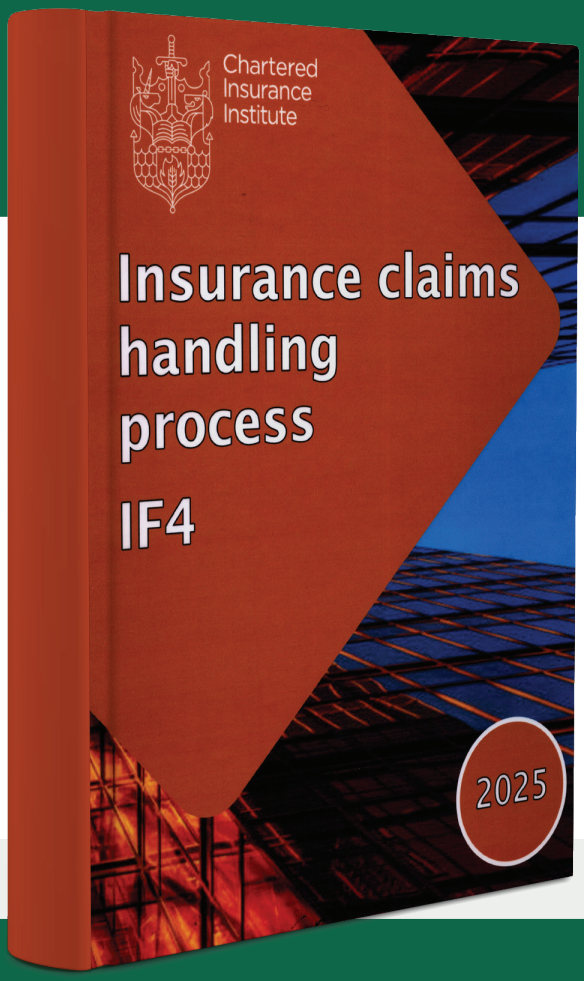

فراخوان ترجمه کتاب

پژوهشکده بیمه

پژوهشکده بیمه، به منظور کمک به گسترش دانش بیمه‌ای، ترجمه کتاب

Insurance claims handing process (IF4)

را در دستور کار خود قرار داده است. لذا از کلیه اساتید، پژوهشگران، صاحبنظران و کارشناسان دعوت می‌شود که در صورت تمایل به ترجمه کتاب مذکور، کاربرگ درخواست ترجمه پیوست را به همراه سوابق علمی و اجرایی خود و ترجمه صفحات ذکر شده با ذکر عنوان کتاب، حداکثر تا تاریخ ۱۴۰۴/۰۷/۲۴ به آدرس ایمیل nashr@irc.ac.ir ارسال فرمایند.

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الف- اطلاعات عمومی

نام و نام خانوادگی	
شغل و سمت فعلی	
مرتبه علمی (ویژه اعضای هیات‌علمی)	
آخرین مدرک تحصیلی و رشته	
آدرس	
شماره تماس ثابت	
شماره تماس همراه	
پست الکترونیک	

ب- سابقه تألیف/ترجمه (حداقل ۳ عنوان از آثار خود را اعلام بفرمائید)

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ردیف	محل خدمت	مدت زمان خدمت

Introduction

Now that we have established what a claim is and taken a brief look at the different types of insurance available, we can start to look at how an insurer responds to a claim. We stated in chapter 1 that the claims department is the 'shop window' of the insurance company as it is only when a policyholder comes to make a claim that they find out the value of the insurance they have been paying for. In this chapter, we will look at some of the things that the claims department needs to consider when handling the claims it receives.

Key terms

This chapter features explanations of the following ideas:

Claims handler	Customer service	Disputes	Estimating
Fair treatment of customers	Fraud detection	Incurred but not enough reported (IBNER)	Incurred but not reported (IBNR)
Reserving	Service standards	Third-party claims	

A Claims staff

The claims department plays an important role in shaping the opinion policyholder has of their insurer. Furthermore, the claims department is a vital component in ensuring the proper management of pooled funds.

For these reasons, it is vital that the claims department is efficient, and is staffed by competent and professional claims handlers.

Consider this...
What is the role of a claims handler?

To summarise, the role of a ***claims handler*** is to:

- deal with all submitted claims quickly and fairly;
- settle claims with the minimum of wastage or avoidable overpayment (this is also known as leakage);

Refer to
Leakage covered in *Leakage (or overpayment of claims)* on page 7/3

- estimate accurately the final cost of outstanding claims; and
- distinguish between genuine and fraudulent claims.

This overview embraces the two-pronged function of the claims department and in this chapter, we shall deal with these issues in greater detail.

B Service standards and managing customer expectations

Question 3.1

Whatever job you are currently doing, there may well be targets and goals.

What targets are set in your job?

Customer service has become a dominant issue for a number of reasons. These include the following.

Consumer awareness	Consumers are more aware of their increased rights and insurers have had to react accordingly. They also have a much stronger voice with the rise of social media platforms, such as X [formerly Twitter] and Facebook, and are becoming more vocal about perceived poor service. Consumers are more likely to share a bad experience online, providing instant feedback though the likes of Trustpilot, which could have damaging consequences for an insurer's reputation.
Expectation of service	Customers are ever-increasingly expecting value-added services, driven largely by insurers' marketing campaigns. Service can be used to sell products over price, although most consumers will opt for price in the first instance.
Competition	Insurers cannot expect to compete with other insurers if they are not satisfying their existing customers' needs. In addition, there are new disruptors entering the market which, through the application of new technology and techniques, may be able to provide a better customer service experience and have a greater ability to provide the service the consumer expects.

These increasing consumer demands have led to improved customer service and an increase in the skills and professionalism of the claims handlers providing it.

As with any department or firm, a claims department will have a philosophy that will embrace its ***service standards***, i.e. how it intends to deal with the claims presented to it by its customers. In addition, every insurer will have an approach to key claims issues.

The service standards, as documented within the claims philosophy, will usually have a general section setting out the broad approach and covering the following:

- the quality of service aimed for; and
- how valid claims will be handled.

These will then be further developed, covering such issues as:

- the nature of the claims service at each stage of the claims process;
- the speed of the claims service; and
- the economic efficiency of the claims service.

The service standards should balance the need to treat the customer fairly, efficiently and sympathetically with the need to only pay claims that are valid.

While it is good practice to maintain quality service standards, consumers are likely only to measure their experience against their own perception of what good looks like. This perception could come from an experience of a different sector, or even a previous claim with a competitor. Insurers need to be able to adapt to, and ideally stay ahead of, the ever-changing demand of public expectations, rather than simply refer to a published set of standards. The publication of a claims philosophy can, however, act as a strong statement of the service the insurer intends to provide, and creates a degree of accountability should the customer experience not match the expectations created.

Consider this...
What are the benefits of providing good quality customer service?

Good customer service can come in many different shapes and forms. Typically, it incorporates efficient and prompt notification, investigation and settlement of a claim. It is usually considered to involve treating the customer fairly, with empathy and as a fellow human being.

Providing good customer service does not only benefit the customer, the insurer also benefits. The main benefits of quality customer service are that it:

- encourages customer loyalty: it is a lot cheaper to keep customers than it is to gain new ones;
- attracts new customers;
- attracts and keeps high-quality employees through increased job satisfaction;
- marks the company out from its competitors;
- improves a company's profitability;
- increases productivity; and
- improves the working environment.

If a customer's claim is not handled according to their expectations it can lead to severe dissatisfaction. It can lead to protracted disputes which are costly for insurers.

C Parties to a claim

Consider this...
Who or what is a 'third party' in respect of insurance claims? And who are parties one and two?

Before we deal briefly with third party claims negotiation, it will be useful to define who is a 'third party'.

The **first party**	would be the person or company insured by a particular insurance company (i.e. the policyholder)
The **second party**	can be viewed as the insurance company insuring the first party
The **third party**	refers to anyone else involved in a loss event, e.g. in a motor accident a third party could be another vehicle owner, property owner, a passenger or a pedestrian

Handling ***third party claims*** is an extremely important part of the work of a claims department. For instance, a motor policy will include cover for personal injury to, and damage to the property of, third parties. If an insurer is notified of a claim by its insured and they indicate that there is third party property damage or injury, the insurer must start to take the necessary steps for handling these third party claims as soon as possible.

The third party does not, however, have a contractual relationship with the insurer. This has the following consequences:

- The third party must, legally, pursue their claim against the insured, not the insurance company (which will then indemnify its policyholder.
- In practice, the claim is likely to be presented to the insurer by the claimant or their representative
- The third party's expectations of the level of claims service may be greater than those of the insured because they may be hostile (they are, after all, the victim of the insured's negligence), and may see the insurers as the insured's agent.
- The third party may not identify with the insurer, and so may be more prone to exaggerating their claim.
- The amount of pressure a third party can exert on the insurer to respond quickly will usually be less, as the insurer owes no loyalty to the claimant.
- Conversely, a well-handled third party claim could result in that claimant moving their own policy to the insurer at renewal.
- A third party will not be fully compensated in the event of contributory negligence (i.e. when they're partly to blame for what happened).
- A third party will not be liable for any excess or deductible.
- The recovery of legal costs will generally be more common as a third party is more likely to use the services of a solicitor. If the third party is successful in their claim the insurer will usually be obliged to pay their legal fees, unless the size of the claim does not enable recovery of legal costs.

Other issues which arise when managing third party claims are:

- third party claims are liability claims and could be more complex in comparison to other claims; and
- a third party's final option in a dispute is litigation and they may be more willing to issue court proceedings if they are not managed fairly.

While there is no contractual obligation to do so, it is common and good practice for an insurer to manage the needs of a third party to the same standards as are applied to a paying policyholder. This will ensure the claims handling process avoids disputes and delays, and may lead to increased business in the longer term.

D Estimating and reserving

Refer to
Reserving also covered in chapters 5 and 7

Reserving is the process that a company carries out in order to assess the level of funds that are required to meet current and future claims liabilities. It is a key indicator of whether a company is financially solvent.

Claims reserving is required for internal and external reporting purposes and for monitoring financial performance. It is used to assess the:

- overall financial performance of the company, as the claims reserve will affect the net profit and net worth of the company;
- relative profitability of the various classes of business; and
- adequacy of premium rates.

So, how does an insurance company arrive at a reserve figure? In other words, how do insurers estimate the future cost of claims?

Estimating is done on a case-by-case basis. Insurers place an estimate on each individual claim file, usually split into categories to reflect the sections of the policy being claimed against, e.g. accidental damage (AD), third party damage (TPD) and third party injury (TPI). In household claims the estimate may be allocated against the peril claimed against, e.g. escape of water, fire or theft.

In essence, in order to establish the size of reserve that is required:

- a value is placed on each claim; and
- an allowance is then made for direct claims expenses, e.g. the fee charged by a loss adjuster who has been called on to use their expertise in establishing a claim.

Reserves are regularly reviewed to ensure they continue to reflect the likely cost of the claim.

There are various methods used to produce a 'global' claims reserve, i.e. a reserve covering the whole book of business, but these methods fall outside the scope of this syllabus.

It is vital that underwriters, actuaries and claims managers are involved in reserving reviews. This is because the reserving specialist will require their input on the book of business written and details of any unusual characteristics.

The objective of claims reserving is **to estimate the future cost of claims**. The insurance market and the processing mechanism operating within it involve delays, such as the ones between the:

- incident occurring and the notification of that claim to the insurer; and
- notification of a claim and the settlement of that claim by the insurer.

It is because of these delays that an insurance company needs to set up reserves for unsettled or unnotified liabilities.

D1 Outstanding claims reserve

The **outstanding claims reserve** contains all the reserves allocated to each individual claim by its claims handler. It is the aggregation of individual claim reserves, covering the cost of claims that have been incurred and reported to the insurer.

D2 Incurred but not reported (IBNR) reserve

As the name ***incurred but not reported (IBNR)***reserve suggests, the claim has been incurred by the insured but has not yet been reported to the insurer, who consequently knows nothing about it. There is a possibility that the insurer may incur a liability to pay the claim, but as the insurer is not aware of the matter it is impossible to reserve for it individually.

The amount to be reserved to take account of this situation is calculated using various statistical techniques. These are based on past experience of claims, in conjunction with

actuarial modelling, along with a number of other sources of information, e.g. legislation, market knowledge and judicial developments.

D3 Incurred but not enough reported (IBNER) reserve

The ***incurred but not enough reported (IBNER)*** reserve covers shortfalls in provisions for outstanding claims reserves. This could occur, for instance, where amounts reported are understated, or where the insurer has insufficient information on which to decide what would be adequate reserves.

D4 Other reserves

There are a number of other reserves to be considered while on this topic, such as the following.

Equalisation reserves	These are required by law and are designed to smooth fluctuations in loss ratios (i.e. the ratio of premiums to claims) for certain classes of business
Catastrophe reserves	These are set up to cover a large number of related individual losses arising from one event (e.g. hurricane)
Unearned premium reserve and unexpired risk reserve	The unearned premium reserve is that element of the premium for which insurance cover has not yet been provided. For example, if only six months of a policy period has expired at year end, only half the premium has been 'earned'. An unexpired risk reserve is only needed where a loss is foreseen in relation to the unearned premium reserve
Provision for claims handling expenses	To cover the anticipated future costs of settling claims; it includes direct costs (e.g. loss adjusters' fees) and indirect costs (e.g. office expenses)
Re-opened claims reserves	This occurs where the claim is closed but then the underlying circumstances of the claimant deteriorate. This often occurs with personal injury claims, which have to be re-opened later with a suitable reserve

E Fraud

Consider this…
What constitutes insurance fraud?

Insurance fraud can be illustrated by the following examples:

- inventing a loss event that never took place, e.g. a burglary at home;
- exaggerating the number of items stolen during an otherwise honestly reported break-in;
- deliberately creating an insured event, e.g. throwing paint on a carpet at home; and
- exaggerating the effects of an insured event, e.g. claiming compensation for whiplash after an innocuous car accident where no injuries were sustained.

It is difficult to quantify insurance fraud because it can go undetected. However, quantifying it by collecting data on the types and amounts of fraud is becoming increasingly important. This is because identifying and quantifying the effects of fraud is the first step towards eliminating it.

E1 Fraud prevention

Fraud prevention is best undertaken at a strategic level and the Insurance Fraud Bureau (IFB) was established in 2006 to lead the insurance industry's collective fight against Insurance fraud. It acts as a central hub for sharing insurance fraud data and intelligence, using its position at the heart of the industry and access to data to detect and disrupt organised fraud networks.

It uses a wide range of data and intelligence to achieve two primary objectives, to:

1. help insurers identify fraud and avoid the financial consequences; and
2. support police, regulators and other law enforcement agencies in finding fraudsters and bringing them to justice.

The IFB also administers the Insurance Fraud Cheatline, which is run in association with Crimestoppers. This provides the public with a free and confidential tool to report suspected fraud. This can then be investigated, either by the IFB or the police.

Another fraud prevention tool available to insurers is the Insurance Fraud Enforcement Department (IFED) of City of London Police. This is a unique team of police officers and investigators, funded by a partnership with insurers through the ABI and Lloyd's of London. It provides a specialist unit dedicated to tackling insurance fraud, especially high volume and organised criminality, as well as opportunist fraud.

On the Web

www.insurancefraudbureau.org

www.cityoflondon.police.uk/police-forces/city-of-london-police/areas/city-of-london/about-us/about-us/ifed/

Technology is being harnessed in the drive towards ***fraud detection***. This includes the use of pooled claims databases where insurers can share information with a variety of other insurers. With this practice, insurers can identify claimants who put in repeat claims by matching their new claims details against those already held.

These databases include the following:

Insurance Fraud Register	This is an industry-wide register of known insurance fraudsters administered by the IFB on behalf of ABI members. It holds details of proven fraudsters to help prevent future fraud being committed
IFB Insurance Fraud Intelligence Hub (IFiHUB)	An IFB initiative, developing an industry wide counter fraud sharing platform, where intelligence about fraudsters can be shared in real time.
Motor Insurance Anti-Fraud and Theft Register (MIAFTR 2)	This contains details of all total loss and theft claims. Insurers can therefore check whether a total loss or theft of a vehicle is being claimed for more than once
Motor Insurance Database (MID)	This was set up by the insurance industry and contains details of all registered vehicles in the UK and the related insurance details. This assists the police in tackling motor vehicle crime by identifying uninsured drivers
Claims and Underwriting Exchange (CUE)	This database is shared by insurers across the country and contains information on personal lines claims from the previous three years. Subscribing members submit their claims data on individual claimants and check the true claims history of those individuals. Its aim is to eliminate multiple claims on parallel policies held by a single insured. The register covers domestic buildings and contents, motor, and personal injury/illness incidents reported to insurers, which may give rise to a claim. In addition, it is compulsory for claimants' solicitors bringing personal injury claims in the MoJ/Claims Portal to carry out checks against the database via *askCUE*
Art Loss Register	Founded by the insurance industry and the art world in response to increasing art theft, its operation relies on subscriptions from insurers. Its objectives are to: • increase the recovery rate of stolen art and antiques; and • deter theft by making the resale of stolen articles more difficult. The Register is available to the insurance industry, the art trade, law enforcement and customs agencies, collectors and museums

E2 Fraud detection

The claims handler plays a vital part in detecting fraud. Methods of detection vary across the classes of business, but there are many common indicators. Examples of these include:

- claims made soon after a policy has been taken out;
- frequent change of insurer, which gives the impression that the claimant is trying to disperse the information held about them by frequent changes;
- uncharacteristic increase in the level of cover, e.g. a request to add accidental cover halfway through the policy term;

- financial difficulties, which may not be immediately apparent but may come to light. For instance, when bank statements are provided to substantiate a loss of cash claim;
- prevarication by the insured;
- excessive pressure to settle;
- inconsistencies in the story given;
- lack of co-operation (a genuine claimant has nothing to hide and would want their loss to be remedied as soon as possible);
- poor or missing documentation, e.g. a total lack of receipts to substantiate purchase; and
- perfect documentation, which appears to be 'too good to be true' to the experienced claims handler.

Other measures within the insurance industry have also combated fraud, whilst actually being implemented to enhance customer service and cut costs, for example:

- completing claims forms over the telephone: individuals often find it harder to lie directly, as opposed to when merely filling in a form;
- claims settlement by **replacement** rather than **cash**: if a perpetrator claimed for a 'stolen' television to get cash, it would be frustrating for them to receive a replacement, which they would have to sell to get the cash (the fraud would still be successful, but this acts as a deterrent); and
- the use of cognitive behaviour tools to listen for inconsistencies in voice and action during the claims process.

It is most important for insurers to detect and eliminate as much fraudulent activity as they can in order to maintain a profitable account. Most of the larger insurers now employ one or more in-house fraud detection teams. These tend to be staffed by insurance fraud detection experts who are often people with experience in the surveillance or security services and the police.

E3 Consequences of fraud

Consider this...
What are the **consequences** of fraud?

If a fraudulent claim is paid, it will have an impact on all the various parties concerned:

The insurer	The cost of fraud is enormous. According to the Insurance Fraud Bureau, general insurance claims fraud exceeds £2.1bn per year. If individual insurers fail to take action on this, it will have an impact on their bottom line (profit), claims costs will rise, meaning premiums will too, making them less competitive. They may even get a reputation as a 'soft touch', which may lead to genuine insureds avoiding them whilst attracting an ever growing number of fraudulent claims
Policyholders	Genuine policyholders will be affected by the commensurate increase in premiums, not just the fraudsters
Fraudulent claimants	If they get away with it once, the temptation will be there to continue this practice in the future

There have been many cases heard in law over the question of fraud and the consequences for the claimant who is proved to be fraudulent.

The case of ***Konstantinos Agapitos v. Ian Charles Agnew* (2002)** dealt with the issue at some length. The judge decided that not only would a fraudulent claim fail completely, but that if a claimant instituted an authentic claim that was subsequently found to be exaggerated, this must also fail in its entirety. He quoted Lord Hobhouse's statement from the case of ***Manifest Shipping Co. Ltd v. Uni-Polaris Shipping* (2001)** (the '*Star Sea*' case), where he said:

> The fraudulent insured must not be allowed to think: if the fraud is successful, then I will gain; if it is unsuccessful, I will lose nothing.