committee or similar bodies.

② the phrase “board of directors, etc.” includes the board of directors, the management committee, the management meeting, and similar bodies. Items that are defined as roles of the “board of directors, etc.” would ideally be determined by the board of directors itself, but may be delegated to the management committee, etc. provided that there has been a clear delegation of this authority from the board of directors, the management committee, etc. has kept minutes of its proceedings and other materials that would allow after-the-fact confirmation, and there are adequate internal checking by the measure the results are reported to the board of directors, or auditors are allowed to participate in the management committee, etc.

Note: Explanation of “business base”, “business bases”, “insurance sales”

① The phrase “business base” refers to organizations other than the head office that constitute business bases, such as branch offices, business headquarters, foreign branch offices, and foreign subsidiaries. The phrase “business bases” refers to organizations other than the head office that do not engage in sales activities, such as operating bases, service centers, and foreign liaison offices.
The phrase “insurance sales” refers to insurance agency or insurance agent and does not include insurance broker.

INTRODUCTION

Underwriting and claims settlement are the two most important aspects in the functioning of an insurance company. In the present highly competitive and economically challenging environment, claims settlement can serve as a market differentiator that puts insurance companies at the forefront of industry leadership and innovation.

To be successful, insurers need to improve the operational efficiency of their claim organizations and build an operating model that can minimize claim costs as well as eliminate the unnecessary expenses associated with claims handling.

Many insurers have distinct claim operations, personnel and units that focus on the products (non-life and life) they offer to individuals or on different business sectors. This model often results in massive and soloed claim organizations with unique unit configurations, systems infrastructures and processes for each market segment or line of business. Moreover, in high-volume or highly complex operations, inefficient or sub-optimal process steps can be replicated, often with costly implications to insurers. Consequently, insurers struggle to maintain control over these organizations and implement consistent models for managing claim operations.

Claim best practices look fantastic when they’re mapped on whiteboards, but often fall short when insurers don’t have the ability to execute them. Moreover, each claim
settlement process requires a customized approach that takes into consideration the specific characteristics of the claim.

A strong case management platform helps insurers integrate legacy improvement assets into claim improvement strategies. Insurers can use BPM technology to unlock these static tools and achieve functionality that previously was not possible.

In addition, an efficient case management platform allows insurers to begin automating subsets or entire portions of end-to-end claim processes. To contain costs insurers need to automate work that is of little value to the organization, and let an intelligent system manage the claim process steps that require little or no human intervention. Insurers can realise efficiency, expense and productivity gains by using work automation to manage simple claims.

To do that, insurers should eliminate paper-intensive, inefficient and error-prone file processes. Adjusters need intuitive business tools that can automatically take action based on claim information. A BPM-enabled case management approach supports an optimised claim process by providing a work engine that can organise and manage complex pieces of work across operational silos. It also provides end-to-end visibility into a claim event or a claim operation - something all claim managers love, but are often forced to do without.

The right case management solution can break down claim processes into an infinite number of sub-claim units, each of which is able to be routed, managed and monitored individually, while still providing insight and control. Adjusters and managers can leverage real-time analytics to get comprehensive views of claim operations any time. They have the ability to view and re-route work as needed, enabling a dynamic response to complex claims or shifts in work volume. Insurers can use this insight to drill down into specific tasks to understand which processes are working well, and which are not.

Insurers can apply these concepts to track, measure, and report on an infinite number of sub-units under the primary claim event. This further drives best practice processes and can be extended to other lines of business; it also gives insurers the flexibility to systematically integrate claim processes that are historically segregated or require manual
intervention - a must for insurers trying to contain overall claim costs or bundle new product offerings.

In addition to the competitive environment in which insurance companies operate, these businesses are challenged by more stringent compliance with government regulations and increasing expectations on the part of consumers. Efficient claims management is vital to the success of both large and small companies working within the insurance industry. Major components of the claims handling process include developing strategies to cut costs and reduce fraud while keeping customers satisfied. Small companies in particular can benefit from claims management tools and technology.

**Settling Claims**

Settling insurance claims is just one aspect of the claims management process. The time it takes to process a claim involves several stages beginning with a person filing a claim. The stages that follow determine if a claim has merit as well as how much the insurance company will pay. Insurance customers expect a company to settle claims quickly and to their satisfaction. Because high customer satisfaction levels can give a company a competitive edge, reducing the time it takes to settle insurance claims is one way to decrease the number of customer complaints and improve service. The use of claims management system software that speeds the process and minimizes costs offers a practical solution. Simplifying the claims process through automation helps reduce expenses for smaller companies that operate with smaller budgets.

**Detecting Fraud**

Paying fraudulent claims costs insurance companies money -- a cost the insurance industry then passes on to its customers. Consequently, underwriting guidelines become tougher and the insurance premiums consumers pay increase. Software tools designed to examine payment history and evaluate trends in claim payoffs can help insurance companies detect fraud, according to Wipro, a global IT business. For example, how often the same individual files an insurance claim can be a warning that a person might be filing a fraudulent claim. Unfortunately, settling claims too quickly increases a company’s chance of paying out on a greater number of fraudulent claims. Unlike large
companies that can absorb some losses as a part of doing business, small companies quickly suffer the negative effect on net earnings when paying fraudulent claims. Then again, processing insurance claims too slowly increases the risk of losing dissatisfied customers. In a highly competitive insurance market, small companies can't afford to lose customers.

**Lowering Costs**

Monitoring costs throughout the claims management process determines how much of a customer’s premium rate goes toward paying for the insurance company’s administrative costs. Generally speaking, when settling a claim is delayed, it costs the insurance company more money. The higher claim costs reduce profitability. For small and large insurance companies alike, automation of some of the claims management process can help decrease a company’s operating costs. One example is the increased cost of investigating a claim manually. Information technology systems, though, improve efficiency by decreasing the number of claim errors, detecting fraud early and reducing the time it takes to process and settle a claim -- all factors that cut an insurance company’s costs and increase profitability. Even in a healthy economy, running a small business can be tough. Other essential functions of the claims management process that can reduce costs include developing programs directed at preventing claims before they occur and avoiding future claims.

**Avoiding Litigation**

In most cases involving insurance claim disputes, the insurance company eventually agrees to pay an equitable amount if a customer has a legitimate claim and can present evidence supporting it. Although quickly settling a claim can avoid the chances for litigation, accurate liability assessment is crucial to achieving a quick resolution in a claim dispute. Insurers work to evade litigation because it substantially increases the company's cost of settling a claim. For instance, one-time cases where a person misrepresents information he provides on an insurance application can be expensive for an insurance company to prove legally. Causing a company financial loss is another reason to avoid litigation. Small insurance companies are not immune but rather are increasingly exposed to potential litigation involving claim disputes.
Six Steps in Making an Insurance Claim

- Contact your insurance agent immediately
- Carefully document your losses.
- Protect your property from further damage or theft.
- Working with your adjustor.
- Settling your claim.
- Repairing your home

A) **Contact the insurance agent immediately**

Give name, address, policy number, and the date and time of loss.
Make sure to tell the insurer where they can be reached, especially if you are unable to stay in your home.
Follow up the call with a letter detailing the problem. Keep a copy of the letter.
The insurance agent will arrange for an adjustor to visit your property and assess the damage. Be sure the adjustor is properly licensed.

B) **Step Two: Carefully Document the Losses**

Make a detailed list of lost or damaged property.
Videotape or photograph damaged property before beginning any repairs
Do not throw away damaged property without your adjustor’s approval.
Try to document the value of each object lost. Bills of sale, canceled checks, charge account records, and insurance Evaluations are good evidence. If you have no such records, estimate the value, and give purchase place and date of Purchase. Include this information with the list.

List cleaning and repair bills, including materials, cost of rental equipment, and depreciation of purchased equipment.
The insurance companies have hitherto been handling the claim rather than managing them. Typically this process involves –

i. As soon as a claim is reported, the insurance company checks as to whether the cover was in force at the time of loss and whether the peril is covered under the policy.

ii. A surveyor is appointed who visits the spot, do the assessment and submits the report.

iii. Insurance company examines the report, calls for relevant supporting documents.

iv. On receipt of survey report and documents, the same are examined. The claim file is processed and settlement is offered.

The claims handling is thus more process oriented and does not pay adequate attention to the monitoring and claims cost aspect as also to the service parameters.

In the present liberalized scenario, with cut-throat competition being the order of the day, the insurance companies have to go much beyond the handling of claims. The following aspect needs to be kept in mind.

I. General insurance being a market driven service industry, the customer has to be kept satisfied. With so many options available, a customer once lost is most likely a loss forever. Claim settlement can be used as a marketing tool. Bringing in a new customer is much more costly than retaining the existing ones.

II. In a de-tariffed market, pricing will be the key factor. Proper claims management – quick settlement at optimal cost will help keep the price competitive.

III. A dissatisfied customer is a bad publicity. It has all the potential to damage the reputation of the company. It is an accepted fact that most of the customers complaint relate to claims. It should be the endeavor of any insurance company to ensure that such complaints do not occur in the first place and in some cases if they do occur it is attended promptly, efficiently and transparently.

IV. IRDA guidelines on ‘protection of policyholders’ interest’ stipulates certain obligation on the part of insurance company including time limit for claim settlement. This is a regulatory requirement and insurance company personnel at every level must understand its implication.
V. Delayed claim settlement generally result in higher claims cost. Claims cost is a very important factor vis-à-vis profitability. Why do delays take place in claim settlement? Nobody will buy the excuse that the claimant is not forthcoming with documents and other requirements for settlement of claim. Is it because of the delay in submission of survey reports? If so, who is responsible for this? Are we undertaking necessary follow up steps for timely submission of report? The surveyors are duty bound as per IRDA regulations to submit report within a stipulated time. Even after submission of report and completion of other requirements how much time does it take to finally issue settlement cheque and its delivery to the claimant. Do we have a system to monitor it? How about our accounts department people meeting the claimants for a change to understand “the sensitivity of the client” so that they are better sensitized on the issue.

VI. Claims files must be monitored as they progress. A little time spent thinking clearly right from the beginning will avoid lot of unnecessary and time consuming patch-ups and straightening out later on. Unpleasant decisions conveyed timely with proper justification of the decision is better than procrastination which is bound to create more problems and unpleasant situations.

VII. Proper u/w is essential as defective u/w results in complication at the time of settlement of claims. U/w and claims department should not work in isolation. There has to be a coordination between them. Defective U/w may saddle the companies with unwanted claims. Various court judgments and consumers forum awards bear testimony to the same. Any defect / ambiguity in the documents issued invariably goes against insurance companies. It is therefore of utmost importance that the client is made aware in very clear terms about what exactly is covered and what is not. There should be a strong system of audit for examining the documents being issued.

VIII. Lot of time / energy / money is spent when claim cases go to Ombudsman /Consumer Forum/ Court. Besides, adverse comment bring bad name, when we are held liable. Insurance companies are invariably at the receiving end. The “watch and wait”
attitude must change. There is a need to find out why so many cases go to consumer forum or the ombudsman and what should be done about it.

IX. Claims-settlement have social service angle which must be met. In times of natural calamity lot of bad publicity comes to insurance company for delay in settlement of claims. This is in spite of the fact that in such situation insurance companies goes out of their way to settle claims. In any case claims relating to the assets of weaker section needs to be attended on priority. So do the health/medical related claims.

In view of the above, it is necessary that

• Insurance companies manage the claims rather than handling them.
• Insurance companies have a corporate claims management philosophy

Managing claims involves not only claims processing but goes on to cover the entire gamut of claims management – strategic role, cost monitoring role, service aspect as also the role of people handling the claim.

Out of the total outgo on account of claims it is estimated that around 10 to 15% is because of leakages, frauds and inflated claims. In absolute terms this will be a quite substantial amount. If this can be effectively checked, the benefit can be passed on to the customer by way of reduced premium rates.

• Company’s likely future obligations on account of claims and its ability to meet them.
• Solvency aspect and assessing the true picture of the financial health.
• Analysis of claims trend can help to timely initiate remedial action. e.g. restricting a particular class of business.
• Effectiveness of loss control measure.
• Average time being taken for the settlement of a claim and the claim settlement ratio and how it compares with other operators in the market.

The claims management philosophy involves, the company having written corporate philosophy on claims management setting out the broad approach aiming to provide high quality service. It should specify the nature of claim service at each stage of the claim process, the speed of the claim service and also the IT enabled interactive process to know the status of the claim. Without visiting the office. In fact with web-enablement of
claims processing, services from submission of claims to queries on claims status can be affected on line.

Automation of claims processing will result in seamless connectivity of all personnel involved e.g. client, agents, brokers, surveyors, etc. The present low productivity paper intensive system must be replaced to keep up with the modern day requirement. It should also specify grievance redressal procedure. It should be ensured that claim department which has to deal quickly and fairly with all the claims have competent and well trained staff with right attitude.

The claimant should not be treated as an intruder. In fact he is reason for our existence. The time-gap between reporting of claim and its ultimate settlement needs to be reduced to the bare minimum. System of time-audit for self check may be introduced. Lastly a few words on “attitude”. The attitude of people handling claims is important. You cannot face emerging challenges with past mind set and approaches. The personnel of insurance company should therefore change their present attitude, behavior and must show flexibility to effectively respond to the requirements of the markets. They should thus exhibit empathy. Mere ‘sympathy’ will not do. Let’s settle the claim gracefully. Let’s enjoy good image on that count. Let’s enjoy the confidence and good will of our customer for that is the ultimate litmus test for our service. In the likely changes that are going to take place as can be visualized, the differentiating factor amongst the various players in the market will be the pricing, innovative product lines and the quality of service in general and more particular the claims service. Let it be understood very clearly, if the customer does not get good service everyone is going to pay the penalty.

Insurer’s procedures for handling claims are coming under closer scrutiny by the regulators as well as the consumer forum or courts. If recent judgments are any indication, in so far as retail customers are concerned, in the absence of any frauds the insurers may not be able to repudiate the claim on the ground of innocent, non-disclosure or misrepresentation of facts and non-causation of breaches of warrantee and get away with it.
Nature of claim for various classes of insurance

Any risk that can be quantified can potentially be insured. Specific kinds of risk that may give rise to claims are known as perils. An insurance policy will set out in details which perils are covered by the policy and which are not. Below are non-exhaustive lists of the many different types of insurance that exist. A single policy may cover risks in one or more of the categories set out below. For example, vehicle insurance would typically cover both the property risk (theft or damage to the vehicle) and the liability risk (legal claims arising from an accident). A home insurance policy in the US typically includes coverage for damage to the home and the owner's belongings, certain legal claims against the owner, and even a small amount of coverage for medical expenses of guests who are injured on the owner's property.

Business insurance can take a number of different forms, such as the various kinds of professional liability insurance, also called professional indemnity (PI), which are discussed below under that name; and the business owner's policy (BOP), which packages into one policy many of the kinds of coverage that a business owner needs, in a way analogous to how homeowners' insurance packages the coverages that a homeowner needs.

Auto insurance

Auto insurance protects the policyholder against financial loss in the event of an incident involving a vehicle they own, such as in a traffic collision.

Coverage typically includes:

- Property coverage, for damage to or theft of the car
- Liability coverage, for the legal responsibility to others for bodily injury or property damage
- Medical coverage, for the cost of treating injuries, rehabilitation and sometimes lost wages and funeral expenses

Most countries, such as the United Kingdom, require drivers to buy some, but not all, of this coverage. When a car is used as collateral for a loan the lender usually requires specific coverage.
Gap insurance

Gap insurance covers the excess amount on your auto loan in an instance where your insurance company does not cover the entire loan. Depending on the companies specific policies it might or might not cover the deductible as well. This coverage is marketed for those who put low down payments, have high interest rates on their loans, and those with 60 month or longer terms. Gap insurance is typically offered by your finance company when you first purchase your vehicle. Most auto insurance companies offer this coverage to consumers as well. If you are unsure if GAP coverage had been purchased, you should check your vehicle lease or purchase documentation.

Health insurance

Health insurance policies cover the cost of medical treatments. Dental insurance, like medical insurance protects policyholders for dental costs. In the US and Canada, dental insurance is often part of an employer's benefits package, along with health insurance.

Accident, sickness, and unemployment insurance

- Disability insurance policies provide financial support in the event of the policyholder becoming unable to work because of disabling illness or injury. It provides monthly support to help pay such obligations as mortgage loans and credit cards. Short-term and long-term disability policies are available to individuals, but considering the expense, long-term policies are generally obtained only by those with at least six-figure incomes, such as doctors, lawyers, etc. Short-term disability insurance covers a person for a period typically up to six months, paying a stipend each month to cover medical bills and other necessities.
- Long-term disability insurance covers an individual's expenses for the long term, up until such time as they are considered permanently disabled and thereafter. Insurance companies will often try to encourage the person back into employment in preference to and before declaring them unable to work at all and therefore totally disabled.
• Disability overhead insurance allows business owners to cover the overhead expenses of their business while they are unable to work.
• Total permanent disability insurance provides benefits when a person is permanently disabled and can no longer work in their profession, often taken as an adjunct to life insurance.
• Workers' compensation insurance replaces all or part of a worker's wages lost and accompanying medical expenses incurred because of a job-related injury.

Casualty

Casualty insurance insures against accidents, not necessarily tied to any specific property. It is a broad spectrum of insurance that a number of other types of insurance could be classified, such as auto, workers compensation, and some liability insurances.

• Crime insurance is a form of casualty insurance that covers the policyholder against losses arising from the criminal acts of third parties. For example, a company can obtain crime insurance to cover losses arising from theft or embezzlement.
• Political risk insurance is a form of casualty insurance that can be taken out by businesses with operations in countries in which there is a risk that revolution or other political conditions could result in a loss.

Life

Life insurance provides a monetary benefit to a decedent's family or other designated beneficiary, and may specifically provide for income to an insured person's family, burial, funeral and other final expenses. Life insurance policies often allow the option of having the proceeds paid to the beneficiary either in a lump sum cash payment or an annuity. In most states, a person cannot purchase a policy on another person without their knowledge.

Annuities provide a stream of payments and are generally classified as insurance because they are issued by insurance companies, are regulated as insurance, and require the same kinds of actuarial and investment management expertise that life insurance requires. Annuities and pensions that pay a benefit for life are sometimes
regarded as insurance against the possibility that a retiree will outlive his or her financial resources. In that sense, they are the complement of life insurance and, from an underwriting perspective, are the mirror image of life insurance.

Certain life insurance contracts accumulate cash values, which may be taken by the insured if the policy is surrendered or which may be borrowed against. Some policies, such as annuities and endowment policies, are financial instruments to accumulate or liquidate wealth when it is needed.

**Credit**

Credit insurance repays some or all of a loan when certain circumstances arise to the borrower such as unemployment, disability, or death.

- Mortgage insurance insures the lender against default by the borrower. Mortgage insurance is a form of credit insurance, although the name "credit insurance" more often is used to refer to policies that cover other kinds of debt.
- Many credit cards offer payment protection plans which are a form of credit insurance.

The classification of insurance risks is an essential tool in the exercise of effective supervision of insurance companies. It is a means of categorising insurance business for licensing purposes in order that the supervisory authority can ensure that only companies with sufficiently specialised expertise and the appropriate business framework conduct a particular type of insurance. It allows for additional licensing requirements to be imposed for certain insurance branches. Classification is the principal method by which variations may be imposed in relation to liability assessment; technical reserves and investment rules, in order adequately reflect the differing level of risk pertaining to each type of insurance. It also allows for differentiation of tax and duty rates, should the legislator so wish, in order to reflect national and business priorities.

The unification of classification systems between the European Union Member States allows for the free movement of insurance companies within Europe on a uniform regulatory model. Beyond Europe, the harmonisation of classification systems has significance for insurance companies from one country seeking to establish branches or
subsidiaries abroad, as well as for rating of insurance companies and for obtaining reinsurance of risks in the international market.

**Best Practices in Claims management**

**Features of an efficient health claims management systems**

**Introduction**

Health insurance claims management has evolved significantly in India over the past 10 years. Since the introduction of mediclaim in the mid 1980s till the advent of TPAs in 2002, claims management focused primarily on reimbursement claims. The process was slow and entirely paper based, with no real role for IT. With the advent of cashless hospitalization, the entire claim process changed. New processes, such as prior authorization became vital for providers and payers. Time, which was not a crucial element in processing reimbursement claims earlier, all of a sudden became a vital parameter. Frequently the patient was already admitted when an authorization request reached a TPA, this meant that a response had to be given within 4-6 hours so the full treatment could commence. Authorization limit enhancements were also sought as the treatment progressed or as the patient was ready for discharge, they also required an urgent response. To meet these challenges, increasingly the TPA’s turned to IT.

The early claim systems were ad-hoc applications, frequently improvised upon to incorporate the ever changing multitude of payers / providers requirements, customer expectations and health insurance products. They were mostly reactive systems, supporting existing products and practices and not designed to support future requirements. Thus a peculiar chicken and egg scenario existed- how could an insurer introduce a new product when systems to service it did not exist?

A good claims management system must service existing products well while having the in-built flexibility to support products with new and unique features, such as outpatient coverage or products with a savings component. Increased flexibility to incorporate on-the-fly modifications in benefits and processes, in-built intelligence to standardize routine processes and rules based prompts and alerts are now available in newer claims systems. Not only do they reduce manual intervention and improve process efficiencies, they can
auto adjudicate and process claims which meet all compliance parameters thus enabling claims staff to provide more time for claims that require detailed analysis.

**Features of Efficient Claims management Systems**

Over the next decade, the insurance industry will witness continuous evolution in health insurance products and processes. The trend to move the claims function in-house may also be adopted by more insurers. This will create a unique opportunity for claims system vendors who can offer systems and applications with a high level of flexibility and automation. The starting point is a well defined and intelligent work flow management module to ensure optimum work routing and distribution, in-built escalation and strong external communication features (like auto letter generation for various scenario’s or SMS gateway). The ability to easily configure new products at a granular level is a vital requirement this enables the automation of various validation checks on policy, claimant, benefits and provider. A product configuration or interacts with a rules engine to define product benefits and exclusions to facilitate automated adjudication of claims. Appropriate pre-processing edits before the adjudication can substantially increase efficiency and process claims faster. In fact in the U.S. auto adjudication rates of 65% to 85% are not uncommon, albeit a very high percentage of these are simple primary care claims.

Since new products will attempt to differentiate themselves with new service models, the claims systems will require business process builder to build operational workflow compatible with the product. In summary, the product configuration module, business process builder and rule engine is already becoming the core of the new generation claims systems. Such integrated solutions enable the claims teams to achieve significant automation of validation checks at the policy and the product level including verification of benefit and coverage limits to streamline prior authorization for cashless claims. Access to data in the policy administration system and provider module is vital at this stage. Once the claim data is in the system, pre-defined rules and product specific processes can be applied.

After ensuring that all mandatory information is provided and is valid, the first step would be to match the claim against the prior authorization. The second step would be to
conduct checks for medical appropriateness, compliance with provider contracts and variation from usual and customary practices. Much of this can be automated through the use of standard treatment guidelines embedded in the system to identify excessive or unwarranted billing item, therefore generating cost savings for the insurer. An ideal claims management system should also include a fraud management module that identifies possible fraudulent patterns based on policy holder profile, underwriting information and provider profile. Since fraud or abuse patterns frequently reoccur, such a tool can be very useful.

Once a claim has been processed the claim payment process starts. Integration with payment gateways is a common feature now and significantly simplifies this process when paying network hospitals. In case of non-network hospitals or reimbursement claims, it helps to have a good cheque printing module. Finally, an effective claims management system can provide excellent insight to management. Not only can past trends be identified and leveraged, the vast amount of claims data can be combined with enrollment data to be efficiently used in actuarial pricing and underwriting.

I. THE UNDERLYING REASON FOR CLASSIFICATION

Classification is principally related to Supervision in EU

In all the principal legal systems all insurance companies, in order to work legally, need to have two authorizations, which can be issued together.

As a non personal but capital company (company limited by shares), an insurance company must fulfil certain requirements provided for all capital companies. This is due to the fact that as companies limited by shares their assets and liabilities to third parties are separated from the assets and liabilities of their shareholders. The solvency of the shareholder is of no benefit in creating security for a third party, since third parties are only satisfied by the assets of the company. The main but not the only task of state control is to secure as a very minimum that the share capital is at least deposited and that during its life the company possesses assets at a satisfactory level. However, if the company wants voluntarily to be registered with a higher share capital, the third parties must be not misled if the assets have no relation at all with this capital. But also the state supervision aims to guarantee the same function of the capital company at the real
separation of shareholders and management, as well as the protection of minority shareholders.

If the capital company is an insurance company (joint-stock company or Mutual Corporation) there is also detailed regulation, which is linked with the licence for the conduct of business.

**Different Requirements per Class of Insurance**

In the European Union insurance companies enjoy equal treatment. The intention is to distinguish between classes of risks because there are significant differences as regard the characteristics of the risks. From the risks that can form the object of insurance, classification of risks takes place according to the common characteristics of each group of risks. The common characteristics of the identified group of risks demand that the insurance company has different capacities regarding solvency requirements, reinsurance, technical provisions and matching assets, insurance investment, but also different obligations *vis à vis* the insured persons. State control does not need to insist that all insurance companies fulfil all the requirements which are needed in order to cover all risks, because of the reason that one company may specialize in one risk only; this company should in such a case meet only the specific requirements that are proportionate and appropriate for this risk.

Those different requirements which are due to the difference of types of insurance lead also to specialization in the insurance business and also in the work of insurance supervision. This is positive. Classification is a requirement of our times because it leads to specialization of supervision in fields as diverse as fire, civil liability, transport. Of course the supervision can be done by the same members of staff in the supervisory authority, but most countries have found that as a parallel consequence of the progress and growth of the insurance industry, supervision also grows in terms of specializations. This is a benefit, because specialization makes supervision more effective.

**Criteria for Adoption of Insurance Classes**

The criteria are dependent on the degree that risks have similar characteristics. In some other states like Australia, Canada, and currently in the Russian Federation the law
provides for fewer classes of insurance than in the EU. It is advisable to have a wide variety of classes, because there is only benefit to be gained from this. The criteria must however be broadly the same on a global scale in particular in relation to large risks because of the international character of insurance and also of reinsurance. In order for Russian insurance companies to access the international reinsurance market, they need to show the nature of their business. This is greatly assisted by the use of an internationally accepted classification system.

It would be useful to have a closer look at the example of Canada, as an initial starting point of our comparisons. Canada is, like Russia, a large, federal country, and has a classification system not dissimilar to Russia’s. For Canada the largest category is the insurance of persons, as is the case with the Russian Federation along with property and liability insurance. We notice in the comparison with the EU system only small differences in the Canadian classification system. Canadian property and liability insurance includes insurance for fire, business interruption, transport, liability, legal aid, theft and embezzlement, agricultural, hail and livestock, catastrophe, credit and caution, technical, miscellaneous and motor vehicle. Personal insurance includes workers’ compensation, personal injury, private health insurance, life insurance and pension funds. Finally the Canadian classification system provides for a separate private insurance for social security. The criterion for classification is not only the homogeneity of risks but also the frequency of the insurance and the importance of the business or the risk to which it refers. The importance of the business is probably the reason why it recognizes a special class, business interruption insurance. The criterion of the importance of the risk is the fact that they have special class for catastrophe insurance.

II. The Separation of Life and Non-life

There is a long discussion and dispute among some European Union industrial countries and others as to the necessity to separate life insurance business from non-life insurance business, and in some cases also from the pension insurance business. The reasoning for the argument in favour of separation is obvious. There is no dispute that some separation should exist in the insurance business between insurance for non-life and insurance for
life. The difference between these two categories of insurances comes back to their nature. In non-life insurance the premium is the return for the assignment of risks. Whilst in life insurance, premium can be partially or totally a savings deposit managed by the insurer in an attractive way, maybe more attractively than a simple deposit in a bank. So, it is understandable that a different protection should be granted to those persons who entrust their savings to the insurer than from those persons who rely on the promises of the insurer to grant reliable coverage in the uncertain case of loss. In the second case, the premium is consumed by the expiry of the period of the insurance contract, whereas the premium that has the nature of saving, on the contrary, is expected in any case to be returned plus investment gain.

If in one business entity there is a mixture of categories, the life business is exposed to the risks of the non-life business. Also, the non-life business cannot be compared with life from the point of view of the commercial risk that it is undertaken. The life insurance business is more stable than non-life, with its many ups and downs and dependence on factors that are difficult to predict. A third separation of risks could be non-life, life and pension insurance that is exclusively savings. Nevertheless, in order to reach consensus in the EU, the obligation for separate legal entities for life and non-life does not include pensions as a third category. On the other hand, in the EU it was permitted to the insurance companies that conducted both life and non-life (composite companies) to continue working after the enactment of the new separation regulation in Europe on condition that they create effective separation in their business and accounting practices.¹

A further issue arises when a foreign composite insurance company applies to establish a subsidiary in an EU member state. The EU had to confront the issue of whether to prohibit these composite companies from establishing by subsidiary or whether to allow them to work in both categories of insurance as in its principle place of business. The principle of equality between foreign and domestic companies demands that they should not be permitted to establish subsidiaries to conduct both life and non-life. Holders of life insurance policies will be adequately protected if foreign composite insurers are permitted to establish subsidiaries as either as life or non-life insurers, not both. The subsidiary has a separate legal entity and thus if the parent company faces financial

¹
problems, these are not transferred to the subsidiary by operation of law. Similarly, a composite insurer from an EU Member State wishing to establish a branch in another Member State can only offer life or non-life. Practice has proved that non-life insurers have a greater risk to become insolvent than life insurers, which means that composite insurers would be tempted to fund their non-life portfolios with their life insurance assets. This risk is greatly diminished, if not removed, in insurance companies that keep their life and non-life business completely separate.

**Classification in Europe**

Before the EU set rules allowing insurance companies to establish themselves freely in all other member states, Member States already provided for different categories of insurance. For example, in Greece the law provided for the following classes of insurance: accident, motor third party liability, transport, fire, life and capitalization, ships and airplanes and credit. These classes were found also in other European or non-European legislations.

The uniform classes of insurance business, which apply throughout the European Union, are set out in the first generation of Directives. The first generation of insurance directives (for non-life Directive 73/239 of 24 July 1973 and for life Directive 79/267 of 5 March 1979) coordinated rules and practices for the supervision of insurers, particularly their financial stability and their freedom of establishment. They provide for 18 classes of insurance for non-life and 9 classes of insurance for life.

**Non-life**

The Annex to the first non-life insurance Directive defines non-life (or ‘general’, as it is referred to in the UK) insurance business for the purposes of both the directive and subsequent insurance measures by reference to a number of insurance classes. Originally, there were seventeen, including accident and sickness (but excluding permanent health insurance), marine, aviation and transport risks, fire and other property damage, credit and surety ship, general liability insurance, miscellaneous financial loss and legal expenses insurance. A further class (No. 18) was added by the Tourist Assistance Directive, which covers assistance on the breakdown of a vehicle whilst travelling, in
return for the payment of a premium. The need for this new class is found in the peculiarity of this business rather than the differentiation of the risks that are presented. The Directive covers direct insurance only and therefore its co-ordination provisions do not apply to reinsurance, where individual Member States currently remain broadly free to regulate or not to regulate reinsurers as they please.

Thus, all insurance enterprises working in EU countries, irrespective if they are companies working on a premium basis (as a joint-stock company or other type of business unit) or as a mutual company, have to place all their direct insurance business in one of the above classes. The classes of illness and accident (numbers 1 and 2) can be granted as fixed sum insurance or as indemnity insurance or as combination of the two. The motor vehicles and railway classes could cover all vehicles travelling on ground, but the differences with motor vehicles, which develop very quickly technologically, justify a separate categorization. The other means of transport, vessels and aircrafts were traditionally classified separately in some jurisdictions in the past, and in the EU they are also classified separately. It should be noted that the four classes of insurance listed above which refer to means of transport cover the loss or damage to the vehicles themselves and not to any goods transported. The latter is covered by separate classification. This latter is the classification of cargo insurance. The class of fire and natural forces is the oldest classification because it refers to a typical risk that threatens goods. It is related to class number 9 (other damages to property), but it covers risks which are not included in class 5. Classes numbered 10 to 13 are interrelated because they cover the civil liability that arises from the use of vessels, airplanes or land vehicles but also the civil liability of the persons who professionally exercise the profession of the carrier using all three modes of transport. It should be noted here there is not a separate class for liability insurance for railways. This latter case as well as any other civil liability coverage business falls under the general liability class 13. The classes of credit and surety ship, although related with each other, are divided into two separate classes (numbers 14 and 15). There are special classes of insurance for legal expenses and tourist assistance (numbers 17 and 18). Last but not least the classification of number 16 refers to miscellaneous financial losses.
Life

The original classification of the category of life insurance in Europe used to include the classes of life, marriage and birth, accident and illness as well as pension insurance and capitalization. Later, in the 60’s when the capital market started to gain significance and the role that life insurance with a savings character can play as an investment instrument became more developed, the EU introduced a class that combined life insurance with investment. Thus, when the Directive of 1979 was introduced, it provided for nine classes of insurance that were already provided in Europe. Some amendments were brought by Directive 92/96 that included the concept of a single licence for insurance companies. Permanent health insurance that is not subject to cancellation concerns only the UK and Ireland. Other Member States do not have to create a class of insurance that does not exist in their countries. The same applies to Tontines.

The Impact on the Insurance Contract

The separation between life and non-life from the point of view of classification also exists in connection with the insurance contract. As noted previously, the reasons for the separation into two broad categories (life and non-life) is due to the fact that in life insurance the premium can be partially or totally a saving and thus the insured requires greater protection. The category of life insurance has the characteristic that the insurer pays fixed sums that do not compensate the beneficiary upon the occurrence of the insurance event for loss suffered by them. The character of the payment as a fixed sum and not as indemnity reveals the nature of life insurance as a form of investment or saving. For instance if an insurance contract provides for the return of the capital in 20 years or on death (whichever occurs earlier), it is reasonable that this sum is fixed and not dependent on any external risk; the sum will be paid whether the person dies or not. Consequently, the fact that the insurer pays a fixed sum has an impact on the insurance contract. On the one hand, because finding the scope of the damage in order to calculate the payment is irrelevant. On the other hand, there is an impact on the insurance supervision that is different for life and non-life; the insurer knows that whatever happens, it will have to pay this money – there is no element of risk.
The insurer may also be a manager of group pension funds. In this case, the insurer may conclude an insurance contract and receive the premium but the risk is very different. There is a real debate as to whether this contract should follow the rules of the standard insurance contract. The relation between insurer and insured is more similar to that in private asset management companies. It follows that it is more appropriate to apply the rules for the contract of private asset management. Although the two relationships have a very different nature, still they are both provided in insurance contracts. The manager of group pension funds does not conclude insurance contracts but provides an insurance product according to the legislation that governs the insurance undertaking.

On the contrary, insurance contracts for non-life concern indemnity insurance where the insured interest is measurable in money. Although there are differences in the way of payment according to the category (life or non-life), the general rule is that all non-life insurance policies render sums, which are directly related to the loss. Thus, the liability insurance cannot cover more than the loss, unless there is an agreed value, which even then cannot differ significantly from the actual loss suffered.

### Non-life Classification in Particular

#### Accident

The category of indemnity insurance in the European classification system includes personal accidents. The definition of personal accidents also includes injuries and illness occurring during and occasioned by the execution of an employment contract. The special risks that can be covered totally or partially by this class of insurance are the following: fixed pecuniary benefits, benefits in the nature of indemnity, combinations of the two and, finally, injury to passengers.

It should be noted that the first subclass has a character more suited to the life category, but this is the exception to the rule that fixed sums are connected to life insurance, while indemnity is connected to non-life. Illness that occurs during and occasioned by employment is characterized as accident and not as illness. The significant factor in sickness insurance is the cause of illness. If the cause of illness is found in the conduct of an employment contract, the legislation treats this kind of illness as accident. The relation between insurance classification and private rights/obligations is obvious. Classification...
is closely related with private rights and obligations and not only with the similarity of risks.

The second subclass refers to the costs, which are explicitly related to the accident. The fourth subclass refers only to the accidents caused to persons during their transportation and not to the liability of the carrier. The European classification does not distinguish whether this latter risk is covered on the basis of indemnity system or a fixed sum, thus both systems of payment can be agreed.

**Sickness**

The class of sickness has the same structure with the class of accident. In case of the occurrence of sickness, which has been agreed to be covered by the insurance contract, the insurer may agree to cover the risk by a fixed sum. The insurer may also agree to pay as an indemnity the particular amount of costs (i.e. the cost of treatment in hospital). The payment can be also a combination of both a fixed sum and indemnity (third case).

**General remark which refers to both accident and sickness:**

1. The first two classes of the non-life category concern personal insurance. Because of their mixed character they can also be by a life insurance company. This means that although the regime of separation exists (life/non-life), a life insurance company that has obtained a licence for health insurance of the category of life is allowed to conduct non-life insurance business for accident and sickness. This is irrespective of the fact that in such a case the life insurance company is granting coverage for accidents and sickness of an indemnity nature.

2. It is obvious but worth noting that an insurance company that covers accident and illness can include many other types of coverage in the same policy. For the authorization of a licence for accident and illness the Supervision Authority checks only the nature of the coverage, whether it is fixed, indemnity, a combination of both or transportation of persons. Thus, for instance, if an insurance company has a licence for sickness it can agree that the injured person will be paid either the cost of the hospital treatment (the percentage that is not covered by social insurance), or a fixed sum for each day that he is not working or treated in the hospital or a return of a percentage of the premium after x
years of non occurrence of the insurance event, or any other cover which may be agreed. The Supervision Authority that grants the licence does not intervene in the policies of the company. It checks the product as presented to the Authority at the time of establishment. On its own responsibility the insurance company having the licence for accident and illness may grant every kind of coverage at a later stage within the scope of its licence. Another rule must be considered by the insurance company that has the licence for illness and accident. By the construction of modern, sophisticated, insurance products, it is possible (actually very common) that the coverage actually refers to other classes of insurance for which the company has no licence. The insurance company does not necessarily need to have a different licence in order to grant a new companion product. Based on the principle of ancillary risks (introduced by the EU by the first generation of directives in the 1970’s) the insurance companies can cover risks for which no licence has been granted if those risks are (1) connected with the principal risks and (2) if they are provided by the same insurance contract.

The question is what happens if the insurance company covers risks which do not fulfil the abovementioned two preconditions. The answer is that this does not affect the validity of the insurance contract. The rights and obligations of the insurer and the insured remain the same. There are some exceptions if the insurer has promised to the insured by policy to cover liability, for instance, when it has no licence for it. If the insurance company grants liability coverage as a connected risk when it is not an ancillary risk but the main risk, the company violates the law by conducting business outside the framework of the official licences granted. It violates the obligation which it has vis a vis the supervision authorities (public law provision), but also violates its promise to the insured, because it misleads the insured about the existence of an authorisation which it does not possess. So in this case the general rules of law of contract find application. Whether the policy is invalid or not, and to what sanctions the insurance company will be liable, depends on the circumstances of the case, whether the misrepresentation is important or not. The sanctions are of public law. It is at the discretion of Member States to provide flexible or inflexible sanctions on the insurer in such circumstances.

1. Land vehicles
The class of land vehicles refers to damage to land motor vehicles or land vehicles, which do not move by their own power. The risk, which is covered, is not defined by the directive, so any kind of risk which results to the damage of the physical, mechanical, optical (theft) or the existence of damage to the body of such vehicles is covered. Thus, the class of land vehicle is “all risk” insurance. The principle criterion for this class of insurance is the fact that the vehicle is in a state of movement. It is also evident that the consumer and other insureds do not have any concern to separate different risks but they have an interest to insure all of them, which is a matter of commercial logic.

There may be a question concerning a policy in which the insurance company has a licence to insure against fire, which threatens all the movable and immovable assets of an enterprise. Insurance companies may be unsure as to whether the coverage includes damage to the vehicles of an enterprise, which are damaged by fire, or should this risk be excluded because this damage is covered by the classification of motor vehicle ‘own risk’ insurance. The answer depends on the role of classification and its impact on the insurance contract. The insured is not obliged to find out the risks for which an insurance company has a licence. From the other side, if the insurance policy is not clear whether it covers all the movable or immovable assets of an enterprise, the insurer has to grant coverage. He is not entitled to argue that his licence does not include this risk in his contractual obligations. By this occasion it is good to see why it is advisable for insurers to state in their policies detailed description of the assets, which are covered. This reflects the importance of the principle of the separation of risks and assets that are covered. This principle is enhanced by the detailed classification of risks. For example, if an insurer insures a warehouse against fire, he cannot deny payment for a van also destroyed by the fire.

2. Railway rolling stock

The classification of railway is based on the same philosophy as the class of land vehicles. The body of any rolling stock is covered. It makes no difference whether or not
it moves on rails, has an engine, whether it is electrical or not, or if it is underground or not.

3. Aircraft

The Directive does not make a distinction if the aircraft is in service or not or if it is under construction. It does not make any differentiations between various kinds of aircraft, but it does not include spacecraft.

4 & 5. Ships

Close to the class of aircraft damage or losses is the class of ship damage. This class covers all damage to the body of vessels (hull). The same “all risk” principle applies to vehicles, railway, aircraft and ships for all kinds of damage.

6 & 7. Goods in transit

The last class, which has to do with movable assets, is the class of goods in transit. The all risk principle for all kind of damage again finds application. The characteristic of this coverage is that it covers all kinds of risks, which threaten the goods for all kinds of damage. No distinction is made if the goods in transit are merchandise or not, are packaged or not, are in the form of money or other valuable things, or whether or not they are carried by a professional carrier.

It is important to mention here that the goods, packages and merchandise are covered under this class of insurance only if they are in transit. But the characterization of what is transit or not is a question of private law. So, the contract of transport is going to characterize at the end of the day whether the damage falls under this class. The legislation on the transport of goods and contracts internationally characterize the beginning of transport as the day on which the carrier has the right of disposition of the goods, which is usually earlier than the day of shipment and later than the day of discharge. So the goods are covered under class 7, even if they are not actually in transit, but would be defined as such under the above distinction. But moreover the insurer can define as transit a specific time before the shipment (60 days) in order to cover the risks while the goods are in warehouse. The question is if the insurer who has no licence for
fire and natural forces has the right to cover the damage of goods caused by fire in the warehouse based on his policy which grants coverage a couple of days after the discharge of the goods. The answer is that the insurer does not violate the law, firstly because this extension of coverage is close to the nature of transport of goods and the needs of the transport business and secondly, at the end of the day the principle of ancillary risks applies if fire coverage is regarded as ancillary.

8&9. Fire and natural forces

The oldest kind of modern insurance is for fire. Fire includes explosion, storm, and natural forces other than storm, nuclear energy and land subsidence. EU law provides explicitly that this class of insurance does not include the classes of motor vehicle, aircraft, railway, vessels and goods in transit. But, however, as noted before, coverage of such ancillary risks is on occasions unavoidable. For the insurance contract this class is very important, together with class 9, because it includes the regulations, which are applicable to all kinds of damage to goods. It is worth mentioning that an insurance policy described as fire insurance usually includes many other risks that threaten other goods. Also, it is notable that legislation regulates, in particular, the fire insurance contract and the same regulations are applied by analogy also for coverage of goods against risks other than fire. Every insurance of goods is insurance against fire.

10. Motor vehicle liability

The class 10 includes two types of coverage. The first is the well-known, extremely important class of the civil liability of the driver and owner in using motor vehicle. The second is the liability of the professional that exercises the profession of transportation of goods. This kind of insurance can be ancillary to fire.

11. Aircraft liability

This is the well known, extremely important class of the civil liability of the pilot and owner in using an aircraft and also the liability of the professional that exercises the
profession of transportation of goods by air. This kind of insurance can also be ancillary to fire.

**12. Legal expenses**

Legal expense insurance includes the costs of litigation. It should be mentioned here that legal expenses insurance is by its nature also partially included in any civil liability insurance according to the well-known contract law legislations. But the civil liability coverage covers only the expenses for the defence of the insured (plus, of course, the expenses of the compensation of third party), while the legal expenses insurance covers also the legal expenses to bring an action against a third party. The fact that it can overlap with civil liability coverage and legal expenses is of no relevance for the granting of the licence.

This class has the lowest guarantee fund requirements.

**Life Classification in Particular**

I. ‘Life insurance’ category includes the life insurance, which in turn includes the following three categories:

1. Life insurance, that is to say, the class of insurance which comprises, in particular, assurance on survival to a stipulated age only, assurance on death only, assurance on survival to a stipulated age or on earlier death, life assurance with return of premiums, marriage assurance, birth assurance;

2. Annuities;

3. Supplementary assurance carried on by life assurance undertakings, that is to say, in particular, insurance against personal injury including incapacity for employment, insurance against death resulting from an accident and insurance against disability resulting from an accident or sickness, where these various kinds of insurance are underwritten in addition to life insurance.

II. Birth and Marriage insurance

III. The class of life insurance can be supplemented with investment e.g., life, assurance, annuities, marriage assurance, birth assurance.
1. This investment refers to the benefits included in the policy and which are directly connected with the value of the units of a mutual fund or the value of the assets which are included in an internal fund of the insurance company which is usually divided into units; or
2. Which are directly connected with an stock or share index or connected with another value different than those mentioned in para.1 above.

IV. The ‘health’ class includes accident and illness which includes the same risks as in class 1 and 2 of the category of non-life. But the class of health includes also the permanent health insurance not subject to cancellation provided by certain countries.

V. ‘Tontines’, whereby associations of subscribers are set up with a view to jointly capitalizing their contributions and subsequently distributing the assets thus accumulated among the survivors or among the beneficiaries of the deceased.

VI. ‘Capital redemption operations’: this refers to works which are based on actuarial calculations and by which certain obligations and for certain period of time and for a certain amount are undertaken in return for periodical or single payments.

VII. The seventh class is the class of management and group pension funds, which refer to managing the investments for the insured undertaking and in particular the assets representing the reserves of bodies that effect payments on death or survival or in the event of discontinuance or curtailment of activity. It also refers to the above mentioned operations where they are accompanied by insurance covering either conservation of capital or payment of a minimum interest.

VIII. The eighth class refers to operations carried out by insurance companies such as those referred in Chapter 1 Title 4 of the French Code d’ Assurance. This insurance practice in France does not cover risk but are in the nature of savings.

IX. This class covers operations related to the length of human life in social insurance legislation when they are affected or managed at their own risk by assurance undertakings.

**Classification in the Russian Federation; Recommendations for Change**

Whilst the Russian Federation is not obliged to adopt the EU classification system, RF’s proximity to the Eurozone and its insurance and reinsurance markets, combined with the
fact that the EU’s classification system has remained almost entirely unaltered for nearly thirty years provides good evidence of its effectiveness in providing a clear and reliable framework for insurance supervision purposes. The use of internationally accepted classification rules also provides a firm foundation on which the activities of foreign insurance companies can be assessed for the purposes of inward investment into Russia, as well as allowing Russian insurance companies to restructure themselves on lines which will improve their ability to access foreign markets. Russian insurance companies’ access to foreign reinsurance markets will also be eased by the use of internationally accepted classification criteria.

The introduction of the amended law "On organisation of Insurance Business in the RF" 10 December 2003 (hereinafter referred to as the "new law") has made a considerable step in the development of the Russian classification system. One of the major points to mention is that separation between life and non-life has been provided in the new law. According to Art.2 para.2 of the law "On introducing amendments to the law"On Organisation of insurance business in the RF" specialisation of the companies established prior to the enforcement of the new law should be finished by 1 July 2007 the latest. The separation between life and non-life is a topical issue for the Russian insurance market. Currently an amendment to Art.13 para.3 of the new law, which says companies having licences to write life assurance cannot re-insure risks under property insurance written by these insurers, is being discussed by the State Duma. The amendment in question refers to the putting off the date of enforcement of this particular part of the article to 1 July 2007 when the specialisation process of the companies should be over. There are two large groups/classes of insurance in the Russian Federation: personal insurance and property insurance. The subclasses of personal insurance - life, accident, sickness and medical insurance are equivalent to life insurance in the EU legislation, most Australian jurisdictions (e.g. New South Wales) and others. The subclasses of property insurance are insurance of property damage, civil liability and entrepreneurial risks. The most important remark one can make on long-term life assurance in the RF is that it has not up to now been given separate treatment analogously with its special characteristics as a long-term investment product, rather than a short-term risk. Also, the
legislation does not recognize as a separate class of insurance the management of pension funds (which implies, for example, the activity where an insurance company manages the investments of commercial companies’ pension plans which they have set up for their own employees) or other funds; this means that the insurance company is regarded and treated exclusively as the risk carrier and not also as a possible exclusive manager of assets. This failure to define long-term life insurance business, as an investment does not allow for the specialised supervision needed for these products. The way in which long-term life insurance products are treated will also be significant for insurance reserves and mathematical provisions, but also in the way in which assets of an insurance company are treated in insolvent liquidation. The second point to mention here is that medical insurance is separated from accident and sickness insurance, which has of course its explanation in the structure of the health system of the RF.

The second large group/class is property damage insurance (Art. 4, para.2.1 of the new law), which in the RF does not differ significantly from the European system but it has a lower number of classes. These classes include ground, railway, air, water transport, cargo insurance, and agricultural insurance, insurance of property of legal entities, except for vehicles and agricultural insurance and insurance of property of citizens, except for vehicles.

Under the RF property insurance group (Art.4, para.2 of the new law) a subclass of “Insurance of entrepreneurial risks” (class 22, Art.32.9), together with Class 21 (Art.32.9 of the new Law) “Insurance of civil liability for default on or improper performance of obligations under a contract and class 23 “Insurance of financial risks””, could be relatively easily re-divided into the EU classes of Credit, Suretyship and Other Financial Losses (Classes 14-16). As these types of insurance are particularly high risk for the insurance company, we would recommend that a separate licence should be required for these branches, particularly credit and suretyship.

The class of ‘other types of property’ (which now includes insurance of property of legal entities, except for vehicles and agricultural insurance, and insurance of property of citizens, except for vehicles, Art.32.9 paras. 1.12 and 1.13) could be usefully amended to create separate insurance classes of fire and natural forces as well as the further class of other damages on goods. Having in mind the expected rapid growth of the insurance
products in the RF, another subclass of property insurance for fire and natural forces should be added in order to distinguish these specific risks from other types of damage to property. This allows for separate rules on financial control and solvency, as well as allowing for pure reinsurance companies (who conduct only reinsurance business) to reinsure both life and non-life business, as an exception to the usual division between life and non-life insurance.

**Systems of Classification and State Supervision**

The relation between classification and state supervision is a very close one. There is of course not only one purpose of classification but the most important is to help State Supervision. Therefore in this topic it may be good to focus on the difference between granting a licence to conduct business and the procedure for granting a new class authorisation to an existing insurance company.

If an undertaking grants insurance coverage without a licence to conduct insurance business, heavy sanctions are imposed to any person involved in this proceeding. It is of no difference if an unauthorised insurer has the capacity to honour his promise to cover the risk and of course it does not make any difference if the client knew that the insurance company is not licensed. The rights of this client are the same as the rights vis a vis a real insurer. But once the undertaking has managed to obtain a licence for one class of insurance then he is a real insurer.

The sanctions that are imposed on an insurer that has not obtained a licence for a specific risk it covers but has obtained a licence for another risk are not the same as the sanctions imposed on someone who has not obtained a licence at all. It is not difficult to understand why this is the case. A non-life insurance company, which has a licence, for instance, for fire and operates according to the law, has created the necessary guarantee fund, technical reserves, solvency margin etc. It does not present a danger to the rights of the insured.

The modern state supervision system empowers the Supervision Authority to have flexibility and judge according to the principle of proportionality, namely the degree of gravity of the violation. The first case is when an insurer covers an ancillary risk for which he needs a separate licence. Example: the insurer has a licence for cargo. The cargo is alcoholic beverages, the price of which consists of 80% taxes and only 20% is
the actual value of the goods. The transport outside the country can be done only if a bank guarantee or guarantee issued by insurance companies is issued in favour of the Tax Authority that if the product is not exported within x days the guarantee should be paid to

Types of claims

**Maturity Claim** - On the date of maturity life insured is required to send maturity claim / discharge form and original policy bond well before maturity date to enable timely settlement. Most companies offer/issue post dated cheques and/ or make payment through ECS credit on the maturity date.

**Death Claim** (including rider claim) - In case of death claim or rider claim the following procedure should be followed.

Follow these four simple steps to file a claim:

1. **Claim intimation/notification**
   The claimant must submit the written intimation as soon as possible to enable the insurance company to initiate the claim processing. The claim intimation should consist of basic information such as policy number, name of the insured, date of death, cause of death, place of death, name of the claimant. The claimant can also get a claim intimation/notification form from the nearest local branch office of the insurance company or their insurance advisor/agent. Alternatively, some insurance companies also provide the facility of downloading the form from their website.

2. **Documents required for claim processing**
   The claimant will be required to provide a claimant's statement, original policy document, death certificate, police FIR and post mortem exam report (for accidental death), certificate and records from the treating doctor/hospital (for death due to illness) and advance discharge form for claim processing. Based on the sum at risk, cause of death and policy duration, insurance companies
may also request some additional documents.

3. **Submission of required documents for claim processing**

   For faster claim processing, it is essential that the claimant submits complete documentation as early as possible. A life insurer will not be able to take a decision until all the requirements are complete. Once all relevant documents, records and forms have been submitted, the life insurer can take a decision about the claim.

4. **Settlement of claim**

   As per the regulation 8 of the IRDA (Policy holder's Interest) Regulations, 2002, the insurer is required to settle a claim within 30 days of receipt of all documents including clarification sought by the insurer. However, the insurance company can set a practice of settling the claim even earlier. If the claim requires further investigation, the insurer has to complete its procedures within six months from receiving the written intimation of claim.

**Insurance financing vehicles**

- Fraternal insurance is provided on a cooperative basis by fraternal benefit societies or other social organizations.
- No-fault insurance is a type of insurance policy (typically automobile insurance) where insureds are indemnified by their own insurer regardless of fault in the incident.
- Protected self-insurance is an alternative risk financing mechanism in which an organization retains the mathematically calculated cost of risk within the organization and transfers the catastrophic risk with specific and aggregate limits to an insurer so the maximum total cost of the program is known. A properly designed and underwritten Protected Self-Insurance Program reduces and stabilizes the cost of insurance and provides valuable risk management information.
- Retrospectively rated insurance is a method of establishing a premium on large commercial accounts. The final premium is based on the insured's actual loss experience during the policy term, sometimes subject to a minimum and
maximum premium, with the final premium determined by a formula. Under this plan, the current year's premium is based partially (or wholly) on the current year's losses, although the premium adjustments may take months or years beyond the current year's expiration date. The rating formula is guaranteed in the insurance contract. Formula: retrospective premium = converted loss + basic premium × tax multiplier. Numerous variations of this formula have been developed and are in use.

Claim settlement & its significance

The Insurance Policy is taken by the consumers to compensate them in the event of happening of an unforeseen event. It is a hedge against unavoidable circumstances. In general insurance the loss is payable only on happening of some specific event. If the insured does not suffer any loss no claim is paid to him. The premium is charged on yearly basis and no accumulation takes place. However the scenario is different in case of life insurance. If the insured dies during the policy period he gets the sum assured along with the bonus accrued under the policy if any. If the insured survives the policy period he gets the maturity amount accrued under the policy.

CLAIM SETTLEMENT

Payment of claim is the ultimate objective of life insurance and the policyholder has waited for it for a quite long time and in some cases for the entire life time literally for
the payment. It is the final obligation of the insurer in terms of the insurance contract, as
the policyholder has already carried out his obligation of paying the premium regularly as
per the conditions mentioned in the schedule of the policy document. The policy
document also mentions in the schedule the event or events on the happening of which
the insurer shall be paying a predetermined amount of money (S.A.).

There may be three types of claim in life insurance policies—

1. Survival Benefit Claim
2. Maturity Benefit Claim
3. Death Benefit Claim

**Survival Benefit:**

Survival benefit is not payable under all types of plans. It is payable in endowment or
money back plans after a lapse of a fixed period say 4 or 5 years, provided firstly the
policy is in force and secondly the policyholder is alive. As the insurer sends out
premium notices to the policyholder for payment of due premium, so it sends out
intimation also to the policyholder if and when a survival benefit falls due. The letter of
intimation of survival benefit carries with it a discharge voucher mentioning the amount
payable. The policyholder has merely to return the discharge voucher duly signed along
with the policy document. The policy document is necessary for endorsement to the
effect that the survival benefits which was due has been paid. The survival benefit can
take different forms under different types of policies.

**Maturity Claim**

It is a final payment under the policy as per the terms of the contract. Any insurer is
under obligation to pay the amount on the due date. Therefore the intimation of maturity
claim and discharge voucher is sent in advance with the instruction to return it
immediately. If the life assured dies after the maturity date, but before receiving the
claim, there arises a typical problem as to who is entitled to receive the money. As the
policyholder was surviving till the date of maturity, the nominee is not entitled to receive
the claim. The policy under such conditions is treated as a death claim where the policy
does not have a nomination. The insurer in such a case shall ask for a will or a succession
certificate, before it can get a valid discharge for payment of this maturity claim. In case the policy has been taken under Married Women’s Property Act, the payment of maturity claim has to be made to the appointed trustees, as the policyholder has relinquished his right to all the benefits under the policy. It is for this relinquishment of right that the policy money enjoys a privileged status of being beyond the bounds of creditors etc. If the maturity claim is demanded within one year, before the maturity it is called a discounted maturity claim. This amount is much less than the maturity claims.

**Death Claim**

If the life assured dies during the term of the policy, the death claim arises. If the death has taken place within the first two years of the commencement of the policy, it is called an early death claim and if the death has taken after 2 years, it is called a non early death claim.

**Procedure of claim settlement**

Maturity Benefit

If the policyholder lives through the duration of the policy and becomes eligible to get the maturity value it is called the settlement of a maturity claim. As the policyholder is alive, the nomination is of no significance. Age is normally admitted at the stage of the proposal. If it has not been admitted for some reason, it is necessary to submit the age proof before the payment of the maturity value. Much before the date of maturity the insurer sends the claim discharge voucher which has to be returned duly signed and witnessed along with the policy document for payment of the maturity value.

**Death Claim**

In case of the death of the policyholder at anytime during the duration of the policy, the claim amount becomes payable to the nominee mentioned in the policy document. The
nominee or the nearest relative shall send an intimation of death of the policyholder to the insurer stating therein the fact of death, the date of death, cause of death and the place of death along with the policy number. Insurer deals with the death claim differently on the basis of the duration or the policy. If the policyholder has died within two years of the commencement of the policy, i.e., acceptance of risk which may be different from the date of commencement if the policy has been dated back it is treated as “early or premature claim” and if the death has occurred after 2 yrs of the commencement, it is treated as normal death claim. In a normal death claim, that is if the life assured has died after two years of the commencement of risk, the insurer, on being intimated about the death of the policyholder, calls for the age proof, if not earlier admitted, the original policy document and proof of death. The proof of death can be a certificate from the municipal authorities under which cremation has taken place, or other local body like death registry. The claimant generally is required to fill in a form giving certain routine information about his title to the policy money and the information relating to death, which is normally called a claimant’s statement.

**Premature claim**

It is a premature claim if the death has occurred within two years from the commencement of the policy or the date of last revival, or medical examination. The insurer takes certain precautions before making payment under such a premature claim. It wants to satisfy itself that it is a genuine case i.e., the correct policyholder has died and that the cause of death does not go back to a date prior to the commencement of the policy. The duration of last illness is of vital importance to eliminate any fraudulent intention. Last medical attendants’ certificate, hospital report, burial certificate, employees’ leave record, if he was an employee in a reputed firm etc., are the different records examined and normally a senior officer is deputed by the insurer to make on the spot investigation, through neighbors, colleagues or doctor of the locality.

As the revival of the policy is a de novo contract of insurance, the insurer would like to verify whether the statement contained in the declaration of good health given at the time of revival is correct. If such a statement is proved fraudulent relating to a material fact,
the claim may be rejected. Life insurance is a contract of utmost good faith and good faith has to be observed, not only at the time of the proposal, but also at the time of the revival of the policy whenever it is done. In case there is a rival claimant to the insurance money, the insurer can get a valid discharge by paying to the nominee. The rival claimant can approach a court of law which may order to stop the payment till the case is finally disposed of. However if there is no nomination under the policy, the insurer shall await a valid title through either a will or a probate as a letter of administration or a succession certificate. It may take quite some time to get such certificate from the court and in the meantime the family may suffer. A good agent therefore shall ensure that there is a valid nomination or assignment. If there is an assignment, the policy money is paid to the assignee. If there is a reassignment of the policy, it is necessary that a fresh nomination is done, as assignment invalidates the existing nomination. However, if there is a nomination in favor of the insurer for taking any loan, the nomination is said to be unaffected subject to the claim of the insurer. If the premature death has been due to an accident, it is necessary to get a police inquiry report in lieu of the attending physician certificate. Suicide, if it has taken place within one year of the beginning of the risk, exempts the insurer from the liability of the payment of the claim. The propensity to commit suicide is a moral hazard and is not expected to continue beyond one year.

If the policyholder disappears and he has not been heard of for 7 years by those who would naturally have heard of him, if he had been alive, he is presumed dead as per Sec 108 of the Indian–Evidence Act, 1872. However, it is necessary to keep the policy in force during this period by payment of the due premiums on the due dates.

**Claim concession**

Normally, a death claim becomes payable so long as the policy is kept in force by payment of due premium. In other words if the payment of premium is stopped and the grace period expires and if the death occurs thereafter the policy is treated as lapsed or paid up depending upon whether the premium has been paid for less than 3 yrs or 3yrs & more. Under a lapsed policy no claim is payable. In case of a paid up policy, only the paid up value is payable. However, some companies provide certain concessions with regard to the claim payment, if the policy has run for 3 yrs or more:
1. If the premiums under a policy have been paid for a minimum period of three full years, and the life assured has died within 6 months from the date of the first unpaid premium insurer pays the full sum assured instead of the paid up value and only the unpaid premiums for the policy year are deducted from the claim amount.

2. This concession is extended to a period of twelve months and the full sum assured is paid if the life assured dies within one year from the due date of the first unpaid premium, provided the premiums have been paid for a minimum period of 5 years subject to deduction of the unpaid premiums for the policy year.

**Ex Gratia claim**

When a policy has not acquired paid up value and claim concession rules are not applicable, nothing is payable in case of death. However some insurers relax the rules in favor of the claimant. If the premiums have been paid for more than 2 years and (a) the death occurs within three months from the first unpaid premium, full sum assured with bonus, if any, is payable;

(b) If the death occurs after 3 months, but within 6 months, half the sum assured is paid

(c) If the death occurs within one year from first unpaid premium, notional paid up value is paid.

Under the first condition, the unpaid premium with interest for the policy year of death will be deducted from the claim and no deduction is made in the other two conditions.

**CLAIM SETTLEMENT OPTIONS**

Most claims are paid in single lump sum. In case of a small sum assured, this lump sum payment may become necessary for immediate needs. (However, where the sum assured is large the amount if paid in installments would be a valuable aid to the family maintenance). It is surprising that adequate attention is not paid to this aspect of the settlement options either by the claimant, or by the agent or the insurer. The settlement options as available are not competitive in interest rates and therefore most claimants probably would not opt for it. Lump sum payments are most likely to be spent much
faster leaving the family without the benefit of security. The family in the absence of the breadwinner may not have the foresight and the ability to look to the safety of the capital, rate of return, liquidity and ease of management of money. Many insurance companies world over are facilitating the management of the claim by offering a lot of options to the claimant.

Life insurance can be described as the creation of capital and annuities as a method of distribution of capital. Life insurance companies therefore, can convert this capital into annuity payments as per the needs of the claimant. An agent would do well to advise the widow in this regard and help her to purchase a suitable annuity policy with this claim amount so that the family can look after itself smoothly for quite some time. Annuities of various types are available, as has been discussed in the chapter on “Life Insurance Products”.

Lump sum payment, let it be remembered, does not offer protection against the creditors of the beneficiary, while the payment through annuity payment does. For beneficiaries, inexperienced in the art of money management receiving guaranteed payments in installment may be more desirable.

**IRDA REGULATION ON POLICYHOLDERS PROTECTION**

The Insurance Regulatory and Development Authority have issued the Protection of Policyholders’ Interests Regulations, 2002. This regulation states the matters to be stated in the life insurance policy for the protection of policy holders interests. It also lays down the procedure to be adopted towards the settlement of claim under a life insurance policy.

Claims procedure in respect of a life insurance policy

(i) A life insurance policy shall state the primary documents which are normally required to be submitted by a claimant in support of a claim.

(ii) A life insurance company, upon receiving a claim, shall process the claim without delay. Any queries or requirement of additional documents, to the extent possible, shall
be raised all at once and not in a piece-meal manner, within a period of 15 days of the receipt of the claim.

(iii) A claim under a life policy shall be paid or be disputed giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and clarifications required. However, where the circumstances of a claim warrant an investigation in the opinion of the insurance company, it shall initiate and complete such investigation at the earliest. Where in the opinion of the insurance company the circumstances of a claim warrant an investigation, it shall initiate and complete such investigation at the earliest, in any case not later than 6 months from the time of lodging the claim.

(iv) Subject to the provisions of Section 47 of the Act, where a claim is ready for payment but the payment cannot be made due to any reasons of a proper identification of the payee, the life insurer shall hold the amount for the benefit of the payee and such an amount shall earn interest at the rate applicable to a savings bank account with a scheduled bank (effective from 30 days following the submission of all papers and information).

(v) Where there is a delay on the part of the insurer in processing a claim for a reason other than the one covered by sub-regulation (4), the life insurance company shall pay interest on the claim amount at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

Case study:

To under the claim settlement, let’s go through some case studies:

Flood is a major risk that affects many parts of our country and is a worldwide phenomenon. Countries all over the world, experience the wrath of nature in the form of cyclones, hurricanes and typhoons. Recently, a hurricane christened Charley, the most powerful storm to strike the US since 1992, killed at least 16 and left millions homeless when winds of 140 miles per hour hit the
Southwest Florida coast. Losses due to the recent Hurricane Ivan, which stormed the Caribbean region late September, are yet to be ascertained. As the people across the region pick themselves up from the devastation, another storm Jeanne wreaked havoc in Dominican Republic of Haiti and South Eastern coast of Florida. The fury of floods causes losses to property and lives besides infrastructure facilities like roads, bridges and communication facilities. It is therefore naturally prudent to have adequate insurance cover for such risks that man has no control over nor any known means to avert. Insurance is the only form of protection that is known to man and can at least recover the losses monetarily. Recently, the heavy and incessant rains on 1st & 2nd August 2004, coupled with opening up of the floodgates of Madhubani Dam at Upper Silvassa, the entire area covering approx. 20 Kms radius in Dadra & Nagar Haveli and were flooded and inundated. Continuous rain in the Gujarat region also inundated various areas of Surat and nearby areas. All approach roads to Silvassa and Dadra & Nagar Haveli were closed due to damage to bridges and washing away of roads. Heavy rain continued Silvassa even on 3rd & 4th August, 2004 making it difficult to gain an approach to any of the affected areas. This has led to loss of 128 humans and several animals. In a proactive approach, Bajaj Allianz immediately rushed a team from the Mumbai Regional Office on August 4, 2004 and got in touch with the clients based in the affected area. The team was given a clear mandate to survey and assess the loss based on the situation on the ground, assist in documentation formalities so as to ensure speedy settlement of claims with the minimum of inconvenience to the insured.

The team returned to Mumbai on August 6, 2004 and the first on account payment started rolling out from August 8, 2004 within a week of the loss having taken place. Claims reported from Silvassa alone estimated were to the tune of Rs.14 Cr. On August 8, 2004, we had disbursed approx Rs.2 Cr as on-account payments to various parties. The devastation story repeated itself in Northern India when incessant rain hit Chandigarh, Bhilwara, Jaipur, Kota etc. Water levels reached heights of 10 to 12 feet resulting in extensive damage to factory buildings including machines and stocks lying therein. Electricity supply was disrupted for over a week, which further aggravated the situation preventing emergency measures and loss prevention activity, most equipment and stocks were under water for nearly 18 hours.
Closer inspections of the site after the event showed extensive damage to stocks and extensive rusting to machinery. In some cases, equipment and material were swept away from the original site by nearly 15 to 20 meters away from the original site. After the storm calmed and when everything was gradually returning to normal, the Bajaj Allianz team worked at a furious pace to ensure that the claims payments were released as early as possible. This was absolutely necessary so that the clients could get back to work in the earliest possible time Precautions However there are some loss control measures which can be taken to minimize flood losses. They are: As far as possible, the go down should be selected in such a location where the surrounding road level is lower than the ground level of the place where the building is located. Building should have good plinth height, a minimum of 2 ft. If the complex has a compound wall and gate, the road level at gate should be higher than road level outside the complex. Storage inside the building should be done at a higher level, preferably at a height of 1-2 ft depending upon the nature of susceptibility of the items against water. Any items which are susceptible to water damage should not be stored in the open during the monsoons .Basement storage should be avoided. If basement occupancy cannot be done away with, it should be provided with dewatering pumps which could operate in the event of a water logging, to pump out the all the excess water. The complex should be provided with good storm water drains which should be cleaned regularly.

**Dispute, Litigation & Arbitration**

In concept, arbitration of insurance disputes is desirable since it offers some measure of confidentiality, sidesteps court congestion, provides for consideration of the issues by industry-seasoned and insurance-savvy individuals, and supposedly avoids the time commitments inherent in discovery and motion practice.1 And yet, in reality, arbitration of insurance disputes is not a cure-all. The inadequacy of the arbitration clause, or the parties’ failure to address issues such as choice of law, venue, scope of discovery, enforcement of the award, and right to appeal, often leaves the arbitration proceeding riddled with ambiguity. In addition, without stare decisis, arbitration offers less predictability than do court proceedings.
Further, anyone exposed to the arbitration process can testify to the difficulties and delays that occur during the parties’ selection of the arbitrators, and especially the selection of the neutral umpire. In fact, because of delays, resolution of disputes by arbitration sometimes takes longer than resolution by litigation.\(^2\) Moreover; many believe that arbitration panels render compromise verdicts. Arbitration clauses typically provide that the arbitration panel shall be comprised of disinterested officials of insurance or reinsurance companies, active or retired. As industry insiders, there is tremendous potential for bias and conflict of interest among the arbitrators. Likewise, the panel may be reluctant to issue a ruling that castigates one of the parties. In addition, some believe that officials of insurance or reinsurance companies are ill-equipped (or not inclined) to enforce legal principles strictly. Also, the inability to join necessary third parties (such as intermediaries and brokers who are not parties to the contractual agreement to arbitrate),\(^3\) may result in piecemeal resolution of the dispute and potentially inconsistent rulings.

One popular method of resolving disputes in the reinsurance industry is arbitration. Arbitration is defined as a process of dispute resolution in which a neutral third party (arbitrator) renders a decision after a hearing at which both parties have an opportunity to be heard.”

Arbitration in the reinsurance context allows parties to a reinsurance contract to have their disputes resolved by an impartial third party who is versed in the intricacies of reinsurance. While some may believe that arbitration is a relatively new alternative to litigation, it is quite the opposite. In fact, arbitration has been a method of resolving disputes since ancient Greek times when traveling wise men, for a fee, would act as ad hoc arbitrators.

In medieval times, arbitration was used to settle business disputes between merchants. In early England, however, arbitration was dis-favored by the English courts, since the judges, who were paid based upon the number of cases they decided, likely felt that arbitration infringed on their livelihood. This contempt toward arbitration eventually carried over to the U.S. judicial system. However, such animosity has lessened, and U.S. courts now look favorably upon arbitration as an alternative method of dispute resolution.
In fact, courts now lean defer to arbitration awards. In a 1997 decision, the U.S. District Court for the Southern District of New York adopted the high standard recognized by the Second Circuit—“manifest disregard of the law”—as the standard by which to vacate an arbitral award.

The court further supported the common practice of not providing reasons for an arbitral decision, and held that for an award to be overturned, the arbitrators must disregard a law that is well defined, explicit, and clearly applicable. This high standard clearly demonstrates the trend toward judicial deference to arbitral awards.

Of course, there is no requirement that reinsurance disputes be arbitrated. In fact, certain reinsurers, particularly facultative reinsurers, often prefer to litigate. If the reinsurance contract contains an arbitration clause, however, it is likely to be found valid and enforceable if it was consented to by the cedent and the reinsurer. In most cases, U.S. courts strongly favor enforcement of arbitration clauses. In other words, in the absence of an arbitration clause, U.S. courts will not go so far as to order arbitration, but a cedent and a reinsurer may agree to arbitrate and need not fear interference from the court.

Today, most reinsurance contracts contain arbitration agreements intended to steer the parties toward this type of dispute resolution. Even though a contract contains an arbitration agreement, however, the parties are free to later agree not to arbitrate and can then resolve their dispute in another manner, including litigation.

One might run up against a health insurance claim denial when you use a medical service. Fortunately, routes are available for disputing claim denials, including getting help from the government in many states.

It's usually worth fighting your denial. Sometimes your insurer will surrender and pay your claim to avoid the expense of handling an appeal. Sometimes your protests will uncover and reverse a mistake the insurer has made. And often a combination of the two will result in at least a partial payment.

**Prevention**

The best way to avert a claim problem is to avoid a dispute in the first place.
This will take a little work on your part: You must read your policy and understand what it covers -- and doesn't cover -- before you get treatment. Pay particular attention to procedures and treatments that require prior approval from your insurer. If you fail to get prior approval, your care may not be covered.

Alert your doctor about what's covered under your policy and try to make sure that she knows when prior approval is required. Your doctor deals with many patients and health insurance companies, so you can't expect that she will be as familiar with your health plan as she is with your medical history.

If you are enrolled in a PPO or HMO make sure that you understand your health plan’s policy about using network providers. If you are in an HMO you will not be covered for any health-related services outside the HMO network unless you need some type of procedure that is not available in the network. You will need to get prior approval from the HMO for such services. The same applies for your PPO, you most likely can go out-of-network, but you will have significant out-of-pocket expenses.

If there is anything in your policy that you don't understand, call your health plan's customer service line and ask for an explanation.

Once you file a claim or you have asked for a pre-approval of a treatment, keep all of the records -- provider bills, explanations of benefits notices from your insurer and all other correspondence -- in a folder or paper-clipped together, so you can review them at a glance if the need arises.

**If Your Claim is Denied**

Start by reviewing paperwork file. Then call your health plan's customer service line. Often, mistaken denials can be cleared up at this level. Be sure to take notes on all phone conversations, including the date and time of the call, the names of the people you talk to and what was discussed.

**Formal Appeals**

If speaking with a customer service representative does not work, you may have to escalate to a formal written appeal.
Your insurance policy will outline the paperwork your health plan requires you to file. You can expect to provide a great deal of information in writing, including copies of bills, your healthcare provider's name, address and phone number, and your physician's statement about why your treatment was or will be necessary.

Many health plans have several steps in the appeal process. If your initial appeal is denied, you most likely will have additional appeals available. The entire appeal process should be outlined in the benefits booklet you received from your health plan.

**Independent Reviews**

In many states, you can ask your state insurance commissioner's office to perform an independent review of your dispute. This step is usually taken after you go through your health plan's internal appeals process first.

To find out about an independent review, check your health plan benefits booklet (sometimes referred to as “Evidence of Coverage”), which in some states is required to inform health plan members about appeals options external to the health plan. Another important resource is your state’s insurance department, or agency.

**Arbitration**

Some health plans offer arbitration, in which an independent third party reviews the dispute and recommends an outcome. Whether the arbitrator's ruling is binding depends on the state and the health plan.

If arbitration is offered under an employer-provided health plan, federal law says you can't be charged for using it.

**Be Organized and Persistent**

The more information you have, the more likely you are to win your claims denial appeal. Create a paper trail by keeping the following:

- your health insurance policy
- copies of denial letters from your health plan
- copies of any correspondence between you and your health plan, or between your health care provider (such as your doctor, hospital, or lab) and your health plan
detailed notes of conversations with your health plan

copies of correspondence with your state insurance department

If you get your health insurance through your employer, you should discuss your claims situation with your company’s benefit manager, who may have some leverage with your health plan.

**Litigation**

The impact of litigation against a company can be tremendous, both in terms of expenses involved and its effect on a company’s reputation. Even where a potential adverse outcome is considered remote, the outcome of such litigation can significantly reduce a company’s perceived value.

In a sale purchase, restructuring or refinancing transaction, disclosure and due diligence may identify a potential litigation which, although remote, could cause a prospective buyer or financier to re-evaluate the transaction. In order to take the transaction forward the buyer or financing bank may require that either part of the consideration is placed in escrow or an adjustment is made to the consideration or loan facility. This may impact the value or overall viability of the deal.

Litigation insurance can be a useful tool to provide ring-fenced third party security for the contingent litigation risk, thus enabling the transaction to move forward. It is a bespoke policy put in place with the specific objective of covering the adverse outcome of a potential litigation, including damages, awards and/or settlements along with the defence costs that may be incurred by the insured party in connection with the resolution of the litigation.

The litigation may be perceived as a remote risk (i.e. where a notification was made from a claimant some time ago but no proceedings have been issued), or can be more advanced in the claims process, for example, where the risk relates to an adverse outcome from appeal. Typically, for cases in which insurance is structured the risk is remote but the quantum of an adverse outcome is significant and can represent a major percentage or even exceed of the value of the target. Policies can be structured to transfer the entire financial risk or, as is typically the case in more advanced litigation, arranged as a ‘cap’ excess of a certain assessed level of risk outcome or self-insured level, thus offering
‘worst case’ coverage. Whilst generally negotiated in conjunction with a transaction, coverage can be arranged as a commercial or strategic objective for clients wishing to transfer a litigation risk that could impinge on a business’s ongoing balance sheet. The process of arranging litigation insurance typically takes a minimum of two weeks and consists of the following stages:

**Feasibility:**

Our experts can make an initial assessment of feasibility through discussions. However, in order to obtain indications of appetite for the risk and to provide any guidance on premium levels from underwriters, the policy negotiation process involves providing the following:

– an overview of the litigation risk;
– Copies of any advice (legal) provided by the clients’ advisers on the risk;
– Copies of any other documentation relevant to the risk including pleadings and rebuttals; and
– A conference call with the client and/or their advisers to answer any queries.

**Indication:**

Insurers will then offer an indication of terms including premium and any requests for further information. This indication will be subject to the insurers’ own due diligence review.

**Insurers Underwriting Diligence:**

Insurers will appoint their own advisers to conduct an underwriting diligence review in order to assess the risk. At this stage, more extensive documentation may be required by the insurers.

**Policy Negotiation:**

As each litigation risk is individual in nature, the policy wording for each project is specifically adapted. Willis’ knowledge, expertise and experience in such negotiations is central during such discussion.
Completion:

Once the policy wording negotiations are settled, the client can accept the offer from insurers. Cover will be incepted subject to insurers being in receipt of the premium. It is difficult to provide accurate guidance on premium levels without knowing the details of the litigation risk. Unlike other transaction insurances where a more generic premium range is applicable, every litigation risk is viewed on its specific circumstances. Insurers’ evaluations will vary depending upon the complexity of those circumstances and the likelihood of a litigation process being commenced. In our experience, if the risk is insurable the rate (which is applied to the aggregate policy limit) varies between 4-8%. In addition, the insurers may instruct external advisers for their underwriting due diligence. The growing use of binding, pre-dispute arbitration clauses poses a huge threat to insurance consumers. It represents a major shift in the balance of power between insurers and consumers that must be addressed by state legislators and insurance regulators.

Background: How Arbitration Differs From Litigation

Arbitration is a form of alternative dispute resolution (ADR). Its original purpose was to provide a swift and informal means of adjudicating disputes between businesses. Its use has also been customary in fixing the amount of loss for purposes of property damage, uninsured motorist and no-fault automobile coverage. Unfortunately, in recent years businesses have realized that binding, pre-dispute arbitration clauses can be used to gain an unfair advantage in fighting lawsuits by consumers and workers. It now appears that some insurance companies have begun using the clauses to immunize themselves from suits over bad faith claims settlement practices, consumer fraud, and denials of treatment in managed care.

The advantage a company may gain comes from five unique characteristics of arbitration: High costs. While the court system is publicly subsidized, arbitration is not. In fact, the costs of litigating in a private court system are very steep. Typically filing fees in arbitration cases range between $750 and $3,000. Arbitrators hourly fees, which must be deposited in advance, amount to thousands of dollars more. These costs raise an insurmountable barrier for most litigants, who usually are financially distressed because
of the same incident that gave rise to their legal problem. The result is that claims that could have been asserted in court must be abandoned.

*Arbitrator bias.* Arbitrator bias results from two features of the system. First, the potential for receiving "repeat business" provides an incentive for arbitrators to favor companies that are frequent users of the system. Arbitrators who issue high awards or rule for plaintiffs in close cases can be and have been blackballed from future cases. Second, most arbitration panels include representatives of the industry being sued. Needless to say, people having such sympathy for defendants would never be included on a jury. As a result, arbitration awards tend to be a fraction of what juries award in comparable cases.

*Unavailability of class actions.* Class actions are extremely important in remedying nickel-and-dime cheating by businesses. It is not feasible for consumers to recover small-scale overcharges in individual proceedings. This means that pro-consumer laws such as the Real Estate Settlement Procedures Act, which bans kickbacks in mortgage transactions, are harder to use in combating frauds such as "packing" of credit life insurance policies by predatory lenders. Insulation from class actions gives unscrupulous insurers a license to steal in small increments.

*Unavailability of discovery.* Discovery is the procedure by which parties to a lawsuit obtain information from each other and from third parties. Discovery is especially important to consumer plaintiffs who need access to business records to prove their cases. While discovery is a right in court proceedings, in arbitration it is a privilege granted at the discretion of the arbitrator. Moreover, arbitrators have no authority to order non-parties to comply with subpoenas, often requiring the filing of a court case which arbitration is supposed to make unnecessary.

*Finality.* It is nearly impossible to appeal an arbitration ruling, even if an arbitrator ignores the law. Not only can this lead to unfairness in individual cases, but it also prevents the law from evolving in response to new problems.

### How Arbitration Clauses Threaten the Protection of Insurance Consumers

There are three primary areas in which arbitration abuses arise in the insurance context.

**Bad Faith Claims Settlement Practices**

Lawsuits over "bad faith" or unfair claim settlement practices play an important role in protecting insurance consumers. Often an insurance company will "low-ball" claimants or
unreasonably delay or deny claims. Some disreputable insurers do this on a regular basis. The "bad faith" lawsuit remedies such practices, by requiring the insurer to pay punitive damages and/or attorney's fees in addition to the amount of the claim. Raising the stakes in this manner is a crucial deterrent to insurer misconduct.

The case of Southern United Fire Insurance Company v. Pierce, 775 So.2d 194 (Ala. 2000) demonstrates how an insurance company may draft an arbitration clause to insulate itself from damages for bad faith refusals to pay claims. The clause they used required panels of three arbitrators, tripling the fees that the consumer must pay to have his case heard. The clause also prohibited the arbitrators from allowing discovery of "evidence relating in any way to a transaction other than the [consumer's] specific transaction." This restriction makes it impossible to prove that the company engaged in a pattern of improper denials of claims, a crucial element of establishing a case for bad faith activity.

Managed Care

The second area in which arbitration threatens insurance consumers is managed care. As states have slowly begun to impose liability upon HMOs for arbitrary denials of treatment, and Congress seems poised to allow liability for ERISA health plans, insurers have begun imposing arbitration clauses upon patients. Unless Congress prohibits HMOs from requiring arbitration, Patients Bill of Rights legislation may be rendered toothless.

Even under current law, HMOs can be liable for medical malpractice committed by the doctors they employ. The table below compares medical malpractice awards in Kaiser Permanente's arbitration program in California to jury verdicts. As the table clearly shows, by any measure, injured patients receive far less compensation from arbitrators than they do from courts.

Misrepresentations and other deceptive practices have all too often been used in marketing insurance, and arbitration clauses are preventing consumer advocates from remedying them. One example is the sale of single premium credit life insurance policies as part of predatory lending transactions. Consider what happened to Lorraine King of Dolton, Illinois, who was solicited for a subprime mortgage refinancing. The lender added a credit life insurance policy at a cost of $10,555.61. The lender admitted receiving a six percent kickback from the life insurance company. The same life insurance
company sells the credit life policy to borrowers in the prime market for $16.50 per month.

A Consumers Union study found that the loss ratios for credit life policies (the ratio of benefits paid out to premiums paid in) "are unconscionably low far below any reasonable measure of benefit in relation to the premium charged to consumers."

Arbitration clauses are being used to insulate credit life insurers from judicial scrutiny of their practices. Credit life insurers began using the clauses in response to a spate of fraud lawsuits initiated by state attorney generals and individual consumers. Not surprisingly, an arbitration agreement was included in the loan documents signed by Mrs. King.

**State Regulation of Arbitration**

The Federal Arbitration Act (FAA) mandates that all arbitration clauses be enforced by the courts, and preempts state legislatures from banning them. The exception to this rule, however, is arbitration clauses in insurance contracts. The McCarran-Ferguson Act "reverse preempts" FAA and allows states to restrict the use of arbitration by insurance companies.

Some states ban the use of arbitration by insurers. In eleven states there is a statutory ban applying across the board to any insurance contract, although three of those states courts have not upheld the ban. In three states, there is no statutory ban but courts have refused to permit arbitration of bad faith lawsuits. Most states, however, have not enacted any restrictions on arbitration, and consumers are seriously threatened.

For years the business community has lobbied legislators to roll back consumers right to sue. Now, however, they can accomplish through the use of preprinted forms more than they ever hoped to accomplish through legislation: abolition of the right to trial by jury, de facto caps on damage awards, and elimination of class action lawsuits. Indeed, the head of one arbitration provider has told corporate counsel that using arbitration clauses lets them enact "do-it-yourself civil justice reform."

This abuse of arbitration demands attention by insurance regulators. We propose that NAIC consider model state legislation and model regulations to protect consumers from unfair arbitration clauses.
Potential Solutions

We believe the best approach to this problem is to simply ban the imposition of binding, pre-dispute arbitration clauses altogether. This leaves open to consumers the option of choosing arbitration after a dispute has arisen. When arbitration is a post-dispute option, the parties are free to compare different ADR methods and providers with court litigation, and can choose the most efficient and cost-effective forum for an individual case. This competitive marketplace for dispute resolution options, sometimes called the "multi-door courthouse" approach, forces both the courts and ADR providers to resolve cases speedily and inexpensively.

The other approach is to regulate the imposition of binding, pre-dispute arbitration. The attached summary of state laws on arbitration demonstrates that there a number of options in this regard.

Some states have chosen to simply require that conspicuous notice be given to consumers of arbitration requirements. We feel that this is insufficient, given the realities of the insurance market. First, consumers do not understand the significance of the arbitration clause; certainly those consumers who fall prey to predatory practices such as single-premium credit life policies would be unlikely to understand it. Second, arbitration clauses are becoming so prevalent that it may be impossible to find a competing insurer who doesn't require them. Third, health insurers are usually chosen by one's employer, making notice requirements moot in the context. Finally, consumers who object to the clauses identify themselves as rights-conscious, and may be subject to informal blacklisting.

Any regulation of arbitration must be carefully tailored to address all five of the problems enumerated at the beginning of this paper: cost, bias, class actions, discovery, and appeals and must extend in scope to the three main problem areas: fraudulent marketing, managed care, and bad faith.

Medical Malpractice Awards: Arbitration versus Litigation

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<th>System</th>
<th>Mean Award</th>
<th>Median Award</th>
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<td>Kaiser Arbitration</td>
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Each year, many millions of business transactions take place. Occasionally, disagreements develop over these business transactions. Many of these disputes are resolved by arbitration, the voluntary submission of a dispute to an impartial person or persons for final and binding determination. Arbitration has proven to be an effective way to resolve these disputes privately, promptly, and economically.

The American Arbitration Association® (AAA®), a not-for-profit, public service organization, offers a broad range of dispute resolution services to business executives, attorneys, individuals, trade associations, unions, management, consumers, families, communities, and all levels of government. Services are available through AAA headquarters in New York and through offices located in major cities throughout the United States. Hearings may be held at locations convenient for the parties and are not limited to cities with AAA offices. In addition, the AAA serves as a center for education and training, issues specialized publications, and conducts research on all forms of out-of-court dispute settlement.

**Standard Arbitration Clause**

The parties can provide for arbitration of future disputes by inserting the following clause into their contracts:

*Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration administered by the American Arbitration Association under its Commercial Arbitration Rules and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.*

Arbitration of existing disputes may be accomplished by use of the following:

*We, the undersigned parties, hereby agree to submit to arbitration administered by the American Arbitration Association under its Commercial Arbitration Rules the following*
controversy: (describe briefly) We further agree that the above controversy be submitted to (one) (three) arbitrator(s). We further agree that we will faithfully observe this agreement and the rules, that we will abide by and perform any award rendered by the arbitrator(s), and that a judgment of any court having jurisdiction may be entered on the award.

In transactions likely to require emergency interim relief, the parties may wish to add to their clause the following language:

*The parties also agree that the AAA Optional Rules for Emergency Measures of Protection shall apply to the proceedings.*

**Pros of Arbitration**

Promoted as a way to resolve disputes efficiently, proponents of arbitration commonly point to a number of advantages it offers over litigation, court hearings, and trials.

**Avoids hostility.** Because the parties in an arbitration are usually encouraged to participate fully and sometimes even to help structure the resolution, they are often more likely to work together peaceably rather than escalate their angst and hostility toward one another, as is often the case in litigation.

**Usually cheaper than litigation.** Arbitration is becoming more costly as more entrenched and more experienced lawyers take up the cause. It is not unusual, for example, for a well-known arbitrator to charge $3,000 to $4,000 per day for his or her services. And most parties in arbitrations will also hire lawyers to help them through the process, adding to their costs. Still, resolving a case through arbitration is usually far less costly than proceeding through litigation because the process is quicker and generally less complicated than a court proceeding.

**Faster than litigation.** According to a recent study by the Federal Mediation and Conciliation Services, the average time from filing to decision was about 475 days in an arbitrated case, while a similar case took from 18 months to three years to wend its way through the courts.

**Flexible.** Unlike trials, which must be worked into overcrowded court calendars, arbitration hearings can usually be scheduled around the needs and availabilities of those involved, including weekends and evenings.
**Simplified rules of evidence and procedure.** The often convoluted rules of evidence and procedure do not apply in arbitration proceedings -- making them less stilted and more easily adapted to the needs of those involved. Importantly, arbitration dispenses with the procedure called discovery that involves taking and answering interrogatories, depositions, and requests to produce documents -- often derided as a delaying and game-playing tactic of litigation. In arbitrations, most matters, such as who will be called as a witness and what documents must be produced, are handled with a simple phone call.

**Private.** Arbitration proceedings are generally held in private. And parties sometimes agree to keep the proceedings and terms of the final resolution confidential. Both of these safeguards can be a boon if the subject matter of the dispute might cause some embarrassment or reveal private information, such as a company's client list.

**Cons of Arbitration**

Being aware of the possible drawbacks of arbitration will help you make an informed decision about whether to enter or remain in a consumer transaction that mandates it -- or whether to choose it as a resolution technique if a dispute arises.

**Limited recourse.** A final decision is hard to shake. If the arbitrator's award is unfair or illogical, a consumer may well be stuck with it and barred forever from airing the underlying claim in court.

**Uneven playing field.** Some are concerned that the "take-it-or-leave-it" nature of many arbitration clauses work in favor of a large employer or manufacturer when challenged by an employee or consumer who has shallower pockets and less power.

Most retailers -- car dealers are repeat offenders here -- do not mention the arbitration clause before requiring the customer to sign the purchase agreement. Or they will wait until you are ready to drive the car off the lot, then casually mention that they won't sell unless you sign.

**Questionable objectivity.** Another concern is that the process of choosing an arbitrator is not an objective one, particularly when the decision-maker is picked by an agency from a pool list, where those who become favorites may get assigned cases more often.

Adding possible complication: Many of the national arbitration groups actively market their services to companies that issue credit cards or sell goods to consumers, casting additional questions on the alleged neutral's objectivity. And an arbitrator chosen by a
party within an industry may be less objective, more likely to be biased in favor of the appointing group.

**Lack of transparency.** As mentioned, the fact that arbitration hearings are generally held in private rather than in an open courtroom, and decisions are usually not publicly accessible, is considered a benefit by some people in some situations. Others, however, lament that this lack of transparency makes the process more likely to be tainted or biased, which is especially troublesome because arbitration decisions are so infrequently reviewed by the courts.

**Rising costs.** While most still claim that arbitration is less costly than litigation, its costs are increasing. According to a recent survey by Public Citizen, a consumer watchdog group, the cost of initiating an arbitration is significantly higher than the cost of filing a lawsuit: $6,650 to $11,625 to initiate a claim to arbitrate a consumer claim worth $80,000 versus $221 to file that action in a particular county court. Add to that the arbitrator's fees -- multiplied by three if a panel is involved -- in addition to administrative costs, and the process appears to be less of a bargain.

**Smart Steps for Consumers**

Given the possible perils and unevenness for those who unwittingly enter arbitration contracts, the wise consumer can take a number of steps to become better informed and, possibly, ward off a bad experience.

**Know the terms of your agreements.** Read or reread all agreements you've entered with a retailer, credit card company, or health care provider that may contain arbitration provisions. If the writing obligates you to binding arbitration, and that is not your wish, shop around for another provider.

**Heed all agreement changes.** If a company switches the terms of its contract to include mandatory arbitration, it must notify you in writing first. Some of these notices may come buried in the envelope itemizing your bill. Resist the temptation to recycle them on sight -- and read the fine print.

**Speak your mind.** If you find an arbitration clause objectionable, be sure to make your feelings known to company management. It is sometimes possible to negotiate the provisions away if the company wants your business badly enough. And even large
behemoths have been known to change their mandatory arbitration policies if they cause enough distress among their customers.

Here's what to expect in a typical arbitration.

**Initiating the arbitration.** If your agreement requires you to use one of the large arbitration associations, the agency helps select the arbitrator, or panel of up to three people for more complex cases, who will hear and decide the dispute. These agencies usually impose their own procedural rules and oversee the housekeeping details such as notifying the parties about when and where to meet.

If no group has been specified, the parties are on their own to administer the proceeding, choose arbitrators, and set the schedule and rules that will control. Such ad hoc arrangements are often quicker and less expensive than when an agency is involved, but require a fair amount of cooperation between the disputing parties, who must agree on important matters, such as which arbitrator will decide the matter.

**Pre-hearing conferences.** Brief conferences are sometimes held before the arbitration hearing to sketch out details such as the need for confidentiality throughout the entire process and to iron out hotly contested issues, such as whether an arbitrator can also decide related claims.

**The arbitration hearing.** Unlike trials, which are generally confined to courtrooms, the parties can agree to have arbitrations in any convenient setting, although a neutral office or conference center is usually deemed best. Cost, formality, and location also weigh into the decision.

At the hearing, each side has the chance to present his or her version of the conflict, usually with a brief opening statement bolstered by evidence such as relevant contracts and other paperwork, and tangible things -- for example, a piece of broken or shoddy merchandise if that plays a role in the dispute. Witnesses may also be called to testify and be questioned and cross-examined.

That is usually followed by brief closing arguments during which both sides summarize the evidence, explain how it relates to the individual theory of the case, and set out why the arbitrator should rule in his or her favor. In some arbitrations, there are no closing arguments, but the parties are encouraged instead to write out their theories and evidence in post-hearing briefs.
The arbitration decision. Arbitrators are free to base their decisions on their own ideas of what is fair and just. Unlike judges, they are not required to follow the law or the reasoning of earlier case decisions. Most will submit their decisions in writing -- sometimes as a simple statement of who won and how much money is due him or her, sometimes with explanations and a rationale of the reasoning ranging in length from a few to dozens of pages. While one goal of arbitration is to get disputes resolved quickly, arbitrators operate under widely varying deadlines -- from ten days to six months -- as to when their decisions are due.

Appealing the arbitration decision. Arbitration decisions are usually regarded as final and it is very tough to get a court to review or vacate them. Generally, an arbitrator's decision can only be appealed if there is proof that:

- corruption, fraud, or undue influence was used in securing the award
- the arbitrator was corrupt or biased
- the arbitrator refused to postpone the hearing even though there was sufficient cause to delay it, or
- the arbitrator exceeded his or her power.

Below are the steps for a better management of claims:

1: Claims reporting

The insurance company writes insurance policies in easily understandable language. Policies spell out what is covered and what is not covered. If necessary, plain language explanations could be an addendum to the legal language. The insurance company draws the attention of the policyholder/claimant/beneficiary both when he/she signs a policy (for policyholders only) and when he/she reports a loss on his/her duties related to claim reporting which include:

- To try to minimize losses;
- To report claims in a timely fashion; To co-operate in the investigation by providing the company with all relevant information and, in particular, copies of official documents regarding the damage (accident, loss, etc.);
To authorize the company to handle necessary inspections and assess the extent of the damage prior to any repairs or replacement; To ensure that the claims reporting phase proceeds as smoothly as possible, the insurance company sends to the policyholder/claimant/beneficiary within a reasonable period of time (beginning from when the loss is reported)

An appropriate claim form (when the loss reporting is made in writing) for the type of policy -prepared either by an individual insurance company or at the national level by companies or the supervisory authorities together with instructions and useful information on how to comply with the terms of the policy and the legitimate requirements of the company; The information necessary to help them to report the claim.

2: Receipt of claims by the company

The company claim department and/or the intermediary (if applicable) are as accessible as possible for the claimant. If an intermediary is an initial contact for claimants, claims should be sent to the company claim department within an appropriate time period.

The insurance company contacts the policyholder/claimant/beneficiary or sends an acknowledgement of receipt as soon as the claim is received.

3: Fraud detection and prevention

In order to curb the growth of fraudulent claims and the rise in premium costs that results from them, companies take the following steps:

They establish compliance programs for combating fraud and money laundering appropriate to their exposure and vulnerabilities.

In the claim filing phase, they discourage fraudulent practices by making the policyholder/claimant/beneficiary aware of the consequences of submitting a false
statement (which in particular could be liable to prosecution) and/or an incomplete statement. To this end, insurance companies place a notification on their claims forms referring to the appropriate law, statute or insurance regulation that addresses the filing of fraudulent or incomplete claims.

- Where legally possible, companies participate in relevant databases where claims susceptible to be fraudulent would be reported. Moreover, public authorities may encourage or take steps to initiate the creation of a public or private bureau of insurance fraud.

- Besides, companies provide their claims department staff with adequate training on fraud indicators.

4: Claims assessment

General issues:

- Any method of taking into account specific factors such as depreciation, discounting or negligence on the part of the victim is clearly outlined in the claim file.

- Any loss evaluation methods used by the company are reasonable and coherent.

- The insurance company uses internal methods for assessing claim values based on the applicable law of the jurisdiction.

5: Timely claim processing

In accordance with applicable insurance law, companies may specify in the contract the most likely period of time for responding to correspondence from policyholders/claimants/beneficiaries.

- Once policyholders/claimants/beneficiaries have filed a claim:

- They are informed of the acceptance or denial of the claim within a reasonable amount of time after the receipt of the notification.
The insurance company contacts any other company that is involved in the claim within a reasonable amount of time, and resolves inter-company claim disputes as quickly as possible.

The insurance company endeavours to settle the claim as soon as possible and advises in writing the policyholder/claimant/beneficiary on the reasons for any delay.

Quick claims settlement as well as high-quality and punctual information provided to the policyholder/claimant/beneficiary are key competition features for insurance companies.

After an agreement has been reached between the company and the policyholder/claimant/beneficiary on the amount of compensation, the payment is effected within a reasonable amount of time.

Insurance companies implement and update their own statistical database tracing their performance in the timely settlement of claims as well as in trends in settlements and expenses. A proper procedure for the coding and statistical processing of losses is developed for this purpose.

6: Complaints and dispute settlement
Complaints/Disputes:

- When the policyholder/claimant/beneficiary files a complaint, the company:
  - Acknowledges receipt of the complaint within a reasonable period of time;
  - Provides policyholders/claimants/beneficiaries with explanations on how their complaints will be handled and on the procedures to be followed;
  - Provides information to policyholders/claimants/beneficiaries on internal and external dispute settlement procedures;
• Processes complaints promptly and fairly; Keeps policyholders/claimants/beneficiaries regularly informed of how their complaints are progressing;

• Provides a final response in writing within a reasonable period of time.

• If the policyholder/claimant/beneficiary is dissatisfied with the final response that he/she has been sent by the company, he/she can activate an internal appeals process. He/she can also appeal to the dispute settlement procedures available outside the company (for example, the handling of complaints by the supervisory authorities). In case of a dispute, the insured/claimant/beneficiary should be informed by the company of the existence of these appeal procedures.

7: Supervision of claims-related services

The insurance supervisory authorities may conduct examinations on claims management services especially where problems are suspected.

In these cases, the following elements are taken into account:

• Possible access to non-confidential claims data for all open and closed files within a specified time frame (e.g. for the current year and the two preceding years);

• Maintenance of sufficient and appropriate information on claims files;

• Use of the appropriate type of claim form for the type of insurance;

• Proper qualification of the claims department’s employees based inter alia on the applicable insurance code;

• Valuation of claims payments according to company procedures;

• Appropriate tracking of the nature and number of complaints related to claim management process;
• Monitoring of the proportion of claims that result in litigation;

8: Compliance with procedures for combating fraud and money laundering;

• Regular internal audit practices on claims files;

• Appropriate internal claims procedure manuals;

• Proper procedure for coding and statistical reporting of losses

THE ROLE OF INSURANCE INTERMEDIARIES

Introduction
The importance of insurance in modern economies is unquestioned and has been recognized for centuries. Insurance “is practically a necessity to business activity and enterprise.” But insurance also serves a broad public interest far beyond its role in business affairs and its protection of a large part of the country’s wealth. It is the essential means by which the “disaster to an individual is shared by many, the disaster to a community shared by other communities; great catastrophes are thereby lessened, and, it may be, repaired.” Insurance is an essential element in the operation of sophisticated national economies throughout the world today.

Without insurance coverage, the private commercial sector would be unable to function. Insurance enables businesses to operate in a cost-effective manner by providing risk transfer mechanisms whereby risks associated with business activities are assumed by third parties. It allows businesses to take on credit that otherwise would be unavailable from banks and other credit-providers fearful of losing their capital without such protection, and it provides protection against the business risks of expanding into unfamiliar territory – new locations, products or services – which is critical for encouraging risk taking and creating and ensuring economic growth.

Beyond the commercial world, insurance is vital to individuals. Lack of insurance coverage would leave individuals and families without protection from the uncertainties of everyday life. Life, health, property and other insurance coverage are essential to the financial stability, well-being and peace of mind of the average person.
Insurance is a financial product that legally binds the insurance company to pay losses of the policyholder when a specific event occurs. The insurer accepts the risk that the event will occur in exchange for a fee, the premium. The insurer, in turn, may pass on some of that risk to other insurers or reinsurers. Insurance makes possible ventures that would otherwise be prohibitively expensive if one party had to absorb all the risk. Advancements in medicine, product development, space exploration and technology all have become a reality because of insurance.

Consumers buy automobile insurance to cover both their cars and people who may be injured in accidents. Homeowners and renters buy insurance policies to protect their property and protect themselves from liability. People buy life and health insurance to protect themselves and their families from financial disaster in case of illness or death.

In some instances, governments require businesses to purchase insurance. Known as financial responsibility requirements, government-mandated purchases of insurance is intended to ensure that injured parties will be compensated. Businesses also require other businesses to buy insurance. For instance, a retailer may require its suppliers to carry product liability insurance. Similarly, hospitals may require doctors to carry medical malpractice insurance, and mortgage firms often require their clients to insurance the properties used as collateral. Distribution of insurance is handled in a number of ways. The most common is through the use of insurance intermediaries. Insurance intermediaries serve as the critical link between insurance companies seeking to place insurance policies and consumers seeking to procure insurance coverage. Intermediaries, traditionally called “brokers” or “agents” or “producers,” offer advice, Information and other services in connection with the solicitation, negotiation and sale of Insurance.

Over the last two decades, many professional intermediaries have developed services that go beyond the services related to the transferring of risk from insureds to insurers; Intermediaries now offer services such as the evaluation and implementation of alternative means of funding for potential losses, risk management strategies and claims management.

Insurance Intermediaries
Insurance intermediaries facilitate the placement and purchase of insurance, and provide services to insurance companies and consumers that complement the insurance placement process. Traditionally, insurance intermediaries have been categorized as either insurance agents or insurance brokers. The distinction between the two relates to the manner in which they function in the marketplace.

**Insurance Agents**

Insurance agents are, in general, licensed to conduct business on behalf of insurance companies. Agents represent the insurer in the insurance process and usually operate under the terms of an agency agreement with the insurer. The insurer-agent relationship can take a number of different forms. In some markets, agents are “independent” and work with more than one insurance company (usually a small number of companies); in others, agents operate exclusively – either representing a single insurance company in one geographic area or selling a single line of business for each of several companies. Agents can operate in many different forms – independent, exclusive, insurer-employed and self-employed.

**Insurance Brokers**

Insurance brokers typically work for the policyholder in the insurance process and act independently in relation to insurers. Brokers assist clients in the choice of their insurance by presenting them with alternatives in terms of insurers and products. Acting as “agent” for the buyer, brokers usually work with multiple companies to place coverage for their clients. Brokers obtain quotes from various insurers and guide clients in determining the adequate policy from a range of products.

In some markets, there are distinctions among brokers depending upon the types of insurance they are authorized (licensed) to intermediate – all lines of insurance, property and casualty or life/health coverage. While most, if not all, brokers are active in commercial lines, some also intermediate personal lines policies. There are also distinctions between “retail brokers,” who negotiate insurance contracts directly with consumers, and “wholesale brokers,” who negotiate insurance contracts with retail brokers and agents, but not directly with consumers. Reinsurance brokers solicit, negotiate and sell reinsurance cessions and retrocessions on behalf of ceding insurers.
seeking coverage with reinsurers. Reinsurance brokers can also be involved in a reinsurer’s retrocession of parts of its risk. As a technical matter, a broker’s role may change during an insurance transaction and over the course of an on-going relationship with a client. Many brokers sometimes act as an “agent” of the insurer and other times as a “broker” of the client when assisting a client with insuring its risk exposures through an insurance contract with a traditional carrier.

For example, the broker acts on behalf of the client when negotiating the contract of insurance and placing the policy. When the broker provides services that would otherwise be handled directly by the insurance company, such as premium payments and claims handling, the broker is essentially acting as agent for the company. This unique concept makes the insurance process more efficient for both the policyholder and the insurer. As a practical matter, regardless of the legal role in which a broker is acting, the manner in which the broker approaches all such placements for their clients is as an intermediary – working on behalf of their clients to facilitate the consummation of insurance contracts with carriers that have the ability and capacity to properly insure their risks.

Determining whether an intermediary is legally an agent or broker is not always clear-cut. An intermediary’s status is determined by the totality of the facts regarding the specific transaction at issue. An intermediary might be called a “broker,” but actually represent the insurance company in a particular transaction. In such situations, the broker is actually – and legally – considered the company’s agent, not that of the customer. Although, such an activity-based approach is increasingly used around the world, the legal status of insurance intermediaries varies throughout the international insurance market. For purposes of this memorandum, included within the term “intermediary” are insurance agents, brokers, producers, advisors and consultants.

The Role of Insurance Intermediaries

As players with both broad knowledge of the insurance marketplace, including products, prices and providers, and an acute sense of the needs of insurance purchasers, intermediaries have a unique role – indeed many roles – to play in the insurance markets in particular and, more generally, in the functioning of national and international
Intermediary activity benefits the overall economy at both the national and international levels: The role of insurance in the overall health of the economy is well-understood. Without the protection from risk that insurance provides, commercial activities would slow, perhaps grinding to a halt, thus stunting or eliminating economic growth and the financial benefits to businesses and individuals that such growth provides. The role of insurance intermediaries in the overall economy is, essentially, one of making Insurance — and other risk management products — widely available, thereby increasing the positive effects of insurance generally — risk-taking, investment, provision of basic societal needs and economic growth.

There are several factors that intermediaries bring to the insurance marketplace that help to increase the availability of insurance generally:

**Innovative marketing**

Insurance intermediaries bring innovative marketing practices to the insurance marketplace. This deepens and broadens insurance markets by increasing consumers’ awareness of the protections offered by insurance, their awareness of the multitude of insurance options, and their understanding as to how to purchase the insurance they need.

Dissemination of information to consumers Intermediaries provide customers with the necessary information required to make educated purchases/informed decisions. Intermediaries can explain what a consumer needs, and what the options are in terms of insurers, policies and prices. Faced with a knowledgeable client base that has multiple choices, insurers will offer policies that fit their customers’ needs at competitive prices.

Dissemination of information to the marketplace Intermediaries gather and evaluate information regarding placements, premiums and claims experience. When such knowledge is combined with an intermediary’s understanding of the needs of its clients, the intermediary is well-positioned to encourage and assist in the development of new and innovative insurance products and to create markets where none have existed. In addition, dissemination of knowledge and expansion of markets within a country and internationally can help to attract more direct investment for the insurance sector and related industries.

**Sound competition**
Increased consumer knowledge ultimately helps increase the demand for insurance and improve insurance take-up rates. Increased utilization of insurance allows producers of goods and services to make the most of their risk management budgets and take advantage of a more competitive financial climate, boosting economic growth.

Spread insurers’ risks Quality of business is important to all insurers for a number of reasons including profitability, regulatory compliance, and, ultimately, financial survival. Insurance companies need to make sure the risks they cover are insurable – and spread these risks appropriately – so they are not susceptible to catastrophic losses.

Intermediaries help insurers in the difficult task of spreading the risks in their portfolio. Intermediaries work with multiple insurers, a variety of clients, and, in many cases, in a broad geographical spread. They help carriers spread the risks in their portfolios according to industry, geography, volume, line of insurance and other factors. This helps insurers from becoming over-exposed in a particular region or a particular type of risk, thus freeing precious resources for use elsewhere.

Reducing costs

By helping to reduce costs for insurers, broker services also reduce the insurance costs of all undertakings in a country or economy. Because insurance is an essential expense for all businesses, a reduction in prices can have a large impact on the general economy, improving the overall competitive position of the particular market. Of course, the insurance cycle of “hard” and “soft” markets can have a significant impact on the benefits – both good and bad – of increased availability. Generally, however, increased availability benefits the consumer by leading to product competition, price competition, and improved services. By reducing insurance costs across markets, intermediaries make an important contribution to improving the economic conditions in a country. Insurance intermediation in practice the intermediary’s role within this enterprise stems from two essential functions performed by the intermediary: reducing search costs and uncertainty.
Search costs

Intermediaries reduce the search costs to insurance buyers looking for the right coverage and the right insurer for their risks, and they reduce sales and marketing costs to insurance companies in search of insurance buyers. Intermediaries know the insurance marketplace. They know their clients’ risks; they know the insurers willing to cover those risks; and they know the best way to secure that coverage.

Uncertainty

Insurance purchasers and companies do not have all the information relevant to the placement of a policy, which makes it difficult to negotiate a fair price and the proper terms and conditions of a policy. Purchasers know the risks in need of coverage, but may not know the financial health of the insurer or the prevailing conditions of the insurance market. Insurers, on the other hand, may have all the company and market financial information necessary to make a decision, but are not in a position to know enough about the risk and the prospective client. Intermediaries know the insurance marketplace, they solicit and provide information on insurance purchasers and companies, and they make the information more easily understood to both parties to a transaction. In the interest of long-term client and insurer relations, brokers have a strong incentive to ensure that all parties have the information they need so as they are able to enter into a mutually beneficial arrangement. Insurance purchasers and companies may come to a transaction with unequal bargaining power. A small- or medium-sized insured may come to a transaction with significantly less clout than the large insurer with whom they need to do business. An intermediary is often able to balance the equation by leveraging its business volume with carriers, and thereby obtain better terms and conditions for the client.”Every carrier essentially offers the same promise – to compensate the insured for a loss. To make that promise meaningful, however, the carrier must have the ability to properly understand and evaluate the risk presented and the capacity and financial solvency required to pay any claims that may result from that risk, as well as a reputation that suggests a willingness to make good on that promise.
There are literally thousands of insurance carriers, from large national carriers that offer a broad range of coverage to small regional carriers that may specialize in a single product line. For most clients, coverage terms must be solicited from and negotiated with the carriers on a case-by-case basis. Clearly, numbers dictate that this cannot be done with every carrier in the marketplace that has the capacity to insure a given exposure. Clients rely on intermediaries to know a universe of carriers that are well-situated to address their needs and negotiate with selected companies to obtain the relatively best overall insurance value for them. To do this, the development of a relationship between intermediary and carrier is essential. In order to provide products and services to their clients, intermediaries must have expertise with the risk profiles presented by their clients and the savvy to go to the right place for the right coverage for each risk profile. The best way for an intermediary to evaluate a carrier’s ability to insure a risk and its capacity to pay claims is by working with that carrier over time. Similarly, a carrier will be in a much better position to understand and evaluate the risk presented if it understands and trusts the intermediary presenting the risk to be insured. Intermediaries are valued by insureds and insurers as an essential element of the insurance marketplace.

Intermediaries search the insurance marketplace to find and place coverage for their clients’ risks. They also assist clients in the development of alternative risk transfer mechanisms for risks that otherwise would be impossible – or prohibitively expensive – to insure, and they provide services to both insureds and insurers. In today’s complex insurance marketplace, however, intermediaries have become more than middlemen between insurance companies and insurance buyers.

They bring experience and expertise to the insurance marketplace, using their knowledge of the insurance markets, their familiarity with their clients and clients’ risk, and their access to insurers forged through long-term relationships, to sell and service insurance coverage for costly, and in many cases unique, risks. Commercial insurance clients are generally professional risk managers. As sophisticated insurance purchasers, they realize that commercial insurance products are not commodities; rather, they are customized risk transfer tools, the price and terms of which are generally negotiated on a case-by-case basis. Placement of such risks can be a long and difficult process. Sophisticated
commercial purchasers rely on their intermediary to fully understand and appreciate their insurance coverage needs and to find the coverage suited to address those needs.

Intermediaries and Risk management Risk managers increasingly use enterprise risk management tools to allow them to understand their risk profile, identify cost drivers and analyze enterprise-wide risk. Some intermediaries are active in providing such tools.

One of the functions of some insurance intermediaries is to help clients manage their risks, improving their risk profiles and reducing the likelihood that an insured event will occur. Not all risks must be accepted as they are. When properly managed, risks can be controlled and minimized. Some can be avoided; others can be modified to limit their frequency or financial consequences.

Risk management is the process of analyzing possible exposure to loss, reducing loss potential, and protecting financial assets. Businesses often look to their intermediary to act as consultants on risk management and advise them on the best ways to mitigate risk. Some intermediaries therefore represent their clients in all phases of the risk management process: helping clients evaluate risk exposures; implementing measures to minimize such exposures; identifying and facilitating the purchase of insurance products or risks management systems best suited to a client’s insurance needs; and managing the claims process. There are many ways to protect financial assets. Purchase of insurance is the traditional way to transfer risk, but there are other methods that intermediaries and their clients use to ameliorate risks. Use of alternative risk transfer mechanisms – such as forming a captive insurance company, accepting higher insurance deductibles, or setting up reserves to pay losses – is an example.

**Self-insurance**

Self-insurance can take many forms. Policyholders can assume higher deductibles or accept lower amounts of insurance coverage. Self-insurance programs, however, must be carefully balanced with a well-managed loss control program to minimize the exposure a business faces and to protect third parties that are injured. That is where skilled intermediaries come in – to act as consultants in designing programs.

**Captives**
Creating a captive insurance company is a popular risk-financing alternative, especially when insurance costs are high. Captives are also popular options for commercial enterprises that want to finance and control their risks.

A captive insurer is an insurance company that is wholly owned by a non-insurance organization, typically a large company or group of companies in the same business. An intermediary may help a client to establish a captive and/or manage the captive once it is up and running.

A captive’s primary purpose is to insure or reinsure the risks of the parent organization, but they can also cover risks of non-related parties. A well-run captive can provide insurance coverage at lower rates than are generally available in the traditional insurance marketplace. Captives rely on reinsurance to spread the risk, just as traditional underwriters do.

Risk management involves far more complexity than the simple purchase of insurance. A large part of the task is preventing risk in the first place. Some Insurance Intermediaries are skilled in the art of working with their corporate clients in analyzing and controlling risk, setting up safety programs and other risk control techniques, and arranging alternative risk transfer mechanisms, as necessary. These activities and services are beyond those typically associated with the placement and servicing of a policy contract, and have contributed to the evolution of intermediaries from their role as providers of basic brokerage services into full-service intermediaries, providing not only strict intermediation services, but a wide variety of fee-based risk management and consulting services, as well.

UNIT IV
TRENDS IN CLAIM

Introduction:
In day to day life every human being is engaged in some activity, it may be related to earn livelihood or household activity. The activity which provides livelihood is known as economic activity. Though there are so many economic activities like manufacturing, trading, banking, transportation and insurance and many more. But in this module we are explaining only the Insurance activity which can be taken by an individual or group of persons to earn their livelihood.

The global life insurance industry witnessed growth in 2010 mainly in the Asian region. The growth trend is likely to continue in 2011, although profit margins are expected to remain under pressure. Regional differences exist, with emerging markets growing at a faster rate than mature markets. The life insurance industry is witnessing shifting trends in front office, policy administration, and claims—the three core functions of the insurance value chain. This paper identifies key emerging trends in the claims management function of life insurance firms.

Life insurance firms continue to struggle with manual and time intensive claims processing functions. Legacy claims processing usually involves multiple systems, multiple processes, and multiple channels. As life insurers look to improve customer experience and control their claims expenses, they are increasingly shifting to an end-to-end claims management solution. Such an integrated solution can help life insurers reduce claims settlement time, minimize human error, and eliminate inefficiencies by streamlining claims processing.

Claims processes often suffer from large amounts of unstructured data collected from multiple sources and insufficient quantifiable performance metrics. This limits firms’ capabilities to gain actionable insight from the claims experience. Life insurance firms are increasingly looking for real-time analysis of their claims process by implementing an approach built on key performance indicators (KPIs) and enhanced quality in deliverance. A KPI-based dashboard can provide financial, claims processing, operational, and efficiency perspectives. The dashboard allows a firm’s management to make both tactical and strategic decisions to enhance claims efficiency and monitor and measure improvement. The insurance sector is divided in two parts life and general or non-life Insurance. Life insurance deals with only human lives and non-life deals with other than
human life. In 2000, Indian insurance sector has taken U turn i.e. Privatization (private insurance companies to nationalization (Government Companies) to Privatization/mixed economy (Private/Government companies).

Life insurers are expected to increasingly implement advanced fraud detection technologies to reduce fraud-related costs. Traditionally, the fraud detection process was manual, leading to poor detection rates and high occurrence of false-positive cases. Advanced fraud detection solutions use a combination of methods such as data mining, rule-based engines, predictive analytics, link analysis, and social network behavior/activity analysis. They help insurers to reduce fraud-related expenses, which leads to lower premium rates for customers.

**Definition of claim:**

A formal request to an insurance company asking for a payment based on the terms of the insurance policy. Insurance claims are reviewed by the company for their validity and then paid out to the insured or requesting party (on behalf of the insured) once approved. Insurance claims cover everything from death benefits on life insurance policies to routine health exams at your local doctor. In many cases, claims are filed by third parties on behalf of the insured person, but usually only the person(s) listed on the policy is entitled to claims payment. Trends in claims keep changing every year.

The insurance industry is on the brink of numerous sweeping changes over the next few years, mostly driven by technology. While other industries move more quickly to embrace technology, insurance companies are *shockingly* conservative and are usually late to the party. In fact, it is typically consumers who ultimately force insurers’ hands.

**More Usage-Based Insurance**

Snapshot is Progressive’s effort to start shifting insurance pricing away from traditional variables like credit history, age, accident/claim history, geography, etc to pricing based on what all of these previously mentioned variables were really designed to model: your driving behavior (and thus likelihood of accident/claim). They are able to do this by
installing a telematics hardware device installed to an OBD (on board diagnostic) port in your vehicle.  
The global life insurance industry witnessed growth in 2010 mainly in the Asian region. The growth trend is likely to continue in 2011, although profit margins are expected to remain under pressure. Regional differences exist, with emerging markets growing at a faster rate than mature markets. The life insurance industry is witnessing shifting trends in front office, policy administration, and claims—the three core functions of the insurance value chain. Life insurance firms continue to struggle with manual and time intensive claims processing functions. Legacy claims processing usually involves multiple systems, multiple processes, and multiple channels. As life insurers look to improve customer experience and control their claims expenses, they are increasingly shifting to an end-to-end claims management solution. Such an integrated solution can help life insurers reduce claims settlement time, minimize human error, and eliminate inefficiencies by streamlining claims processing. Claims processes often suffer from large amounts of unstructured data collected from multiple sources and insufficient quantifiable performance metrics. This limits firms’ capabilities to gain actionable insight from the claims experience. Life insurance firms are increasingly looking for real-time analysis of their claims process by implementing an approach built on key performance indicators (KPIs) and enhanced quality in deliverance. A KPI-based dashboard can provide financial, claims processing, operational, and efficiency perspectives. The dashboard allows a firm’s management to make both tactical and strategic decisions to enhance claims efficiency and monitor and measure improvement. Life insurers are expected to increasingly implement advanced fraud detection technologies to reduce fraud-related costs. Traditionally, the fraud detection process was manual, leading to poor detection rates and high occurrence of false-positive cases. Advanced fraud detection solutions use a combination of methods such as data mining, rule-based engines, predictive analytics, link analysis, and social network behavior / activity analysis. They help insurers to reduce fraud-related expenses, which leads to lower premium rates for customers. Overall, life insurers are looking to claims
transformation to reduce cost, improve customer satisfaction, and enhance fraud detection.

Life insurers across the globe are looking to reduce cost and improve customer retention. Claims processing remains a defining factor in ensuring customer satisfaction. The life insurance industry is suffering from inefficiencies in the claims management process, mainly due to manual processes and multiple systems. Legacy systems offer little flexibility and often lead to inconsistent data. Combined with multiple systems and inefficient processes, the legacy systems result in a huge amount of unstructured data. Moreover, claims fraud is on the rise due to the inability of life insurers to detect fraud at an early stage. Furthermore, firms are increasingly looking to retain as many assets as possible during a claims payout by providing options (or cross-selling products) like structured settlements (e.g. annuities) and guaranteed income vehicles.

Several key trends related to claims globally have emerged:

- Increased implementation of end-to-end claims management solutions.
- Increased focus on key performance indicators leading to improvement in claims process.
- Expected increase in adoption of advanced fraud-detection technologies.

**Trend 1: Increased Implementation of End-to-End Claims Management Solutions**

Traditionally, the claims process in life insurance has been largely paper-based, manual, and dependent on old technologies. Legacy claims systems have remained highly inefficient, requiring each customer to use different claims systems depending on the product line and channel. Firms usually have multiple systems which remain difficult to use for agents, brokers, and customers. Firms may also have multiple claims settlement processes (based on type of product or distribution channel used) which make it difficult for users to experience a standard claims process across products and distribution channels.

There are several main drivers leading to an increased investment in automation and management solutions for claims:

- Life insurers are looking for efficiencies in processing to reduce the cost of claims.
• The claims staff is looking for a faster and more effective way to access and analyze data related to claims.
• Claims data is often scattered across functional areas and multiple systems which makes the claims process more time- and labor-intensive.
• Firms’ old claims systems are no longer suitable to handle multiple claims requests from single policyholder such as critical illness, disability, or long-term care.
• Multiple systems result in a longer claims processing time, negatively impacting customer experience.
• The manual process and data entry usually results in high redundancy and inconsistency in claims data, which often leads to errors in processing.
• Claims management solutions need to be flexible enough to allow for changes arising from new regulations or reporting requirements.

An increasing internet penetration among insurance customers is also leading to need for web-based interface for claims processing.

Global IT spending by life insurers on claims processing is expected to grow to $6.04 billion by the year 2015, with a Compound Annual Growth Rate of 4.9% in 2010-2015. The Asia-Pacific region is expected to witness the fastest growth rate in IT spending on claims processing, with a Compound Annual Growth Rate of 7.0% in 2010-2015, fuelled by the high growth in insurers’ business volume. As life insurers look to invest in claims processing technologies, they are expected to implement end-to-end claims management solutions to enhance processing and reduce cost. An effective claims process can be a key contributor to a differentiated customer experience, improved customer loyalty, and the ability to attract new customers.

The new claims management solutions also allow life insurers to offer a web-based interface for faster claims filing, as well as process status and payout. An end-to-end claims management solution integrates all the steps of the claims management process. The benefits fall under two broad categories discussed below.

**Improved Operational Efficiency**

• **Shortened claims life cycle:**
An integrated claims management implementation minimizes the manual process, which reduces the overall time for claims processing.

- **Increased fraud detection:**
The data available in an integrated system allows the firm to improve its fraud detection.

- **Reduced leakage:**
An integrated claims management solution helps to identify inefficient and redundant steps in the claims process, which allows minimizing the inefficiency in the process and reducing leakage.

- **Improved service quality:**
As the claims process is automated and manual data entry eliminated, the human error factor is minimized. Reduced turnaround time and improved productivity leads to an enhanced service level for the end customers.

- **Quick response to process change:**
Claims management solution offers flexibility to implement any new requirement due to process change or regulation change.

- **Real-time claims data visibility:**
This assists the claims staff to process claims much faster and allows them to concentrate on fraud detection instead of administrative tasks.

**Reduced Operational Risk**

- **Streamlined automated process:**
The end-to-end claims management solution provides streamlined automated processing, which minimizes errors arising from paper based and manual process.

- **Standardized claims processing:**
An integrated system would offer a standard and consistent process to agents, brokers, and customers, replacing multiple system implementations which lead to inconsistent data.

- **Reduced manual handling:**
The end-to-end claims management system minimizes the manual intervention in the claims process and helps to limit the human error.

- **Increased availability of information:**
The end-to-end system provides easy access to claims-related information, helping staff to detect fraud, identify common mistakes, and minimize loss.

Benefits of End-to-End Claims Management Solutions:

- **Shortened claims lifecycle**: Increased fraud detection, Reduced leakage
- **Improved service quality**: Quick response to process change, Real time claims data visibility
- **Streamlined automated process**: Standardized claim processing, Reduced manual handling

**Trend 2: Increased Focus on Key Performance Indicators Leading to Improvement in Claims Process**

An inefficient claims process continues to result in higher claims expenses and a poor customer experience. The existing complex manual process results in a number of challenges for insurance firms:

- The complex and inefficient process results in a long claims settlement cycle, leading to low customer satisfaction.
- The current claims process generates a huge amount of unstructured data, which prevents firms from deriving any useful insight.
- There has been a rise in claims fraud activities. Reducing process inefficiencies would help life insurers improve their response time and quality.
- There is often a lack of metrics for measuring the performance of the claims process.
These challenges have a significant impact on customer satisfaction. The increasing pressure for customer retention is driving life insurers to gain actionable insights on their current claims processing process and improve it.

**Trend 3: Expected Increase in Adoption of Advanced Fraud Detection Technologies**

The current risks of legacy systems and a desire to lower the cost of claims fraud is driving life insurers to look for the latest and most advanced fraud detection technologies. Life insurers expressed a slightly higher concern and interest in improving fraud detection and identification processes than property and casualty insurers, according to a survey among the insurance firms in North America in 2009. Approximately 13% of life insurers, compared to 7% of property and casualty insurers, were extremely concerned about fraud detection.

Advanced fraud detection solutions should assist life insurers in the early identification of fraud. The new investigation solutions based on risk scoring and predictive analytics allows more granular analysis of data to identify fraud patterns. The scoring models use a combination of rules-based engines, data mining, database searches, predictive modeling, and network link analysis to identify the possibility of fraud in an insurance claim. Thus, the new technologies offer a better fraud detection process than manual processes. The newer technologies offer a flexible fraud detection system which is easy to adapt to the changing requirements in terms of business rules or claims process. The solution also allows better integration with the core processing systems of the insurer. Firms may look to implement an enterprise-wide data warehouse system which captures historical information from fraud cases and integrates information from third-party sources and the insurance industry. These benefits result in better control over the premium rate increase as insurers reduce overall claims expenses. The customer experiences a dual benefit of a lower insurance price and better claims experience. Hence, a better fraud detection process leads to both low claims expenses and improved customer satisfaction for a life insurance firm.
The global non-life insurance industry is experiencing shifting trends across the front office, policy administration and underwriting, and claims – the three core functions of the insurance value chain. This paper examines key emerging trends in the claims function of non-life insurance companies. The claims function is not only the major part of an insurer’s expenses, the settlement process, itself, also determines the customer experience which determines retention rates. To achieve operational excellence and enhance customer satisfaction, there is an increased focus on claims transformation. To that end, non-life insurers are looking to eliminate inefficiencies and reduce claims-related expenses.

There is a significant opportunity to leverage advanced predictive modeling techniques in the claims process. An early identification of claims with high probability of large losses and risk of fraud will allow insurers to proactively manage the settlement process. This will help reduce fraud-related costs and improve customer experience.

A sharp rise in social media offers abundant opportunity for non-life insurers to utilize the information generated on these platforms. Social media platforms may provide a significant amount of information related to claimants and incidents during fraud investigation of a claim. While a number of non-life insurers have already started manual investigation, an automated capability will allow insurers to leverage social data to its full potential.

The global non-life insurance industry witnessed a modest 1.9% growth (in real terms) in premium volumes during 2011. The global economic slowdown, particularly in Europe, was the primary culprit. Sluggish growth was somewhat offset by the trend of rising premium rates in certain regions and lines of business. Overall, however, industry profitability remained under pressure globally as a result of record losses from 2011’s catastrophic events and a sub-par investment environment. Growth, in premium volume and profits, appears uncertain for the near future, as the slowdown in Europe and North America continues to forestall economic growth in Asia-Pacific.

The non-life insurance industry is experiencing shifting trends across the front office, policy administration and underwriting, and claims – the three core functions of the
insurance value chain. This paper examines key emerging trends in the claims function of non-life insurance companies. The claims function is not only the major part of an insurer’s expenses, the settlement process, itself, also determines the customer experience, which, of course determines retention rates. To achieve operational excellence and enhance customer satisfaction, there is an increased focus on claims transformation. To that end, non-life insurers are looking to eliminate inefficiencies and reduce claims-related expenses. There is a significant opportunity to leverage advanced predictive modeling techniques in the claims process. An early identification of claims with high probability of large losses and risk of fraud will allow insurers to proactively manage the settlement process. This will help reduce fraud-related costs – and improve customer experience .A sharp rise in social media offers abundant opportunity for non-life insurers to utilize the information generated on these platforms. Social media platforms may provide a significant amount of information related to claimants and incidents during fraud investigation of a claim. While a number of non-life insurers have already started manual investigation, an automated capability will allow insurers to leverage social data to its full potential.

Global non-life insurance premiums grew at a moderate (real) rate of 1.9% in 2011. This growth was primarily caused by an increase in the premium rates in certain geographies and lines of businesses. Advanced economies experienced a minimal 0.5% growth in premiums due to recession in Europe and weak growth in the United States. On the other hand, emerging markets continued their robust growth with a 9.1% rise in premiums, although at a slower pace compared to 2010. Significant catastrophic losses during 2011, particularly in Australia, Japan, and New Zealand, negatively impacted the profitability of the overall non-life insurance industry. Investment income was also truncated in the prevailing low interest rate environment. Forecasted slow growth in the North American economy and a recession in several European countries are expected to continue to put pressure on the growth of the non-life insurance industry in these regions in the near future. Premium growth in Asia-Pacific is expected to remain robust (and support global premium growth). However, this growth

**Trends seen in non life insurance industry:**

European countries are expected to continue to put pressure on the growth of the non-life insurance industry in these regions in the near future. Premium growth in Asia-Pacific is expected to remain robust (and support global premium growth). However, this growth
could remain lower than that in the recent past mainly due to slower economic growth in the region. Non-life insurers seek the capability for early identification of high-risk claims cases and potential frauds. These requirements are driving an increased adoption of predictive modeling solutions. As fraud continues to remain a primary concern for the industry, insurers are looking to leverage social media data to improve their fraud detection capability.

These changes have led to the emergence of the following key trends in claims processing and payout for non-life insurance companies globally:

1. Enhanced focus on claims transformation
2. Increased adoption of advanced analytics, such as predictive modeling
3. Increasing usage of social data for fraud detection

**Trend 1: Focus on Claims Transformation**

The claims function is more than merely an expense item for an insurer. It can often be the defining moment in the customer/insurer relationship. Effectiveness and efficiency of the claims settlement process are key differentiators determining the customer experience.

While the claims function has a direct impact on profits and customer satisfaction, non-life insurers continue to suffer a number of challenges with the current state of claims management. An inefficient claims process leads to customer and internal staff dissatisfaction, and consequently, high customer and staff turnover. The administrative tasks in the claims function currently take significant staff time, thus leaving less time for adjudicating claims, costs tend to run higher. To help trim these costs, insurers are looking to build the capability to respond to regulatory changes and enhancement requirements, quickly and effectively. However, their response time and effectiveness is often limited by an inflexible and inefficient claims process. Insurers suffer from large amounts of unstructured and redundant data, which has limited utilization in generating actionable insights. In order to achieve fast and easy claims settlements, there is a growing need for integration between insurers and third-party service provider’s (e.g., auto repair shop) system.
External pressures from customers, competition, technology, and regulations also drive a need for claims transformation for insurers. With declining profits, the non-life insurance industry is witnessing increased competition for customer retention and acquisition. According to a recent Gartner survey conducted in the United States, customer retention emerged as the top priority for P&C insurers, with 81% of respondents indicating it as extremely important.

Customers are demanding a better claims experience with fast settlement, self-service ability, better accuracy, and improved communication. New technologies, such as mobile, location-based solutions, social media, and cloud-based solutions are offering an opportunity for insurers to provide more customized and a faster claims process for its customers.

Advancements in analytics and business intelligence solutions allow insurers to analyze the huge amount of data (historical, current, third-party) derive insights/trends, and surface the data in dashboards and scorecards. As regulations and capital adequacy requirements change, insurers are looking to build flexible insurance systems allowing quick response times

**Trend 2: Adoption of Advanced Analytics and Predictive Modeling**

Fraud is a major component of claims expenses. The Insurance Information Institute estimates that property/casualty fraud costs more than $30 billion a year from 2006 to 2010. In an effort to improve fraud detection, insurers are striving to detect fraud early on in the claims process. Specifically, insurers are looking to identify, claims with a high probability of significant loss or additional future loss. An early recognition of complex and high-risk cases will also allow insurers to allocate these cases with highly skilled claims adjustors. A prediction on the likely outcome for a claims case may help insurers manage the claims cycle in a more efficient manner, while reducing costs

**Trend 3: Use of Social Data to Detect Fraud**

While the non-life insurance industry seeks newer ways to increase business and control costs, claims fraud remains a key concern. Although the issue of claims fraud is as old as
the industry itself, the cost is expected to increase over time. It is generally believed that fraud costs about 10% of the P&C insurance industry’s incurred losses and loss adjustment expenses each year. A 2012 Insurance Networking News survey conducted in the United States, found that 32% of P&C insurers considered that fraud cost more than 20% of total claims expenditures. Moreover, 54% of respondents indicated they expected fraud costs to rise in 2012 when compared to 2011, while only 3% expected a decline.

As the number of social media users continues to accelerate, insurers are eager to leverage the vast amount of information generated on social platforms. According to eMarketer.com, the number of social media users (identified as those who use social networking sites at least once a month) is likely to grow at a CAGR of 15%, reaching close to 1.9 billion by 2014. The region with the highest number of social network users is Asia-Pacific, where 853.1 million internet users are expected to log on to social sites by 2014.

With the growing use of social media, people are increasingly making their day-to-day activities public on social media platforms, particularly Facebook and Twitter. With an intense focus on controlling claims fraud, insurers have started to utilize claimant’s information available on social media. Claims investigators are visiting the social profiles to collect information about the claimant and the incident. Personal and social information, such as current health condition, family relationships, and posts/photos of daily/social activities help determine the validity and/or severity of claims. For example, photos/videos of a person on social networks can indicate the severity of bodily injury in an accident to help determine if the claims are legitimate.

**ROLE OF IT IN CLAIM ADJUSTMENT**

Insurance companies are facing increasing pressures not only from regulation, but from more demanding customers. Aging technology systems just will not fit the bill and insurance executives need to stay focused on using IT and the network to improve core operations including policy administration, claims management and billing. Whether it’s a customer viewing a policy on an iPad or a 20 year old document being archived, we underpin everything that insurance companies do. Solvency II is at the heart of some of
the regulatory changes that are driving investments in IT and the network, as insurers start to re-evaluate the architectures they deploy.

What makes the life insurance industry different from the other financial services is the long-term nature of the relationship of the company with its customers, often lasting a lifetime. The leaps in technology have helped us track the relationship with the customer and also given us the information to analyse the changing needs/profile of the consumer. Moreover, the life insurance business is highly complex with the evolving statutory regulations that IT systems must deal with. Also with the emergence of multiple channels such as banc assurance, corporate agency, and broking, the company’s IT systems need to be adapted with the systems of the channel partners without compromising the information flow. Some key benefits of technology have been reduction in turnaround time as well as multiple interaction points with the customer through emails, facsimile, websites, and ATMs, to name a few, which have resulted in improved disclosure to policy holders.

The most significant changes we see are being driven by changing customer preferences and behavior. The contact centre has always been at the core of many insurers businesses, but customer interactions are changing. Customers want to be able to interface via a number of different devices and channels – social networks, online comparison sites, touch sensitive tablets and smart phones are all providing opportunities for insurers to transform their business models.

Employees are changing too – whereas those currently working within the firms grew up with email and Outlook, the generation Y of current graduates grew up with social networking and Facebook and will expect to interact with their colleagues in a similar way. The way insurance companies provide services to their employees will change dramatically over the next few years.

To remain competitive, insurers will need to use IT and the network for information analytics to stay customer relevant and to exploit trust-based social relationships to enhance their brand. As tablet sales now outstrip PC sales and the mobile market continues to explode, insurers will also need to tune their transactions, interactions and operating models to be mobile-relevant. Ultimately, the call centre will need to be overhauled to become a true multi-channel customer interaction centre.
**Customer service**

The insurance industry is experiencing increasing pressure to develop strategic, customer-centric service organizations that move beyond traditional types of customer services. The key to making that transition is turning service into sales. Within this whitepaper we explore the evolution from traditional customer service to strategic customer service, and ultimately to breakthrough customer service. We also examine how that evolution is enabled by both technology and organizational change.

Three insurance industry-specific case studies, including affinity to cross-sell, premium service for premium customers and policy conservation, are reviewed and solution principles are developed as the foundation for defining necessary capabilities to enable the service transformation. Finally, we discuss significant challenges in enabling those capabilities, both from a technical and organizational perspective.

**Traditional Types of Customer Service**

Customer service traditionally has fallen into one of three major categories: advisory services, informational services or transactional services. Each category focuses on achieving specific goals or outcomes and generally is associated with a service channel through which services are delivered. Most often, each type of service is delivered in a silo with little or no integration or information available across categories.

**Advisory Services**

Advisory services are the most interactive category and generally focus on longer-term relationships, ensuring that customer needs are satisfied with appropriate insurance products or services. Such services are a critical component of long-term value, since customer insurance needs change over time. Many insurance companies traditionally rely on agents to provide advisory services, which ensure that the client has the optimal amount and kind of coverage, and is aware of the options related to deductibles, premiums and other coverage.

**Information Services**
Information services provide accurate and timely information in response to customer inquiries. Examples include requests for payment address or status, claims or contract status, and financial and rating information. The delivery of informational services primarily involves self-service channels such as telephony/VRU or the Web. Alternatively, some companies continue to provide informational services directly or alternatively through call centers.

**Transactional Services**

Transactional services are specific requests that initiate or trigger actions or changes, and tend to take the form of material changes to a policy, administrative changes or fulfillment. Examples include a first notice of loss, the addition of a vehicle or coverage to an existing policy, coverage changes, address changes and requests for ID cards and forms. Call centers are the traditional delivery channel for transactional services, although the trend in many insurance companies has been to drive transactional services to lower-cost, self-service options.

**Impact of Technology on Traditional Types of Service**

Between now and 2009, technology will change the face of customer service profoundly by removing obstacles that currently limit the implementation of self-service. In fact, many of those changes are under way and will become increasingly widespread as more companies implement new technologies. Technology has the ability to impact self-service availability and acceptance on a number of fronts. First, self-service will become available at a much faster pace and become more seamless to customers. Next, the nature of customer self-service will change from a highly impersonal one-size-fits-all model to one where self-service interactions are highly personalized to individual customers. In addition, self-service will be available on demand; currently spotty availability plagues many self-service offerings. Finally, self-service will continue to move toward higher levels of security. As a result of those trends, information and transaction services will move from customer service representative (CSRs) to channels dominated by self-service. Higher-volume services will be handled via lower-cost self-service, while higher-
value, relationship-building advisory services will remain the focus of agents and call center representatives.

Insurance Operations – Claim Procedures and the Claim Adjustment Process

Claims adjusting is the process of determining coverage, legal liability, and settling a claim. The claim function exists to fulfill the insurer’s promises to its policyholders. Claim adjusting is integral to establishing an insurer’s relationship to its policyholders. The reputation of the insurer in settling claims directly impacts the marketing and retention of policyholder insurance.

Goals of the Claim Function:

(1) Complying with the contractual promises in the policy Insurer fulfills this promise by providing prompt, fair and equitable service in either paying first party claims covered under the policy or paying claims on a third party loss against the insured due to liability. Insurance is marketed not only as a financial mechanism to provide indemnity on covered losses, but also to ensure peace of mind after a loss has occurred. Were it not for insurance and the claim settlement process recovery might be slow, inefficient and difficult. In some cases, having a claim settlement process allows a policyholder to settle a case that might not easily be resolved due to emotion — e.g. plane crashes — Airlines benefit by having insurance and the claims adjustment process to settle with loved ones.

(2) Supporting the insurer’s profit goal and avoid paying for fraudulent claims An effective claim settlement process should be designed to control costs and assure that covered losses are fairly reimbursed. Policyholders are entitled to fair claim resolution. However, overcompensation of claims will raise the cost of insurance and cause better risks to pay more for their coverage. Conversely, unpaid claims that fall under the contract can result in angry policyholders, litigation, or regulatory sanctions. A reputation of resisting meritorious claims can invalidate the effectiveness of insurer advertisements.

(3) Users of Claim Information Marketing — needs information about customer satisfaction, in addition, information gathered from the claims department can be used to fashion new coverage to better meet the needs of policyholders — e.g. insurance provision
for power surges. In some cases, premiums may need to be altered at the agency level to account for increased claims cost. Claim personnel must inform producers of court rulings that affect the insurer’s loss exposures or pricing, such as interpretations of policy exclusions or application of limits. Underwriting—a post-evaluation of claims costs can reveal characteristics of loss that an underwriter may have been able to detect when considering an application for insurance. Reviewing a claim can uncover operations and activities that if the underwriter had more thoroughly investigated might have led to either denial of the policy or offering it on a different basis. A number of similar claims could also alert underwriters to an emerging problem with a particular class of policies---

-e.g. several years ago there was a controversy in the auto insurance industry over the use of aftermarket parts. Actuarial—require accurate information on the actual claims costs, as well as, up to date information on claims that have occurred and need to be reserved against settlement later on [IBNR].

Claim Department Contacts

Public --- Providing information to policyholders about the claims process, demonstrating that commitment of the insurer to meeting promises to the insured’s through a fair settlement process. Claimants’ Attorney - In some cases claimants are more likely to hire attorneys leading to costly litigation --- although it is not necessarily that all claims will be settled with higher litigation costs [ many cases are settled out of court – legal fees are the claimants responsibility] Litigation of third party claims has become more expensive ---time to get the case into court, deposition costs, legal research expenses] Defense Attorneys-The duty to defend under liability policies may cause the insurer to hire outside defense attorneys. Managing defense expenses is an essential component of managing over claim costs. Insurers generally hire an attorney from the jurisdiction in which the claim occurred. The ideal situation is for the insurer to avoid litigation --- a litigated claim might indicate that some aspect of the claim adjusting process failed to operate properly.

State Regulators —monitor insurers ‘activities in the claim settlement process. Regulators control the licensing of adjusters, investigation of consumer complaints, and performing market conduct investigations. Ultimately, a regulator also has the authority
to suspend an insurer from being able to operate in its state. Enforcement for claims may be handled through the Unfair Claims Settlement Practices Act.

**Licensing** --- not all states currently license adjusters, which Iowa does not license independent adjusters, but Minnesota does. Those states that do require licensing usually have applicants pass a written exam, pay a fee, and secure a fidelity bond. Some states also license vehicle-damage or property appraisers.

Temporary permits or licenses are frequently granted to out-of-state adjusters that insurers may need to use to adjust claims in the aftermath of major storm damage.

**Consumer Complaints** – Most states have a specific time limit within which a claim inquiry must be responded to – failure to respond can result in fines and even the loss of an adjuster’s license. Market Conduct Investigations – regulators periodically investigate claims processes as part of a normal audit of insurer activities or in response to complaints – a typical market conduct investigation includes looking into claim practices.

**Organization of the Claim Settlement Process**

Centralized versus Decentralized Claims Settlement

A centralized approach consists of either one home office where all claims are handled or a home office with a few regional offices. Centralized operations are more efficient that decentralized operations in terms of cost of rental space, supervisory overhead, MIS, and support staff. Decentralization can be more costly/difficult to supervise, but allows for adjustment to occur in person -- because claim tasks cannot be done as well from remote locations, claims can never be completely centralized. The type of insurance, volume of business, geographic location and density of loss exposures can determine how an insurer structures its claim operations ---e.g. location of claims office closest to an area where there is a majority of the cases. Some insurers organize the claim function by type of insurance or class of business – a property claim dept. handles first party claims, a casualty claim dept. handles third party claims, a marine dept. handles marine TRANSPORTATION claims. Responsibility is generally divided amongst geographic regions.

**Claim Function Management and Settlement Authority**

Structure and authority varies among insurers ---- VP of Claims is a key member of the management team. Reporting to the VP of Claims -- one or more assistant VPs responsible for certain insurance lines. Claim Managers – person below the top executive
level has the title of claim manager—often in charge of both claim files and general administration and supervision of the claim department.

Examiners – found in either regional or home offices. An examiner is primarily a claims specialist who determines coverage, liability, and damage factors; extends settlement authority to adjusters and recommends settlement amounts or other authorization to superiors up the chain of the claims process.

**Insurer Claim Dept. Structure**

```
VP Claims
     ||
Assist. VP Property               Assist. VP Casualty
Property Manager                  Casualty Manager

Examiner    Support Staff    Examiners    Support Staff

Regional, Branch or Claim Office Staff

Office Manager
     |||
House Counsel outside       Counsel Supervisors
Company Adjusters Independent Adjusters
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**Supervisors** - claims dept. divided into subdivisions by type of coverage or geographic location. Each unit is under a supervisor’s direction. The claim supervisor is usually responsible for the unit’s daily activities --- a supervisor might have certain levels of settlement or denial authority --- many insurers have a list of approved outside attorneys in localities where losses are most likely to occur.
Adjusters --- those responsible for investigating, evaluating and negotiating the coverage, liability and damages related to a claim. An adjuster can be an employee of the insurer, an employee of an insurer-owned adjustment bureau or an independent adjuster retained either on a contract basis or on an individual adjustment basis. Adjusters are usually employed as field adjusters who operate outside the claim office or as inside adjusters who adjust claims from within the claim office. Field adjusters spend much of their time visiting the scene of a loss, interviewing witnesses and investigating damages - coordinating loss appraisal. Inside claim adjusting is appropriate for claims whose expenses are known or for claims that need little investigation. The level of responsibilities for inside adjusters varies amongst insurers.

Public Adjusters --- represent policyholders in property claims cases against insurers. They assist clients in preparing verification of loss, negotiating values to be paid, and preparing settlement documents. Producers --- independent agency insurers sometimes permit their producers to handle minor claims within a specific settlement authority. Most large personal insurers have separated out their marketing and claim settlement functions.

Other Claim Adjusting Personnel

Insurers rely on special experts to handle unusual or particular claims. Both independent and staff adjusters tend to specialize in one area of the claim settlement process. One type — catastrophic adjuster who travels to the location of disasters and remains until all claims have been completed. Another — marine or average adjuster who handles freight, cargo, vessels, aircraft [average in marine insurance is a term used for loss].

Origin and Cause Experts --- attempt to determine where and how a fire began – seek to find out whether a fire loss may be due to arson. Material Damage Appraisers - inspects the damage, and if it is repairable, estimates the repair cost. If an item is not repairable or is lost, the appraiser assists the adjuster in determining the value or replacement cost of the item and in disposing of salvage [for commercial coverage – in the case of Homeowner’s policy salvage is the responsibility of the homeowner]. Reconstruction Experts, Private Investigators, Accountants, Health and Rehabilitation Experts, Medical Cost Containment Consultants, Professional Engineers, Support Personnel.
**Unbundled Claim Services** --- large commercial firms have both the necessary expertise and desire to retain, rather than insure losses. Even though they have financial resources to insure losses, they may not have or want to maintain in-house talent to settle their own claims.

**Claim management:**

Insurance claim management is a core issue for the protection of insurance policyholders and hence a priority concern for the OECD Insurance Committee. From the insurance company viewpoint, claim management is a key element in the competition between insurance providers and for the improvement of industry’s public image. To date, however, there has been no international guidance on claim management, and very little comparative information at the international level to allow the sharing of experience between countries in this key area of insurance activity. This is a matter of concern since most policyholder complaints focus on claim management, suggesting there is room for improvement in this area of client service.

The Insurance Committee therefore decided in June 2000 to launch a project on claim management in OECD countries designed to collect information on Member country claim management practices and to explore the scope for international co-operation to improve the quality of claim management processes. On the basis of a survey on Member countries’ regulations and practices related to claims handling by insurance companies, the Committee’s Working Party of Governmental Experts on Insurance developed a set of good practices to guide both public authorities and insurance companies.

These good practices address every step of the insurance claim management process that Working Party experts had identified as particularly important: adequate information and assistance to the policyholder for claim reporting; efficient claim filing methods; operational fraud detection and prevention measures; adequate, fair and transparent claim assessment and processing; expeditious claim settlement; effective complaint and dispute settlement procedures; and appropriate supervision of claims-related services.

The OECD good practices on claim management are neither binding nor exhaustive, but meant as a “checklist” to assist insurance companies in handling claims. Other appropriate ways to manage claims may exist and may already be reflected in a country's
national laws and regulation and/or in company or industry codes of conduct. Insurance companies could also go further, for instance through the launch of public awareness programmes on claims management issues.

Claims processes often suffer from large amounts of unstructured data collected from multiple sources and insufficient quantifiable performance metrics. This limits firms’ capabilities to gain actionable insight from the claims experience. Life insurance firms are increasingly looking for real-time analysis of their claims process by implementing an approach built on key performance indicators (KPIs) and enhanced quality in deliverance.

Life insurers are expected to increasingly implement advanced fraud detection technologies to reduce fraud-related costs. Traditionally, the fraud detection process was manual, leading to poor detection rates and high occurrence of false-positive cases. Advanced fraud detection solutions use a combination of methods such as data mining, rule-based engines, predictive analytics, link analysis, and social network behavior/activity analysis. They help insurers to reduce fraud-related expenses, which leads to lower premium rates for customers.

Below are the steps for a better management of claims:

1: Claims reporting
The insurance company writes insurance policies in easily understandable language. Policies spell out what is covered and what is not covered. If necessary, plain language explanations could be an addendum to the legal language. The insurance company draws the attention of the policyholder/claimant/beneficiary both when he/she signs a policy (for policyholders only) and when he/she reports a loss on his/her duties related to claim reporting which include:

- To try to minimise losses;
- To report claims in a timely fashion; To co-operate in the investigation by providing the company with all relevant information and, in particular, copies of official documents regarding the damage (accident, loss, etc.);
• To authorize the company to handle necessary inspections and assess the extent of the damage prior to any repairs or replacement; To ensure that the claims reporting phase proceeds as smoothly as possible, the insurance company sends to the policyholder/claimant/beneficiary within a reasonable period of time (beginning from when the loss is reported).

• An appropriate claim form (when the loss reporting is made in writing) for the type of policy -prepared either by an individual insurance company or at the national level by companies or the supervisory authorities together with instructions and useful information on how to comply with the terms of the policy and the legitimate requirements of the company; The information necessary to help them to report the claim.

2: Receipt of claims by the company

• The company claim department and/or the intermediary (if applicable) are as accessible as possible for the claimant. If an intermediary is an initial contact for claimants, claims should be sent to the company claim department within an appropriate time period.

• The insurance company contacts the policyholder/claimant/beneficiary or sends an acknowledgement of receipt as soon as the claim is received.

3: Fraud detection and prevention
In order to curb the growth of fraudulent claims and the rise in premium costs that results from them, companies take the following steps:

• They establish compliance programs for combating fraud and money laundering appropriate to their exposure and vulnerabilities.

• In the claim filing phase, they discourage fraudulent practices by making the policyholder/claimant/beneficiary aware of the consequences of submitting a false statement (which in particular could be liable to prosecution) and/or an incomplete statement. To this end, insurance companies place a notification on their claims forms referring to the appropriate law, statute or insurance regulation that addresses the filing of fraudulent or incomplete claims.
Where legally possible, companies participate in relevant databases where claims susceptible to be fraudulent would be reported. Moreover, public authorities may encourage or take steps to initiate the creation of a public or private bureau of insurance fraud.

Besides, companies provide their claims department staff with adequate training on fraud indicators.

4: Claims assessment General issues:

- Any method of taking into account specific factors such as depreciation, discounting or negligence on the part of the victim is clearly outlined in the claim file.
- Any loss evaluation methods used by the company are reasonable and coherent.
- The insurance company uses internal methods for assessing claim values based on the applicable law of the jurisdiction.

5: Timely claim processing

In accordance with applicable insurance law, companies may specify in the contract the most likely period of time for responding to correspondence from policyholders/claimants/beneficiaries.

- Once policyholders/claimants/beneficiaries have filed a claim:
- They are informed of the acceptance or denial of the claim within a reasonable amount of time after the receipt of the notification.
- The insurance company contacts any other company that is involved in the claim within a reasonable amount of time, and resolves inter-company claim disputes as quickly as possible.
- The insurance company endeavors to settle the claim as soon as possible and advises in writing the policyholder/claimant/beneficiary on the reasons for any delay.
Quick claims settlement as well as high-quality and punctual information provided to the policyholder/claimant/beneficiary are key competition features for insurance companies.

After an agreement has been reached between the company and the policyholder/claimant/beneficiary on the amount of compensation, the payment is effected within a reasonable amount of time.

Insurance companies implement and update their own statistical database tracing their performance in the timely settlement of claims as well as in trends in settlements and expenses. A proper procedure for the coding and statistical processing of losses is developed for this purpose.

6: Complaints and dispute settlement Complaints/Disputes:

- When the policyholder/claimant/beneficiary files a complaint, the company:
  - Acknowledges receipt of the complaint within a reasonable period of time;
  - Provides policyholders/claimants/beneficiaries with explanations on how their complaints will be handled and on the procedures to be followed;
  - Provides information to policyholders/claimants/beneficiaries on internal and external dispute settlement procedures;
  - Processes complaints promptly and fairly; Keeps policy holders /claimants beneficiaries regularly informed of how their complaints are progressing.
  - Provides a final response in writing within a reasonable period of time.
  - If the policyholder/claimant/beneficiary is dissatisfied with the final response that he/she has been sent by the company, he/she can activate an internal appeals process. He/she can also appeal to the dispute settlement procedures available outside the company (for example, the handling of complaints by the supervisory authorities). In case of a dispute, the insured/claimant/beneficiary should be informed by the company of the existence of these appeal procedures.

7: Supervision of claims-related services
The insurance supervisory authorities may conduct examinations on claims management services especially where problems are suspected. In these cases, the following elements are taken into account:

- Possible access to non-confidential claims data for all open and closed files within a specified time frame (e.g. for the current year and the two preceding years);
- Maintenance of sufficient and appropriate information on claims files;
- Use of the appropriate type of claim form for the type of insurance;
- Proper qualification of the claims department’s employees based inter alia on the applicable insurance code;
- Valuation of claims payments according to company procedures;
- Appropriate tracking of the nature and number of complaints related to claim management process;
- Monitoring of the proportion of claims that result in litigation;

8: Compliance with procedures for combating fraud and money laundering;

- Regular internal audit practices on claims files;
- Appropriate internal claims procedure manuals;
- Proper procedure for coding and statistical reporting of losses

QUALITY ASSURANCE AND INSURANCE

The economics of health care field studies demand and supply of health care resources, that is, allocation of the resources, within a given health care system. The health care system is defined as “the organizational arrangements and processes through which a society makes choices concerning the production, consumption, and distribution of health care services.”

Because healthcare resources are limited, each society has to make decisions in terms of the distribution, consumption, and production of these services. A key factor that shapes the delivery of health care in any health care system is the evolving system for financing and reimbursement for health care services. The types of services delivered and the organizational approaches to delivering services are heavily influenced by how health care is paid for.
In the health care market, patients or consumers, health care providers or producers, and third-party payers are three major players. According to the principles of economic theory, consumers or patients on the demand side seek to maximize their utility or satisfaction, which is largely determined by the consumption of medical services and quality of care. On the supply side, producers or health care providers seek to maximize profit. The prevalence of uncertainty on the demand side and on the supply side is a unique feature in health care. Because the incidence of illness and the cost of treatment are uncertain from an individual consumer's perspective, the third-party payers, including private health insurance companies and governments, play an important role in the health care system. These third-party payers serve as intermediaries between the consumer and the provider. To manage the financial risk associated with the purchasing of health care services, third-party payers seek to minimize their costs and control for their budgets.

Pressures are rising throughout the industrialized world to constrain the rise in expenditures on personal health care services, although specific approaches differ. The financing system that has evolved over the past 30 years in the United States involved a complex blend of public and private responsibilities. This system varies substantially from the largely public financing systems that exist in many European countries. To understand better the potential impact of specific changes that may occur in the U.S. system, one can look at the existing, largely publicly financed health care systems in European countries. The European countries provide an interesting model because they face financial pressures similar to those seen in the United States, but each country has addressed those pressures in different ways.

Health care systems are classified into four categories in the industrialized countries: traditional sickness insurance, national health insurance (NHI), national health services (NHS), and mixed. From an economics perspective, the essential difference among these health care systems is how financial risks are distributed among the purchaser of health care, the provider of care, and the insurer.

Germany is an example of a health care system that is characterized by the socialized health insurance program, sickness funds. Approximately 88% of Germans have social health insurance, 10% have private insurance, and the remaining 2% are covered by public programs. The German system is based on government-mandated financing by
employers and employees. The sickness funds are financed by contributions from employers and employees according to a percentage of earned income. Coverage of employees by a sickness fund extends to all dependent family members. The sickness funds negotiate reimbursement rates with the individual hospitals and the association of the insurance physicians. Ambulatory care is provided by fee-for-service, office-based physicians. Hospitals are paid at fixed fees.\textsuperscript{5}

The German system offers the advantage of comprehensive health care. A disadvantage of this approach is that because there is no competition between sickness funds, there is little pressure to provide efficient care. Moreover, because of the near-monopoly power of the sickness funds, reimbursement rates for outpatient services can be low, fostering an \textit{assembly line} style of medicine. Another major problem that is beginning to stress this system is the continuing aging of the population. Starting in 1993, Germany explored managed competition among sickness funds by giving them financial incentives for efficiency.\textsuperscript{1}

Canada has a compulsory NHI program administered by each of its 10 provinces. The national and provincial general tax revenues are used to finance this federal decentralized NHI system. In all provinces, there is a governmental authority in charge of the hospital insurance program. There are variations in arrangements for patient ambulatory care. The NHI program provides first-dollar coverage, and no limit is imposed on the level of medical benefits an individual can receive during his or her lifetime. There is no copayment or deductible. Patients are not required to pay a proportion of their medical bills. The \textit{first-dollar} coverage includes a comprehensive \textit{package} of hospital and medical services.

Physicians in ambulatory care and in hospitals are commonly paid on a fee-for-service basis, according to fee schedules negotiated between physicians' associations and provincial governments. There are few private, for-profit hospitals in Canada. Most acute-care hospitals in Canada are legally private, nonprofit institutions. Their operating expenditures are financed through the NHI system, and most of their capital expenditures are financed by the provincial governments. The financing is through a complex shared federal and provincial tax revenue formula.
Strength of the Canadian NHI is comprehensive coverage of the population. A major weakness of the system is that, with respect to economic efficiency, the hospital, the physician, and the patient have no incentive to be economical in the use of health care resources. The dependency on central control and lack of incentives at the individual level result in inefficient use of health resources. Patients consider medical care as free public goods or services. They have no incentive to choose cost-effective forms of care. There is no incentive for a patient to use community health centers rather than rush directly to the emergency department when he or she is in need of urgent care. Waiting replaces financial cost as a regulator of demand.

Although the province authorities tightly control the global health care budgets, physicians lack incentives to use health resources efficiently. There are no incentives for providers to evaluate service levels and the kinds of therapy performed in relation to improving health status. There are no incentives for altering input mixes to affect practice style. Health care providers and a single payer tend to support the status quo. On the one hand, providers organized in strong associations have strong monopoly power, which they use to defend their legitimate interests; on the other, the monopoly power of sole-source financing (NHI) keeps provider interests in check at the cost of not intervening in the organizational practice of medicine.

The U.K. National Health Service is a comprehensive health service available to all British residents. The NHS is financed by general taxes. The medical services are provided free to the residents. Ten percent of the population carries private health insurance coverage. The NHS pays general practitioners on a capitation basis and hospital physicians, known as consultants, largely on a salaried basis. Every member of the population is entitled to register with a general practitioner and use the services without fee. General practitioners provide primary care to patients and serve as gatekeepers to specialist care. NHS patients cannot go directly to a specialist. They must go first to their general practitioner. Each year, the NHS decides how much money will be made available to general practices. The total budget is then used to determine the size of capitation payments.

The U.K. NHS separated the responsibility for purchasing services from the responsibility for providing them. This arrangement is known as the internal
market. Within this market, hospitals and other providers compete for service contracts from district health authorities that, in turn, purchase services on behalf of their resident populations. Hospitals and community service units have formed or can apply to be NHS Trusts. Groups of general practitioners with more than 7000 patients can become general practice fund holders. NHS Trusts are not-for-profit organizations within the NHS but outside DHA’s control. Within the internal market, Trusts derive their income from service contracts obtained from district health authorities, general practitioner fund holders, and private patients. General practice fund holders provide budgets to fund diagnostics and ambulatory care. The government functions as the producer of health care services and a third-party intermediary.

The advantage of the NHS is the provision of comprehensive medical care coverage of the population. The U.K. system is, however, the least specialty-friendly of those considered here. By giving general practitioners a gatekeeper role and a strong financial incentive to reduce specialty referral, this system is highly dependent on the general practitioner for provision and rationing of care. This situation was illustrated by the strongly worded complaint from general practitioners when the British Medical Journal published the effectiveness of terbinafine as a treatment for onychomycosis, a condition that the British general practitioner does not wish to consider a medical condition requiring treatment.³

France is a prototype model of a traditional European NHI system. The French NHI system is financed by payroll taxes on employers and employees. The French health care system combines NHI with solo-based, fee-for-service private practice in the ambulatory care sector and a mixed hospital care sector, of which two thirds of all acute beds are in the public sector and one third are in the private sector.

In contrast with the Canadian NHI and the U.K. NHS, there is no gatekeeper in the French health care system. Physicians in the outpatient clinic are independent and free to practice. Patients are free to choose their own physician. The fee schedule was set through a negotiation between physician representatives and the government. Physicians in the ambulatory sector and in private hospitals are reimbursed on the basis of a negotiated fee schedule. Physicians based in public hospitals are reimbursed on a part-time or full-time salaried basis. Private hospitals are reimbursed on the basis of a
negotiated per-diem fee. All public hospitals and some private hospitals are financed through a global budget system. The NHI pays these hospitals at fixed sums equal to the expense of the previous year.

In terms of efficiency in use of medical resources, there are limitations in the French health care system. On the demand side, because of uncertainty about the results of treatment and the wide availability of insurance coverage, patients tend to seek more medical services than necessary. To reduce the risk of misdiagnosis or improper therapy, physicians are always tempted to order more diagnostic tests. In addition, the fee-for-service reimbursement of physicians provides a strong incentive for physicians to increase their volume of services so as to raise their income. Likewise, the per-diem reimbursement of private hospitals provides incentives to increase patient lengths of stay. Because the NHI covers most of the cost, there are few incentives for physicians and patients to be economical in their use of medical care. This lack of incentives results in excessive or inefficient use of services.

Although the global budgets system reduces the problem of excessive or inefficient use of services, this approach tends to support the existing allocation of resources within the hospital sector. It is relatively easy for a hospital to receive an annual budget to maintain its ongoing activities but extremely difficult to receive additional compensation for higher service levels, such as introduction of new advanced technology.

**Quality and Healthcare**

“Quality” health care has a wide variety of meanings. To some people, sitting in the waiting room a short time to see a doctor means “quality” health care. To others, being treated politely by the doctor's staff means “quality” health care. There are those who define “quality” health care by how much time the doctor devotes to examining you.

While these are important, “clinical” quality health care is even more important. For instance, if you take your car to a mechanic, the people in the auto shop can be friendly and listen to your complaints but the most important factor is whether or not they fix the problem with your car. Similarly, when you go to a hospital or provider, you want them to fix your problem and help make you better.

There are many ways to measure "clinical" quality health care. The New Jersey Department of Health (NJDOH) has assembled a range of ways to identify "clinical"
quality health care in hospitals. These measures are based on national practices that measure the clinical performances of hospitals by examining data gathered from hospitals.

To stay competitive and to increase market share insurance companies must practice the modern marketing concept. This is even more important for a compulsory pension product like Mexico’s, as the only way to increase market share is to have superior service quality, leading to a superior product – thus causing potential customers to switch companies. Successful companies today practice the modern marketing concept (this can be reviewed in any standard marketing text) which views the customer as the focal point of all marketing activities. There are four premises to the marketing concept: (1) there is a customer orientation that argues that a firm can be more successful if it first considers the customer’s needs and wants. This sounds simple in theory but in actual practice is difficult to implement as the company often is driven by its own needs and wants, which can differ vastly from those of the customer. (2) To correctly identify the customers needs and wants requires a continuous program of market research. It is important to ask the customers what they need and want too often companies and management merely assumes they know what the customers need and want. Why a continuous market research program? Customers, competitors and companies micro and macro environments change. (3) All activities within the firm need to be integrated so that all departments function like a team working towards the same goals and objectives. Each department must see themselves as an integral part of the team that is in the business of delivering a service to a set of customers. Departments within a company often have their own goals and objectives, and if they are not well integrated can leave individual departments functioning at odds with the goal of delivering the service so that it best fulfills the needs and wants of the customer, thus losing customers to the competition. (4) If a firm operates as if it were a team, carries out continuous market research, has the customer as its focal point and delivers the service to best fulfill the customer’s needs and wants--this provides a quality service, which leads to customer satisfaction, which in turn will lead to loyal customers, repeat business, growing market share and greater revenue. Area of critical importance is the different ways customers evaluate goods and services. When you understand how the customer evaluates your service, you can use your seven
Ps more effectively to provide a quality service and gain customer satisfaction. Customers evaluate goods and services differently, and these differences influence how the service providers market their company’s service product. These differences lead to many of the differences in marketing principles surrounding the seven Ps. When customers begin searching for information about a product they are considering purchasing they have two classes of properties to evaluate and use to make a purchase decision. (1) Search qualities - are product attributes the customer can determine before purchasing a product, style, material, color, fit etc. and goods are high in search qualities. (2) Experience qualities – are attributes that can only be discerned after purchase or during consumption, taste, durability etc. all goods and some services will be high in experience qualities. For the insurance industry, marketers are primarily concerned with third property (3) Credence qualities – which are difficult and often impossible to evaluate for most customers even after purchase and consumption. Insurance products and privatized pension schemes are often difficult for the customer to evaluate. The customer is unaware of all the product attributes, or they may have insufficient knowledge to evaluate how well the product will satisfy their needs and wants both before and or after consumption. They will often be unsure of the quality of the service they have actually received, even after experiencing the service they still do not know if it has been performed well or that the quality was as good as the company promised.

THE BASIC GAP MODEL OF SERVICE QUALITY

The GAP Model of Service Quality is a conceptual model that positions the essential concepts, strategies and decisions in services marketing. A tool will help insurance marketing managers make effective decisions about how to manage the difficult issues outlined above. The GAP Model has five gaps one Customer GAP and four Company GAPS. GAP 5 is the customer gap it is above the line in the model (see below). It is defined as the difference between what the customer perceives they received, from what they actually expected to receive. The closer a customer’s perception is to their expectation indicates better service quality leading to a more satisfied customer. If the customer forms a high expectation about a service based on advertising, and what they hear about the company, and when they actually purchase the service, if they feel or
perceive the service was as good/or not as good as they expected they will be satisfied/or dissatisfied. If the world were perfect this gap would not exist and a customer’s perception and expectations would be the same, the customer would perceive that they received what they thought the service should and would be. Closing Customer GAP 5 is the insurance marketer’s goal. The four Company GAPS are below the line in the model and are the causes of discrepancies within the company that lead to a poorer quality service and directly contribute to Customer GAP 5. Closing GAPS 1-4 are the keys to closing Customer GAP 5. It is critical to understand how customers choose and evaluate service products to be able to begin to close the GAPS.

Company GAP 1 is the result of not understanding what the customer expects from the service. This occurs when the company forms perceptions of what the customer expects based on assumptions and company experience, but without actually asking the customer. Service policies and procedures are often made by people within a company who have little or no direct contact or communication with the customer. Policy makers are often
reluctant to ask the customer about expectations because they may assume they know that the customer needs and wants better than the customer does, alternatively they may not want to know as they may be unprepared to make changes based on what they learn from their customers. Key elements to close Company GAP 1 would include (1) an ongoing market research program with a service quality focus, (2) an upward communication program to ensure all employees from customer contact employees to senior executives learn what the customer has to say, and (3) develop a relationship marketing focus with your customers rather than focusing solely on the transaction. Company GAP 2 is the result of a company not selecting appropriate service designs and standards that will allow delivery of a quality service that will adequately meet customer expectations. Typically company performance standards are established to meet company goals and needs such as efficiency. In an insurance company performance, standards must be driven by customer’s expectations and priorities. Zeithaml & Bitner (1996, p. 41) state, “A recurring theme in service companies is the difficulty executives, managers, and other policy-setters experience in translating their understanding of customers’ expectations into service quality specifications.” The customer-contact employees should be evaluated and compensated on customer-driven performance standards, to ensure the service quality will meet the customers expectations. A company’s market research program needs to include measures of customer perceptions, expectations and satisfaction that will then be aligned with primary operational and performance indicators. Key elements to close GAP 2 would include, (1) establish a management focus on customer requirements for the development of customer-driven service standards, (2) establish service leadership from the top down, and (3) ensure that service design and service positioning are aligned with customer expectations.

Company GAP 3 exists when the service delivery employees fail to deliver the service according to the service designs and standards that have been established. Even when service designs and standards have been developed from a customer focus, they are often not delivered according to those standards by the customer service employees. Employees may fail to deliver the service according to the standards when the company does not provide appropriate resources. The right people must be selected for the job, performance standards for employee evaluation must reflect the service standards,
employees have to be educated and trained to deliver the service according to the standards, employees can be in conflict between the customers and management, lack of technology, and employees may lack the authority to make decisions to deliver a quality service. The human resources department in a company has a critical role in needing to be well integrated with the marketing area to properly align employees, job design, training, etc. with service designs and standards. The customer can also have an impact on the delivery of a quality service. A difficult or problem customer can cause the quality of the service to be poor, even when the employee is doing their job well. Key elements to close GAP 3 would include, (1) the development of human resource policies aligned with service design and standard, and (2) a customer education program. Company GAP 4 exists when promises made through a company’s external communications program do not match with the service actually delivered. A Company's communication program can raise expectations above the standards that have been set or they may promise something that cannot be delivered. Promising more than can actually be delivered by the service delivery employees usually results from poor coordination between operations and marketing. Key elements for closing GAP 4 would include, (1) establish a communications program to reflect service designs and standards, and (2) establish horizontal communications between marketing, operations and human resources. When a company recognizes they have a Customer GAP 5 and they begin a program to improve their services marketing and service quality they should begin with Company GAP 1 and continue working through all the gaps with Company GAP 4 being the last. This provides the optimal approach to making the best improvements.

**Insurance business & claim management in other countries**

Insurance claim management is a core issue for the protection of insurance policyholders and hence a priority concern for the OECD Insurance Committee. From the insurance company viewpoint, claim management is a key element in the competition between insurance providers and for the improvement of industry’s public image. To date, however, there has been no international guidance on claim management, and very little comparative information at the international level to allow the sharing of experience between countries in this key area of insurance activity. This is a matter of concern since
most policyholder complaints focus on claim management, suggesting there is room for improvement in this area of client service. The Insurance Committee therefore decided in June 2000 to launch a project on claim management in OECD countries designed to collect information on Member country claim management practices and to explore the scope for international co-operation to improve the quality of claim management processes. On the basis of a survey on Member countries’ regulations and practices related to claims handling by insurance companies, the Committee’s Working Party of Governmental Experts on Insurance developed a set of good practices to guide both public authorities and insurance companies. These good practices address every step of the insurance claim management process that Working Party experts had identified as particularly important: adequate information and assistance to the policyholder for claim reporting; efficient claim filing methods; operational fraud detection and prevention measures; adequate, fair and transparent claim assessment and processing; expeditious claim settlement; effective complaint and dispute settlement procedures; and appropriate supervision of claims-related services.

The OECD good practices on claim management are neither binding nor exhaustive, but meant as a “checklist” to assist insurance companies in handling claims. Other appropriate ways to manage claims may exist and may already be reflected in a country’s national laws and regulation and/or in company or industry codes of conduct. Insurance companies could also go further, for instance through the launch of public awareness programmes on claims management issues.

RECOMMENDATION OF THE COUNCIL ON GOOD PRACTICES FOR INSURANCE CLAIM MANAGEMENT
THE COUNCIL,

Having regard to Article 5b) of the Convention on the Organisation for Economic Cooperation and Development of 14 December 1960; Considering that insurance claim management is a core issue for the protection of insurance policyholders; Considering the need for enhanced efficiency, transparency and disclosure of information to policyholders during the claim management process, Considering that claim management is a key element in the competition between insurance companies and for the improvement of industry’s public image; Considering that such good practices are expected to fill a gap at
the international level by providing further guidance for the benefit of the insured and that their implementation would further the quality of the service provided by insurance companies; noting that the companies could also go further, for instance through the launch of public awareness programmes on claims management issues; Considering that the good practices presented hereafter are neither binding nor exhaustive; Considering that such good practices provide a checklist which can be recommended to insurance companies and public authorities in the field of insurance claim management, while other appropriate ways to handle claims management may exist and may already be reflected in a country's national laws and regulation and/or in company or industry codes of conduct. Noting that these practices do not cover the management of major claims arising from natural or manmade catastrophe; Recognizing that innovations may occur in the claim handling process, which may require future updating of these good practices; On the proposal of the Insurance Committee: RECOMMENDS that Member countries invite public authorities and insurance companies to ensure the efficient and fair management of insurance claims, having regard to the contents of the Annex to this Recommendation of which it forms an integral part. INVITES non-Members to take account of the terms of this Recommendation.

**Good practice 1: Claims reporting**

The insurance company writes insurance policies in easily understandable language. Policies spell out what is covered and what is not covered. If necessary, plain language explanations could be an addendum to the legal language. The insurance company draws the attention of the policyholder/claimant/beneficiary1 both when he/she signs a policy (for policyholders only) and when he/she reports a loss on his/her duties related to claim reporting which include:

- To try to minimize losses;
- To report claims in a timely fashion;
- To co-operate in the investigation by providing the company with all relevant information and, in particular, copies of official documents regarding the damage (accident, loss, etc.);
To authorize the company to handle necessary inspections and assess the extent of the damage prior to any repairs or replacement;

To ensure that the claims reporting phase proceeds as smoothly as possible, the insurance company sends to the policyholder/claimant/beneficiary within a reasonable period of time (beginning from when the loss is reported):

- An appropriate claim form (when the loss reporting is made in writing) for the type of policy - prepared either by an individual insurance company or at the national level by companies or the supervisory authorities together with instructions and useful information on how to comply with the terms of the policy and the legitimate requirements of the company;
- The information necessary to help them to report the claim.

**Good practice 2: Receipt of claims by the company**

The company claim department and/or the intermediary (if applicable) are as accessible as possible for the claimant. If an intermediary is an initial contact for claimants, claims should be sent to the company claim department within an appropriate time period.

The insurance company contacts the policyholder/claimant/beneficiary or sends an acknowledgement of receipt as soon as the claim is received.

Subsequently, if it appears that the claim cannot be settled rapidly, the company notifies the policyholder/claimant/beneficiary and indicates that he/she will be re-contacted within a reasonable time limit.

When it is necessary for the policyholder/claimant/beneficiary to provide specific documents when filing a claim, the company sends him/her the list of these documents as soon as possible. In addition, a specific notification listing the elements to be provided when another insurance company is involved is sent to the policyholder/claimant/beneficiary.

If it appears that the claim is not covered by the insurance policy, the company sends a notification as soon as possible to the policyholder/claimant/beneficiary, explaining why it is not covered.

When the claimant is not the policyholder, the company sends him/her information on his/her rights and duties when relevant.
When appropriate, the insurance company notifies the policyholder of his/her right of subrogation and informs him/her of the main principles governing the subrogation procedure.

**Good practice 3: Claims files and procedures**

Once a claim has been filed and, when applicable, after any additional documents that are required to process the claim have been received, the file established by a company contains the following documents:

− Claim filing number;
− Policy number;
− Name of the policyholder/claimant/beneficiary;
− Summary sheet showing development / review of the claim;
− Type of insurance concerned;
− Opening date of the file;
− Date of loss;
− Reporting date;
− Description of the claim;
− Information on claimants;
− Assessment date;
− Electronic and/or paper copy of the adjustors’ and investigators’ reports where applicable;
− Identity of the adjuster;
− Estimated cost of damage;
− Dates and amounts of payments;
− Date of denial, if applicable;
− Name of intermediary, if applicable;
− Date of file closure;
− Documents recording contacts with the policyholder/claimant/beneficiary.
Good practice 4: Fraud detection and prevention

In order to curb the growth of fraudulent claims and the rise in premium costs that results from them, companies take the following steps:
− They establish compliance programs for combating fraud and money laundering appropriate to their exposure and vulnerabilities.
− In the claim filing phase, they discourage fraudulent practices by making the policyholder/claimant/beneficiary aware of the consequences of submitting a false statement (which in particular could be liable to prosecution) and/or an incomplete statement. To this end, insurance companies place a notification on their claims forms referring to the appropriate law, statute or insurance regulation that addresses the filing of fraudulent or incomplete claims.
− Where legally possible, companies participate in relevant databases where claims susceptible to be fraudulent would be reported. Moreover, public authorities may encourage or take steps to initiate the creation of a public or private bureau of insurance fraud.
− Besides, companies provide their claims department staff with adequate training on fraud indicators.

Good practice 5: Claims assessment

General issues:
Any method of taking into account specific factors such as depreciation, discounting or negligence on the part of the victim is clearly outlined in the claim file.
Any loss evaluation methods used by the company are reasonable and coherent.
The insurance company uses internal methods for assessing claim values based on the applicable law of the jurisdiction.

The role of claims adjusters:
Companies that use claims adjusters or intermediaries will need to ascertain their competence qualifications. Moreover, if these claims adjusters/intermediaries were to commit any errors or misappropriation of funds affecting their policyholders, claimants or beneficiaries within the framework of the contract with the insurance company, the latter would be held responsible. Consequently, companies may decide to limit the scope
of action of claims adjusters and intermediaries (for example, by setting ceilings on the number of claims they can handle).
Companies notify policyholders/claimants/beneficiaries whenever they use independent claims adjusters or intermediaries. Information to policyholders:
When the damage is assessed through a written estimate made on behalf of the insurer, the insurer sends the policyholder/claimant/beneficiary a copy of the document used to set the amount of compensation.

**Good practice 6: Claim processing**

**General issues:**
A company’s claim procedures are gathered together in a manual for internal use. At least, one staff member should be responsible for ensuring that the manual is kept up to date and additions/amendments are made when necessary.
Companies’ claims department staff possess proper qualifications. To this end, companies encourage ongoing internal or external training of their claim staff.
Regular internal audits are carried out for all claims not settled in their entirety. Internal audits apply to all stages of the claims management process. Peer reviews (where the claims department staff review each others’ files) could also be carried out.
In case of claim settlement procedures involving several insurance companies, policyholder indemnification is a priority: the claim should be compensated in an appropriate time period while potential disputes between insurers are resolved at a later stage. For the most common insurance claims (related to motor insurance, for instance), specific agreements are concluded between insurers to accelerate and simplify claims settlement procedures involving several insured parties.
Insurance companies do not:
- Conceal policy coverage provisions of any insurance policy when they are pertinent to a claim.
- Dissuade policyholders/claimants/beneficiaries from obtaining the services of an attorney or adjustor.
- Attempt to settle claims for less than the amount to which the claimant would be entitled to receive according to any written or printed advertising material accompanying
the application forms. However, insurers may take legal action against any intermediary that has made irresponsible promises.

• Deny a claim without reasonable investigation.
• Transfer responsibility for the claim to others, except as may be expressly provided for by policy conditions.

Provision of information to policyholders:
− The company keeps policyholders/claimants/beneficiaries informed of the progress during the claims process. The company provides information on when payments, repairs or replacements are expected to be made, and, if necessary, explains why additional time is required.

When the company decides to call on outside parties (i.e. loss adjusters, solicitors, surveyors, etc.), it informs policyholders/claimants/beneficiaries of this fact, gives the reasons for this decision and explains the role that these outside parties will play in processing the claim.

When a final payment or offer of settlement is made, the company explains to policyholders/claimants/beneficiaries what the payment or settlement is for and the basis used for the payment/settlement.

The insurance company documents their claim files in order to be able to address questions that may arise concerning the handling and payment of the claim.

Cases of no/partial payment claims:
If the claim is denied, the insurance company states explicitly to the policyholder/claimant/ beneficiary the policy provision, conditions or exclusion on which the denial is based.

If the amount offered is different from the amount claimed, the insurance company explains the reason for this to the policyholder/claimant/beneficiary.

When the insurance company is not responsible (by virtue of policy clauses) for meeting all or any part of the claim, it notifies the policyholder/claimant/beneficiary of this fact and explains why.
**Good practice 7: Timely claim processing**

In accordance with applicable insurance law, companies may specify in the contract the most likely period of time for responding to correspondence from policyholders/claimants/beneficiaries.

Once policyholders/claimants/beneficiaries have filed a claim:

- They are informed of the acceptance or denial of the claim within a reasonable amount of time after the receipt of the notification.
- The insurance company contacts any other company that is involved in the claim within a reasonable amount of time, and resolves inter-company claim disputes as quickly as possible.

The insurance company endeavors to settle the claim as soon as possible and advises in writing the policyholder/claimant/beneficiary on the reasons for any delay.

Quick claims settlement as well as high-quality and punctual information provided to the policyholder/claimant/beneficiary are key competition features for insurance companies.

After an agreement has been reached between the company and the policyholder/claimant/beneficiary on the amount of compensation, the payment is effected within a reasonable amount of time.

Insurance companies implement and update their own statistical database tracing their performance in the timely settlement of claims as well as in trends in settlements and expenses.

A proper procedure for the coding and statistical processing of losses is developed for this purpose.

**Complaints/Disputes:**

When the policyholder/claimant/beneficiary files a complaint, the company:

- Acknowledges receipt of the complaint within a reasonable period of time;
- Provides policyholders/claimants/beneficiaries with explanations on how their complaints will be handled and on the procedures to be followed;
- Provides information to policyholders/claimants/beneficiaries on internal and external dispute settlement procedures;
- Processes complaints promptly and fairly;
• Keeps policyholders/claimants/beneficiaries regularly informed of how their complaints are progressing;
• Provides a final response in writing within a reasonable period of time.

If the policyholder/claimant/beneficiary is dissatisfied with the final response that he/she has been sent by the company, he/she can activate an internal appeals process. He/she can also appeal to the dispute settlement procedures available outside the company (for example, the handling of complaints by the supervisory authorities). In case of a dispute, the insured/claimant/beneficiary should be informed by the company of the existence of these appeal procedures.

**Good practice 9: Supervision of claims-related services**

The insurance supervisory authorities may conduct examinations on claims management services especially where problems are suspected. In these cases, the following elements are taken into account:

− Possible access to non-confidential claims data for all open and closed files within a specified time frame (e.g. for the current year and the two preceding years);
− Maintenance of sufficient and appropriate information on claims files;
− Use of the appropriate type of claim form for the type of insurance;
− Proper qualification of the claims department’s employees based inter alia on the applicable insurance code;
− Valuation of claims payments according to company procedures;
− Appropriate tracking of the nature and number of complaints related to claim management process;
− Monitoring of the proportion of claims that result in litigation;
− Compliance with procedures for combating fraud and money laundering;
− Regular internal audit practices on claims files;
− Appropriate internal claims procedure manuals;
− Proper procedure for coding and statistical reporting of losses;
− Performance in terms of the speed of claim settlements
Good practice 10: Market practices

The public authorities promote the implementation of a benchmark exercise regarding the claims process or a specific part of this process (i.e. handling of complaints). The terms of remuneration of insurance company employees or other services in charge of claim management do not give incentives to disadvantageous treatment of policyholders/claimants/beneficiaries, as regards the handling or the outcome of claims.

Claim Management Company

Claims and loss handling is the materialized utility of insurance; it is the actual "product" paid for. Claims may be filed by insureds directly with the insurer or through brokers or agents. The insurer may require that the claim be filed on its own proprietary forms, or may accept claims on a standard industry form, such as those produced by ACORD. Insurance company claims departments employ a large number of claims adjusters supported by a staff of records management and data entry clerks. Incoming claims are classified based on severity and are assigned to adjusters whose settlement authority varies with their knowledge and experience. The adjuster undertakes an investigation of each claim, usually in close cooperation with the insured, determines if coverage is available under the terms of the insurance contract, and if so, the reasonable monetary value of the claim, and authorizes payment.

The policyholder may hire their own public adjuster to negotiate the settlement with the insurance company on their behalf. For policies that are complicated, where claims may be complex, the insured may take out a separate insurance policy add on, called loss recovery insurance, which covers the cost of a public adjuster in the case of a claim. Adjusting liability insurance claims is particularly difficult because there is a third party involved, the plaintiff, who is under no contractual obligation to cooperate with the insurer and may in fact regard the insurer as a deep pocket. The adjuster must obtain legal counsel for the insured (either inside "house" counsel or outside "panel" counsel), monitor litigation that may take years to complete, and appear in person or over the telephone with settlement authority at a mandatory settlement conference when requested by the judge.
If a claims adjuster suspects under-insurance, the condition of average may come into play to limit the insurance company's exposure.

In managing the claims handling function, insurers seek to balance the elements of customer satisfaction, administrative handling expenses, and claims overpayment leakages. As part of this balancing act, fraudulent insurance practices are a major business risk that must be managed and overcome. Disputes between insurers and insureds over the validity of claims or claims handling practices occasionally escalate into litigation.

A claims management company is a professional service offering advocacy, advice, and consultations for individuals and groups looking to settle insurance claims. The types of claims handled by claims management services can come from a variety of insured parties, including homeowners, business owners, injured persons, hospitals, and real estate investors; a claims management company typically specializes in one or two areas of legal expertise. In addition to practical legal advice, the company might also provide thorough investigations of filed claims, input on settlement negotiation, and, if necessary, they may also enter in a cooperative relationship with outside counsel during any litigation.

Claims management companies do not just represent claimants, however. They may also be hired by a hospital or business that is being targeted by a claim. In these cases, claims professionals go to work investigating the claim, almost becoming detectives working on behalf of the business. They might interview all parties involved in a claim, any witnesses to the incident, and any professionals who can provide input into the nature of the claim. If litigation is required, the claims management professional will typically advise and work closely with the business or hospital's legal representatives.

In real estate cases, a claims management company will commonly come on board to provide legal services after a property has experienced some sort of major damage. They may represent the homeowner, a landlord, or an investor in the property. The claims management experts identify property losses and work to accelerate the claims process since, in many instances, a claimant may be unable to live in his or her own home.
Competition and Change

The insurance industry is competitive and change is constant. The competitive playing field is global and the competition is robust. Industry leaders deliver shareholder value by growing revenue, generating profit and producing above average returns on equity in a constantly changing environment. Predictions for the nature of change expected over the next ten to fifteen years are diverse, insightful and highlight the need for new ways of thinking about insurance operations. In a recent survey of insurance executives, 70% of respondents expect significant change while 30% of respondents expect incremental change during this period; not one respondent envisioned the future to be the same as the present nor expected the need for change to go unnoticed. The survey suggests that “mega trends will force the industry to innovate; old modes of thinking threaten the industry’s ability to innovate; interlopers will increasingly disrupt traditional insurance operations; industry leadership will require experimentation in operating models, processes, products and customer relationships; and strategic investment in innovation today is critical to success” in the future. Innovative change starts with the most senior executives. A recent survey of global CEOs reported that more than 40% of respondents indicated that, within their organizations, they lead business model innovation, while 38% lead operational innovation efforts and just over 30% lead product and service innovations. Executives must provide leadership within their organizations to prepare for the future. The role of the executive, need for innovative change and the need to experiment with operating models and processes to remain competitive in the long-term should drive insurance executives to evaluate the insurance value chain for opportunities to leverage innovative sourcing alternatives.

The existence of a small number of large, well qualified commercial property and casualty claims management service providers in the United States may be attributed to the explosive growth of the alternative risk financing market during the latter part of the 20th century, and the subsequent broader adoption of these services by other bearers of underwriting risk. During this period, we saw large individual commercial insurance buyers self-funding increasingly larger amounts of underwriting risk in the form of self-insured retentions and large deductibles. As a result, they came to desire total control of the claims management process in order to gain process flexibility, fee and expense
transparency, and reduced loss adjustment expenses. A few savvy insurers recognized a market opportunity and spun off their (superior) claims operations to create stand-alone profit centers that today are viable alternatives to the traditional insurance company claims operation.

Good claims management service providers offer competitive advantage through the maximization of efficiency, enhancement and transformation gains produced by their own sourcing strategies. Inasmuch as the claims management process is comprised of several sub-processes, including claims investigation, loss reserving, financial management, litigation management (litigation planning), medical cost containment (managed care strategies), recovery management (subrogation, salvage, second injury fund), settlement, regulatory compliance and information management, each represents an opportunity to provide a superior service that positively influences loss and expense ratios. In addition, other sub-processes involving call center functions, independent adjusting, loss fund administration (loss payment issuance), defense work, medical bill review, nurse case management, PPO network management, structured settlements, and others may offer additional gain if managed effectively. The most successful outsourcers focus on planning for business outcomes, partnering for performance, strong governance for smooth transition and execution with innovation.

**Planning and the claims management service provider**

The outsourcing planning process considers the desired level of impact the outsourcing engagement will have on the organization. Outcomes are commonly classified into three broad categories: efficiency, enhancement and transformation. Planning centers on creating efficiencies by identifying opportunities for cost reductions while maintaining high quality and high process availability. This approach leverages the service provider’s scale of operations, technical capabilities and management proficiency. The overarching objective is to optimize a process in a way that gives an organization a tangible advantage or a new degree of functionality not previously available. Transformation is the most ambitious objective and directly affects the fulfillment of business strategy by altering the organization through significant changes to the business model. Outsourcing may produce all three outcomes, however, transformation is the ultimate objective of the most
successful outsourcing engagements – experienced outsourcers recognize that “value lies in turning costs into capabilities” – a product of successful transformation. Transformation requires an alignment of the service recipient’s and service provider’s business strategies. A successful transformation results in the ability to “innovate and dramatically improve the very competitiveness of the organization by creating new revenues, outmaneuvering the competition, and even changing the very basis on which a corporation operates.” Transformation involves a much higher level of risk and is generally approached as a partnership of equals; the planning, implementation and realization of benefits requires high level interaction, investment and trust.

Claims management service providers can deliver transformational change to commercial property and casualty insurance companies at all stages of the insurance company’s life. Well-planned and executed arrangements favorably impact income, profit and return on equity during the launch, growth, maturity and decline of an insurer. For example, during launch, an executive team outsourcing the claims management process can focus on strategy and tactics that increase value rather than developing a claims management organization; the expertise, scale and scope of the claims management service provider are available for immediate implementation. The fixed expenses of developing a claims operation are avoided as fixed expenses are converted into variable expenses, thus freeing the organization to invest capital in activities producing the highest return on investment. This approach is most successful when speed to market is imperative. One real-life example involves an insurance company that had committed to the “virtual insurance company” model to launch and underwrite property and general liability insurance on a single-state basis. The executive team understood the benefits of the model, and by contracting with a claims management service provider was able to immediately access the deep expertise, scalability and a broad scope of claims-related services that the provider offered. Additionally, the company’s capital was not tied up in office leases for claims staff, their salaries and benefits, advanced claims management information technology, errors and omissions insurance and other related expenses. Service fees paid to the claims management service provider were variable based on a percentage of gross written premium with a very manageable fixed expense component.
During the growth phase, an executive team may choose to outsource the claims management process as it expands product lines, geographic range or total premium writings. To use another real-world example, let’s examine an insurance company that has committed to an all-lines (workers’ compensation, general liability, automobile liability and property) national expansion strategy after years of regional operation as a workers’ compensation insurer. The challenges of expanding the existing regional monocline claim operation to manage claims arising from new product lines on a national basis are many. By using a third-party claims management service provider, the existing claims organization’s regional capabilities simply augment the outsourcing arrangement without disruption to the existing operation.

For a mature insurance company confronted with the constraints of legacy information systems, outdated claims processes, underperforming managed care arrangements and other inefficiencies the outsourcing of the claims management process offers a viable alternative. A third example is an insurance company that had a claims organization yet empowered policyholders with the option of selecting an approved claims management service provider instead. This is common to the individual risk management account market. The mature insurance company continues to underwrite profitable policyholders with the loss of nominal incremental revenue on claims management services.

Insurance companies with discontinued operations are confronted with the same challenges as the start-up. As claims volume declines, the allocation of capital to claims office leases, professional compensation, management information systems, errors and omissions insurance and other related expenditures must be scaled back. Consider an insurance company in runoff. A claims management service provider is capable of assuming claims handling responsibility for all open and closed claims. The runoff insurance company shifts much of the fixed expenses to variable expenses while gaining all of the advantages of the world-class claims management process offered by the claims management service provider. It is possible for the claims management service provider to carve out the existing claims organization, assume staff and facilities, and manage the runoff claims activity as a standalone unit.

Large, competent claims management service providers deliver transformational change to insurance companies. Designated adjuster, dedicated adjuster and dedicated unit
staffing models based on traditional scale and scope of control caseload models provide
great flexibility to executive teams. Claims management service providers are capable of
generating mutually beneficial partnerships.

**Partnering and the claims management service provider**

The focus now shifts to the selection of a service provider through a formal vendor
selection process and contract negotiation. Successful outsourcers no longer view
external service providers as cynically as perhaps they once did, as “the enemy –
dishonest, untrustworthy characters, totally focused on sucking as much money as
possible” from the service recipient. Instead, these organizations “create mutually
beneficial relationships with trusted providers who understand their industry, respect their
corporate cultures, and put mutual interest before self interest.” They frequently consider
these factors above price. Proper evaluation of service providers requires the creation of a
detailed statement of work and contract as part of a provider evaluation packet. Ideally,
the packet is offered to fewer than four relevant service providers. Responses should
define a detailed approach to the work and a price for doing so. Proposals should be
scored based on predetermined criteria and negotiations can thereafter begin with
finalists. This differs from the traditional request for proposal (RFP) process that offers a
list of open-ended questions that invite widely disparate answers that are often difficult to
evaluate objectively. The service provider and service recipient learn little about each
other this way, and vendor selection becomes a highly subjective process. Experienced
outsourcers, however, approach service providers with proven capabilities and structure
the evaluation process to actually test the most important selection criteria. Notably,
experts “ranked the contract as the most important management tool in the first year of
an outsourcing relationship.” Arrangements aimed at organizational transformation
involve the most risk and as such should focus on the successful alignment of
organizations to achieve a well-defined, mutually understood vision. Relationship
management, service delivery, service level expectations and price must also be
considered. The most successful relationships are conducted as quasi-partnerships with
mutual benefits acknowledged by each party.
To generalize, and perhaps oversimplify, in our experience the less successful outsourcing relationships are approached as typical vendor/buyer arrangements. Although a best practice involves some form of the evaluation process described above, most continue to be undertaken through a rigid but less effective RFP process or worse, some form of informal decision making based on who has the best sales pitch. In their responses, prospective claims management service providers should clearly define how they would align their operational capabilities with the insurer’s strategic vision and describe how they would complement the existing claims organization, leverage existing service provider and service recipient relationships and adapt the claims process to better serve the insurer’s needs. A plan describing options for the integration of claim reporting processes and call center services, data exchange processes for policy verification and coverage determination and data interface processes should also be presented to the insurer. The claims management service provider should then determine to what extent independent adjusting firms, managed care services organizations, defense counsel and others should be brought to bear to produce a truly integrated solution. Any changes to the claims process must be evaluated by the insurer with their acceptance explicitly confirmed. Throughout the selection process, both parties should involve a team of stakeholders including executive management, claims operation leadership, information technology experts and others. Claims handling expectations should be memorialized in a formal set of claims handling guidelines. Contract terms should stress the strategic alignment of both organizations through service level requirements. Once the claims management service provider is selected, the focus shifts to transition.

**Transition and the claims management service provider**

The most successful outsourcers recognize transition as a critical part of the outsourcing lifecycle. Identifying an executive sponsor, managing change, defining governance measures and developing an exit strategy are critical to the success of the engagement. Experienced outsourcers realize the importance of identifying executive and general managers with the requisite skills to manage all phases of the outsourcing lifecycle. The most successful understand that “it is best if sponsorship includes the most senior leadership possible – one or more individuals at the c-suite level with a deep passion for
the long-term goals of the arrangement.” Some organizations deploy organizational structures dedicated to sourcing projects. These units are typically staffed with relationship managers, performance managers and contract managers. A relationship manager is responsible for developing and prioritizing requirements, managing issue escalation, monitoring performance, acting as account-level liaison for the multiple service providers (to the extent they’re engaged) and as a liaison for business unit relationship managers. The performance manager is responsible for operations oversight, service integration, incident management, and performance management. The contracts manager is responsible for the management of contract terms and conditions, the management of projects and bids and the enforcement of contracts and schedules. Transition-ing to a service provider involves a great deal of change. The fundamentals of change management suggest that the change agent clarify the need for change, outline a vision for the future and provide a logical first step to achieve the desired outcome. Committing to a comprehensive change management plan that, through sound communication, reinforces the vision and quantifies the strategic objectives sought is a key success factor. Governance measures are applicable to all phases of the outsourcing engagement and include the “formal and informal structures a company and its service provider use to monitor manage and mediate their collaborative effort.” Some service recipients establish formal sourcing units responsible for relationship, performance and contract management. Others rely on operational review committees, capability review committees, joint review boards and compliance committees. These formal committees meet monthly or quarterly. The informal daily contact and interaction create an environment of open and honest exchange and are not to be underestimated. As needs change, service recipients may move work from one service provider to another. Experts contend that it is “important to consider how the next transition will occur if and when the outsourcing relationship ends.” Such planning protects the organization in case a contract is terminated and provides a plan for the next transition.

In practice, claims management transitions are complex and time consuming exercises. Participation expands beyond the claims function to include operations, finance, regulatory compliance, legal, underwriting, actuarial and information technology functions. As a function critical to customer perception and satisfaction, executive level
sponsorship by the chief executive officer, chief operating officer and/or chief claims officer (or equivalent) is crucial. The claims officer is perhaps best positioned to assume the executive sponsor role, articulate business objectives and internally champion the transition. The claims officer is best suited to communicate the message that the insurance company expects to experience more rapid and profitable growth and plans to be able to develop and service new product lines by outsourcing the claims management function, without discontinuance of the existing operation. The claims officer would need to address the existing claims operation’s concerns of obsolescence by emphasizing the strategic importance of the operation in the long-term. The claims officer should assemble and work to closely align an internal team with the claims management service provider’s implementation team. A well-considered collaborative implementation plan will specify key objectives and mutually acceptable deadlines. To execute the plan, the claims management service provider should appoint an implementation manager responsible for leading the overall transition and any related function-specific projects. Related projects may include integration of call center services, adaptation of the claims process to address oversight requirements, coordination of independent adjusting, legal and salvage services, integration of medical cost containment processes, establishment of loss funding mechanisms, development of policy and claims data interfaces and others. The implementation team should include members with experience in each of these areas. During transition, team members generally interact with their counterparts at the claims management service provider while the implementation manager steers the project. Periodic status meetings and other communications should be used to gauge progress, address open concerns and define next steps. The claims management service provider’s relationship manager supports the implementation manager during transition and takes the lead once the transition is complete.

Although the claims management service provider and the service recipient operate closely, process alignment is achievable without complete process integration and the alignment can be undone without catastrophic impact on either firm when the relationship no longer makes sense. Such dissolution of the relationship should be spelled out as an exit strategy in the services agreement between the parties.
Execution and the claims management service provider

Throughout the operational phase of an outsourcing engagement, service recipients often begin to realize significant performance improvements, cost reductions and capability gains. The primary focus of the engagement thereafter shifts to optimizing outsourced processes. According to Accenture, the most successful outsourcers “seek to build on their immediate gains by setting new standards and by seeking out new opportunities to capture value and raise performance.” These outsourcers produce real value by stressing continuous improvement by seeking broader use of process automation and performance improvement strategies. Tremendous value is created when the environment shifts from one in which the service recipient dictates requirements to the service provider to an environment in which the service recipient taps the service provider’s knowledge of best practices. Continuous improvement may be included as a contract feature by adding terms that require defined performance gains – based on key performance measures that are continuously monitored – on an annual basis.

An insurance company in growth mode could derive substantial benefits by engaging a claims management service provider, as support for independent adjusting, medical cost containment, defense, salvage and other critical process would be immediately available and the claims function would be eminently scalable. Such scale and scope of a claims solution is rarely available on a “build-only” basis. The variable expense structure afforded by outsourcing arrangements frees capital for other purposes. Additionally, continuous performance gains often result from the claims service provider’s own pursuit of operational excellence.

Claim management in America

Example of Insurance Office of America:

Getting an auto, property, medical malpractice, product liability or workers’ compensation claim through the insurance claims process is a rigorous exercise for any company. Working with the various adjusters, investigators, appraisers and attorneys that will become involved can be a burden on a company’s resources. Our claims professionals can help you coordinate your claims to ensure they are moving through the
process as quickly and economically as possible. Our property and casualty claims management services are available on all lines.

Insurance Office of America Client Services offers claim professionals who will work with you to implement a custom plan designed to control claims exposure through prevention, early intervention and cost reduction. We recognize that what works in one industry or business model may not work in another. We will take the time to learn your business and identify with you which processes should be targeted for improvement.

In addition to outstanding claims support if you choose to take advantage of our NEW Compass™ Risk Management Portal you will get the industry’s most comprehensive claims management system. Learn more about Compass™ by clicking on our risk services link.

Our scope of services includes:

- **Account Management**- Our goal is to take control of the Claims Management Program in order to reduce the overall claims exposure. Through our efforts, it is our intention to hold the insurance carrier accountable for the level of service they provide. We intend to create a Best Practices Guideline for management of the claims program.

- **Claim Reporting**- The first priority is to establish effective claim reporting procedures for our clients.

- **Claims Review & Audit**- Our goal is to assist you with the management of the claim files and facilitate appropriate guidelines to bring the claim to a conclusion.

- **Insurance Carrier Claims Management Guidelines**- Our Goal is to take control of the claims exposure and mandate that the insurance carrier manage your claims appropriately.

- **Litigation Management**- The litigation management policy requires that referrals to defense counsel must be made in a timely manner with specific instructions regarding outline of claim, outstanding issues, specific expectations and responsibilities of defense.
• **Data Integrity Analysis**- Insurance Office of America Client Services will provide trend analysis of all older claims and concurrent claims in order to assist with the development of loss control activities.

• **Accident Investigation Programs**- An accident investigation program is not only an analysis evaluation, but also a report of the accident, based on the information gathered by the investigator. The quality and usefulness of the information is directly related to the degree of thoroughness of the investigation.

• **Return to Work Programs**- Facilitating a return to work program after an industrial accident can be a monumental task for any employer. Our goal is to assist our clients in developing a process that will return injured workers back to work as soon as possible in order to reduce the overall claims costs.

• **Vocational Management**- The vocational case management process includes such services as transferable skills assessment, vocational evaluation/testing, wage loss evaluation, job placement, labor market analysis, expert witness testimony and a full range of return to work programs including job analysis/modification, job accommodation, ADA compliance and job compliance.

• **Regulatory and Compliance**- Staying abreast of the complexities of multiple state and federal regulations can be perplexing for any employer. Insurance Office of America Client Services assures that each of their clients has been provided with the most up-to-date information for each state that the client has interests in and that they remain compliant under our partnership.

• **Cost Containment Programs**- Develop strategic protocols such as pre-employment screening, fit for duty exams, proactive initial employee training with designated follow-up procedures, strategic alignment with key medical providers or implementation of internal cost allocation structures.

**Claim Management in China:**

**Example of LFC:**

We manage the claims from policyholders through our claims verification staff at our headquarters and branch offices. Typically, upon receiving a claim, a staff person will verify if all materials supporting the claim have been submitted; if so, the claim and its
materials will be forwarded to the liability department to confirm liability and to determine whether a claims investigation is needed. Upon confirming the validity of the claim and insurance liability, the amount payable to the policyholder will be calculated, and the claim will be paid upon completion of the re-verification and approval procedure.

We manage claims management risk through organizational controls and computer systems controls. Our organizational controls include specific limits on authorization for branches at different levels; periodic case inspection and special inspections in particular situations by claims management bodies at all levels of our organization; expense mechanisms linking payout ratios of short-term insurance policies and expense ratios of branches. Except for some health insurance claims below a certain amount, verification of claims by two staff members is also required. We also impose stringent requirements on the qualification and employment of claims verification personnel. Our claims management is strictly processed with computers to streamline claims verification and handling.

**Conclusion:**

The financial services industry has undergone a paradigm shift over the last two decades. This shift has brought about fundamental changes in the manner in which business is conducted and the ways customers perceive the business. This shift has also attracted many control measures by regulators.

Globalization has resulted in exponential growth for many successful enterprises both in financial and non-financial industries. In the majority of these, growth can be attributed to inorganic expansion through mergers and acquisitions (M&As). Specifically, in the insurance industry M&A activity has been on the rise since the early 1990s — especially in the UK, continental Europe and North America. The extent of exposure to risk has grown multifold with the growth in this industry. Recently, the industry has witnessed a government bailout for some carriers. From an IT perspective, both M&As (in organic growth) and bailouts have resulted in systems acquisition and consolidation, leading to enterprise-wide transformation initiatives. For an insurance company, under any circumstances (a situation demanding change driven by market situations, natural calamity or environmental forces), it needs to be agile to fulfill its basic mission, which is to provide direct financial protection to its customers. Among all others, claims
management is one of the important functions for an insurance carrier. For starters, it
directly impacts the carrier’s risk exposure and liquidity. Hence, IT must serve as a
strategic enabler in the management of both these crucial functions.
The current market, the claims repudiation ratio has become an important parameter for
measuring an insurer’s position. So far, more attention has been paid in making the policy
administration, billing and collections functions agile. Of late, insurers have felt the need
to focus on streamlining the claims management process — thus providing a better
customer experience and winning trust. Towards this, a focus on having a consolidated,
modernized and integrated claims management system is crucial.

REVIEW QUESTIONS
Q1. Define Underwriting and Fundamental of Underwriting for general Insurance
Q2. When Declaration is made and discuss the types of Accident benefits.
Q3. What is Claim Management? Discuss the issues and challenges of Claim
    management.
Q4. Describe the essential element of claim management.
Q5. Discuss the role of IT in claim settlement and also describe other counties Claim
    management system.
“The lesson content has been compiled from various sources in public domain including but not limited to the internet for the convenience of the users. The university has no proprietary right on the same.”