FINANCIAL SERVICES AUTHORITY

SAINT VINCENT & THE GRENADINES

GUIDANCE NOTE: NO.12

On

Good Practices for Insurance Claims Management

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1. INTRODUCTION

1.1. The conduct of insurance business in St. Vincent & the Grenadines ("the State") is regulated under the Insurance Act, Chapter 306 of the Laws of Saint Vincent and the Grenadines, Revised Edition 2009 ("the Act"). Regulation and supervision of insurance business is undertaken by the Financial Services Authority ("FSA"/ "the Authority"), acting under the authority of the FSA Act, Act No. 33 of 2011.

1.2. Insurance claims management is a fundamental issue for the protection of insurance policyholders/claimants and hence a priority concern for the FSA. Improper claims management can lead to a poor image of the industry and low insurance penetration. Most insurance complaints received by the FSA relate to claims management, suggesting that there is room for improvement in this area of client service.

1.3. Given the nature of insurance business, in many instances, customers have little or no interaction with their insurance company until there is a claim, therefore customer experience is greatly determined by the way an insurer manages these claims. Thus, managing claims to meet or exceed customer expectations is critical both for retaining customers as well as attracting new customers and thus ensuring profitable growth.

1.4. The Board of Directors is ultimately accountable and responsible for the performance and conduct of the insurer in respect of claims management. Delegating authority to board committees or management does not in any way mitigate or dissipate the discharge by the Board of Directors of its duties and responsibilities.

1.5. The Authority envisages that an efficient claims management process will result in improved service delivery to the public, which will in turn create confidence, improve the image of the industry and eventually lead to a deeper penetration level of insurance service.

2. PURPOSE

2.1. It is intended that these guidelines will be used as a reference point for insurers. The objective of the guidelines is to achieve a claims handling culture and service that ensures claims are managed in a consistent yet flexible and fair manner, that is transparent, accurate and timely.

2.2. These guidelines should allow insurance companies to identify areas of weakness so that the necessary changes and improvements can be made to bring about an enhanced claims handling service. These guidelines encourage insurance companies to evaluate their own performance against the criteria set out herein.

2.3. These guidelines aim to enhance efficiency, transparency, disclosure of information to policyholder/claimant during claims processing and increase consumer satisfaction.

2.4. The guidelines identify eight (8) key elements which must be in place in order to comply with international best practice and the features of each element which need to be demonstrated. These elements are Claims Reporting, Receipt of Claims by the Company, Claims Files and Procedures, Fraud Detection and Prevention, Claims Assessment, Claims Processing, Complaints and Dispute Settlement and Supervision of Claims-related Services.

3. SCOPE OF APPLICATION

3.1. These guidelines apply to all insurance companies operating in the State. These guidelines are not intended to be prescriptive but represent the minimum requirements and do not prevent an insurance company from instituting enhanced policies and procedures.

4. CLAIMS NOTIFICATION/ REPORTING

4.1. There can be many sources of claims (e.g., customers, employees, or members of the public). Therefore, good risk management requires a disciplined claim reporting process, which allows for prompt incident reporting, collection and documentation of evidence, investigative response and collaboration with adjusters, where applicable, to facilitate timely and effective claims resolution.

4.2. Upon receipt of claim notification, the insurer shall take the following actions immediately, but not later than seven (7) working days:

i. Acknowledge the notification.
ii. Provide an appropriate claim form and, if specific documents are required when filing a claim, provide a list of these documents.
iii. Provide any additional information/advice that will assist in processing the claim.
iv. Where applicable, contact any other insurer that is involved in the claim within a reasonable time and resolve inter-insurance claim disputes as quickly as possible.
v. Appoint a service provider(s) as necessary.
vi. Where loss notification is received by an insurance intermediary, immediately transmit to the insurer.

4.3. An insurer should ensure that when the policyholder/claimant signs a policy, he/she understands the coverage exclusions and restrictions and when he/she reports a loss, is aware of his/her duties related to claim reporting which include:

i. To try to minimise losses;
ii. To report claims in a timely fashion. The insured has an obligation to notify the insurer of the loss as soon as it occurs or as soon as reasonably possible. It should be emphasized to the insured that prompt reporting of the loss is important for preserving evidence that may be critical in determining admissibility and quantum of the claim;
iii. To authorize the company to handle necessary inspections and assess the extent of the damage prior to any repairs or replacement; and

iv. The need for policyholder/claimant to cooperate in the investigations by providing the company with all facts and information and in particular official documents regarding the loss (accident, loss, etc.).

5. RECEIPT OF CLAIMS BY THE COMPANY

5.1. The insurer, upon receipt of all the documents in clause 4.2 (ii), shall do/determine the following:

5.1.1. Acknowledge receipt of the documents as soon as the claim is received. If a claim is admissible and can be settled immediately without any further assessment, the insurer shall effect the settlement of the claim expeditiously.

5.1.2. If the claim is admissible but further assessment by a service provider is necessary to quantify the loss, the insurer shall promptly appoint a service provider and advise the policyholder/claimant or the intermediary on the action being taken. The insurer shall, upon receipt and review of the assessment report, make an offer to settle the claim.

5.1.3. Where further investigation is necessary to determine admissibility of the loss under the policy, the insurer shall notify the claimant of this requirement, explain and emphasize to the claimant the need to co-operate with the investigators. Upon receipt of the investigation report, the insurer shall, within seven days, make an offer or communicate declinature and the reasons for such.

5.1.4. Subsequently, if it appears that the claim cannot be settled, the company should notify the policyholder/claimant and indicate that he/she will be re-contacted within a reasonable time limit.

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

5.1.6. If after review, the insurer determines that the loss is not covered by the insurance policy, the insurer shall immediately send a notification to the claimant and/or the intermediary explaining the reasons for the declinature.

5.1.7. When the claimant is not the policyholder, it is the responsibility of the third-party claimant's insurer or attorney to inform him/her of his/her rights and duties when relevant.

6. CLAIMS FILES AND PROCEDURES

6.1. Every insurer shall develop and maintain a manual on its claims handling procedures for different classes of insurance business, which shall include all steps from claim intimation to settlement.

6.2. When formulating the manual, an insurer shall put in place clearly defined controls and reporting systems surrounding the claims management process.

6.3. 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 should contain the following documents:

- Claim filing number;
- Policy number;
- Name of the policyholder/claimant;
- 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 adjusters' 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.

6.4. An insurer shall ensure that any method of considering specific factors such as depreciation, discounting or negligence on the part of the victim is clearly outlined in the claim file.

6.5. An insurer shall develop procedures for declining claims, provided that such procedures ensure reasonableness in the decision to decline.

6.6. An insurer shall not decline a claim on the grounds of: -

i. non-disclosure of material facts which a policyholder/claimant will not reasonably be expected to have known.

ii. misrepresentation unless it is fraudulent or negligent misrepresentation of material facts.

iii. breach of warranty or condition where the circumstances of the loss are unconnected with the breach.

iv. late reporting without establishing and considering the reasons for the late notification.

7. FRAUD DETECTION AND PREVENTION

7.1. To curb the growth of fraudulent claims and the rise in premium costs that results from same, every insurer shall take the following steps:

i. Establish compliance programs for combating fraud and money laundering appropriate to their exposure and vulnerabilities.

ii. Establish systems and controls for detecting and identifying fraud appropriate to their exposures and vulnerability.

iii. Discourage fraudulent practices by ensuring that the policyholder/claimant is aware of the consequences of submitting false statements (which in particular could be liable to prosecution) and/or an incomplete statement in the claims filing phase. To this end an insurer may place a notification on its claim forms referring to the consequences of lodging fraudulent claims.

iv. Where legally possible and feasible participate in any existing database where claims suspected to be fraudulent would be reported.

v. Provide the staff of the claims department with adequate training to scrutinize claim documents in order to detect falsehood and possible fraud.

8. CLAIMS ASSESSMENT

8.1. Proper claims assessment requires an insurance company to:

8.1.1. Check the claim requests for adequate information, validation, justification and authenticity.

8.1.2. Ensure that any loss evaluation methods used by the company are reasonable and coherent.

8.1.3. Engage the services of claims adjusters or intermediaries as necessary and to ascertain their competence and qualifications. Additionally, companies should notify the policyholder/claimant whenever they use independent claims adjusters or intermediaries.

8.1.4. Send the policyholder/claimant a copy of the document used to set the amount of compensation, when the damage is assessed through a written estimate made on behalf of the insurer.

8.1.5. Make available to the policyholder/claimant upon request a copy of the assessment report when an assessment of a claim has been carried out.

8.1.6. Retain competent staff with appropriate skills in claims handling.

9. CLAIMS PROCESSING

9.1. Claims processing is the gateway to the customer that will drive improvement in the insurers' customer acquisition, retention, enterprise business intelligence for product development insights and profitability. Therefore, the speed, accuracy and effectiveness

of claims processing is also paramount for controlling costs, managing risks and meeting portfolio underwriting expectations.

9.2. Claims processing involves the following:

9.2.1. Ensuring that a claim procedures manual is in place for internal use and 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.

9.2.2. Following up with the policyholder/claimant or third party for missing documentation and validating that all required claim information has been collected.

9.2.3. Documenting the claim files to be able to address questions that may arise concerning the handling and payment of the claim.

9.2.4. Ensuring that policy coverage provisions of insurance policies are accessible when they are pertinent to a claim.

9.2.5. Keeping policyholders/claimants informed of the progress during the claims process. The insurer should provide information on when payments, repairs or replacements are expected to be made, and, if necessary, explain why additional time is required.

9.2.6. Providing information about the status of the claim to the policyholder/claimant or the intermediary in a timely and fair manner. Additionally, the insurer shall explain to the policyholder/claimant in simple language claim conditions such as depreciation, average, pre-loss value, reinstatement, excess/deductibles, among others.

9.2.7. Notifying the policyholder/claimant when the insurance company is not responsible (by virtue of policy clauses) for meeting all or any part of the claim, and the reasons why.

9.2.8. Notifying the policyholder/claimant when the company decides to utilise outside parties (i.e., loss adjusters, solicitors, surveyors, etc.), and give the reasons for this decision and explain the role that these outside parties will play in processing the claim.

9.2.9. Explaining to policyholders/claimants when a final payment or offer of settlement is made, what the payment or settlement is, and the basis used for the payment/settlement.

9.2.10. Explicitly explain to the policyholder/claimant the policy provisions, conditions, or exclusion on which a claim has been denied. Additionally, if the amount offered is

different from the amount claimed, the insurance company should explain the reason for this to the policyholder/claimant.

9.2.11. Conducting regular internal audits on 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 other's files) could also be carried out.

9.2.12. Ensuring that the insurers' claims department consists of qualified and competent staff. To this end, companies are encouraged to facilitate ongoing internal or external training of their claim staff.

10. COMPLAINTS AND DISPUTE SETTLEMENT

10.1. When a policyholder/claimant files a complaint, the insurer should:

i. Acknowledge receipt of the complaint within five (5) working days;
ii. Provide the complainant with explanations on how their complaint will be handled and the procedures to be followed;
iii. Provide information on internal and external complaints settlement procedures;
iv. Process complaints promptly and fairly;
v. Update the complainant regularly on the progress of the complaint;
vi. Provide a final response in writing in a timely manner.

10.2. Every insurer shall have a documented system and procedure for complaints to be lodged and resolved. This will include a system to receive and deal with all kinds of complaints that are lodged.

10.3. In the case of a dispute, or where a complainant is dissatisfied with the final response sent by the insurer, the insured should be informed by the company of the existence of the following procedures:

10.3.1. He/she can activate an internal appeals process.

10.3.2. Appeal to the dispute settlement procedures outside the company, for example seeking the assistance of the Authority. **<u>However, it is advised that the FSA be the last resort in these disputes.</u>**

10.4. A complaint will be considered disposed of and closed when the complaint has been settled to the mutual satisfaction of both the complainant and insurer.

11. SUPERVISION OF CLAIMS-RELATED SERVICES

11.1. From time-to-time the FSA will conduct on-site examinations of insurance companies and aspects of claims management services will be assessed, especially where problems are suspected. Moreover, when several complaints are received from insured individuals, it is

the duty of the FSA to increase oversight of the insurer's claims management procedures and processes.

11.2. Therefore, in light of the aforementioned, the following elements are taken into account;

i. 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);
ii. Maintenance of sufficient and appropriate information on claims files;
iii. Use of the appropriate type of claim form for the type of insurance;
iv. Proper qualification of the claims department's employees;
v. Valuation of claims payments according to company procedures;
vi. Appropriate tracking of the nature and number of complaints related to the claims management process;
vii. Monitoring of the proportion of claims that result in litigation;
viii. Compliance with procedures for combating fraud and money laundering;
ix. Regular internal audit practices on claims files;
x. Appropriate internal claims procedure manuals;
xi. Proper procedure for coding and statistical reporting of losses;
xii. Performance in terms of the speed of claim settlements (as assessed according to the statistical database implemented by virtue of item 10).

Guidance Note 7 on Complaints Handling for Insurance Entities, issued by the FSA on September 14, 2017, should also be taken into consideration when applying best practices to complaints and disputes settlement.

COMMENCEMENT

This Guidance Note shall come into effect this 19th day of March, 2024.

Issued by:

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