Codes on

Claims Management

FINANCIAL SERVICES AUTHORITY

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1. 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. Hence, in line with the Financial Services Authority's (herein referred to as "the Authority") risk based supervision approach for the insurance industry, the Authority strives to facilitate the successful operation, specifically the claims management of the insurance companies.

Insurance claims range from straightforward motor vehicles claims to complex and lengthy bodily injury claims. Given the wide range in complexity, it is essential that a claim management system is easily configurable.

Therefore, this code is being issued by the Authority and by the powers conferred by section 33 of the Financial Services Authority Act to be observed by all insurance and reinsurance companies in Seychelles (herein referred to as "insurers") licensed under the Insurance Act, 2008 in order to establish best practices to be adhered on claims management.

2. OBJECTIVES

This code seeks to promote greater fairness and transparency between policyholders and insurers. Strong market conduct ethics serve to reduce mistrust that may exist between clients and insurers, and enhanced mutual confidence improves market efficiency.

The Authority aims to enhance quality control and improve the service offered by insurers to the public. This will in turn increase customer satisfaction and create confidence, minimise risk and loss exposure and develop strong operating results.

This code takes into consideration international standards and best practices.

3. DEFINITION

"Authority" means Financial Services Authority established under the Financial Services Act, 2013.

"Licensee" means any person that holds a license from the Authority and shall include the insurers, insurance intermediaries and service providers as licensed by the Authority.

"**Claimant**" means a person who has a right to a settlement arising from a contract of insurance.

"Complaint" means any communication that expresses dissatisfaction about an action or omission of a service and calls for a remedial action.

"Enquiry" means any communication from a customer for the primary purpose of seeking information about a company or services.

"Policyholder" means the person who for the time being is the legal holder of the policy for securing the contract with the insurer.

"**Service Provider"** means any person appointed to provide a service in facilitating a claim process.

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

4. GENERAL REQUIREMENTS

4.1 The insurer shall issue the insurance policies and provide instructions on what a claimant should do when a loss occurs.

4.2 The insurer shall issue the insurance policies in easily understandable language. Policies should spell out what is covered and what is not covered. If necessary, plain language explanation could be an addendum to the legal language.

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

4.4 The insurer shall draw the attention of the policyholder/claimant/beneficiary the following;

4.4.1 To try to minimize losses;

4.4.2 To report claims in a timely manner as provided for in the policy. 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.

4.4.3 The need for policyholders to cooperate in the investigations by providing the company with all facts & information and in particular official documents regarding the loss.

4.4.4 The need to allow the insurer to handle inspection and assessment of damage prior to settlement.

4.4.5 The need to understand that they may be required to surrender their rights to the insurer for recovery after settlement of the claim under the principle of subrogation.

5. CLAIMS NOTIFICATION

5.1 Notification of the claim may be done as per the policy provided that the claimant shall use any fast means of communication to the insurer's designated contact person or department or through the intermediary by;

(i) Direct reporting
(ii) Telephone call
(iii) E-mail
(iv) Fax
(v) Letter
(vi) Use of insurer's website
(vii) Any other form of technology of wide usage.

Provided that where the mode of communication used lacks written evidence, the insurer shall inform the claimant of the need to follow up such communication with a letter and/or completion of the appropriate claim form.

5.2 If the loss notification is received by an intermediary, such notification shall immediately be transmitted to the insurer within three (3) working days from the date of receipt of the completed claim form.

5.3 Upon receipt of claim notification, the insurer shall take the following action immediately but not later than seven (7) working days;

(i) Acknowledge the notification.
(ii) Avail an appropriate claim form and if specific documents are required when filing a claim, the insurer will provide a list of these documents.
(iii) Provide any additional information/advice that will assist in dealing with 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.

6. CLAIMS PROCESSING

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

(i) Policy number;
(ii) Name of policyholder or claimant;
(iii) Information on claimants;
(iv) Description of the loss;
(v) Claim file number;
(vi) Claim form;
(vii) Checklist of all relevant documents;
(viii) Progress report schedule;

(ix) Opening date of the file;
(x) Initial value of the claim reserve and any subsequent changes;
(xi) Reporting date;
(xii) Request for an adjuster or investigator;
(xiii) Date on which the adjuster's report is received;
(xiv) Electronic and/or paper copy of the adjustors' and investigators' reports where applicable;
(xv) Dates and amounts of payments;
(xvi) Date of denial, if applicable;
(xvii) Reasons for denial or reduced settlement;
(xviii) Name of broker or agent, if applicable;
(xix) Documents recording contacts with the policyholder;
(xx) Documented evidence of agreements or settlements;
(xxi) Claims discharge form and/or acceptance form;
(xxii) Date of file closure;
(xxiii) A record of all communications whether formal or informal; and
(xxiv) Any other information pertinent to the claim.

6.2 The insurer upon receipt of all the relevant claim documents shall;

(i) Acknowledge receipt of the documents within seven (7) working days.

(ii) If a claim is admissible and can be settled immediately without any further assessment, the insurer shall effect the settlement of the claim expeditiously.

(iii) 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 claimant or the intermediary on the action being taken. The insurer shall upon receipt of the assessment report make an offer to settle the claim.

(iv) 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 (7) working days make an offer or communicate declinature and the reasons thereof.

(v) An admission of liability shall be construed to mean performance of an act by an insurer that is consistent with the settlement of the claim and shall include but not limited to making of an offer, issue of a discharge voucher, authorizing repair and replacements.

(vi) If in the opinion of the insurer the loss is not covered by the insurance policy, the insurer shall after exhausting their internal mechanisms on declining a claim, immediately send a notification to the claimant and/or the intermediary explaining the policy provisions, conditions or exclusions on which the claim is being denied.

(vii) If the amount offered is different from the amount claimed, the insurer shall explain the reason for this to the claimant.

(viii) Where the insurer is not responsible for any part of the claim, the insurer shall promptly notify the claimant of this fact and explain the reasons.

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

6.3 A claim that is reported late should not be repudiated without establishing reasons for the late notification. Reasonably late can be considered seven days after date of loss or as stated in prescribed in the insurer's insurance policy.

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

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

7. CLAIMS SETTLEMENT

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

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

7.3 After an agreement has been reached between the insurer and the policyholder or claimant on the amount of the claim, the insurer should effect the payment within three (3) working days.

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

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

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

8. CLAIMS MANAGEMENT

8.1 Every insurer shall develop and maintain a manual on their claims handling procedures which shall include all steps from claim intimation to settlement for different classes of insurance business. The manual shall provide expected timeframes in each of the steps.

8.2 Every insurer while formulating the manual in clause 8.1 shall put in place clearly defined control and reporting systems surrounding the claims management process.

8.3 Every insurer shall file with the Authority the manual in clause 8.1 above. Any changes to such a manual shall be notified to the Authority before implementation.

8.4 The insurer shall inform the claimants about their procedures, formalities and common time frames for claims settlement.

8.5 The insurer shall give information about the status of the claim to the claimant or the intermediary in a timely and fair manner.

8.6 The insurer and or intermediary shall explain to the claimant in simple language claim conditions such as depreciation, average, pre-loss value, reinstatement, excess/deductibles among others.

8.7 Where an assessment of a claim has been carried out, a copy of the assessment report shall be made available to the claimant upon request.

8.8 Every insurer upon recovering through subrogation shall promptly refund the excess or deductible to the insured. The insurer shall set the procedures for recoveries in the manual under clause 8.1.

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

8.10 An insurer shall not decline a claim on the grounds of;

(i) Non-disclosure of material facts which a policyholder 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.

8.11 Every insurer shall maintain competent staff with appropriate skills in claims handling. To this end, insurer shall encourage ongoing internal and external training of their claim staff.

8.12 Every insurer shall carry out regular internal audit of all claims lodged with them. Internal audit shall apply to all stages of the claims management process.

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

(v) The aging of outstanding claims
(vi) Claims reported but not yet admitted;
(vii) Claims reported but not yet paid; and
(viii) Adequacy of claims reserving.

9. COMPLAINTS AND DISPUTE RESOLUTION

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

(i) Acknowledgement of receipt of the complaint within an established period of time;

(ii) Details of how the complainants will be kept informed of the status of their complaint;

(iii) Information to complainants on how and when to access the services of the appropriate entity such as the Financial Services Authority and/or the Fair Trading Commission as an alternative dispute resolution mechanism; and

(iv) Establishment of the time period for sending a final response in writing to the complainant.

10. FRAUD DETECTION AND PREVENTION

10.1 Insurers and intermediaries shall have a well-defined fraud monitoring and control policies, approved by their Board of Directors, with procedures for fraud detection, mitigation and reporting.

10.2 Insurers shall have policies and procedures in place for submitting fully investigated suspected fraud to the Seychelles Police with a copy to the Authority. The Compliance Officer appointed by each insurer is responsible for reporting annually to the Authority on the number of fraud matters identified and how each was resolved, the number referred to the Commercial Crime Unit and the outcome of each referral.

10.3 Insurers and intermediaries shall ensure that the organizational structures and systems are designed to facilitate communication on actual or attempted fraud to the board of directors, management members and other concerned staffs.

10.4 Insurers and intermediaries shall provide anti-fraud training to all employees and members of the board of directors whenever necessary.

10.5 Insurers and intermediaries shall maintain fraud register that shall at a minimum contain detailed records of the fraud including:

(i) name and complete address of the suspected fraudster;
(ii) description or type of fraud (embezzlement, cheating, forgery or others);
(iii) causes of the fraud;
(iv) position or profession of the suspected fraudster (director, employee, customer, or other party);
(v) amount of actual or estimated fraud;
(vi) date of occurrence of fraud;

(vii) date of detection of fraud and reason for the delay (if any);
(viii) place and area of operation where the fraud has occurred;
(ix) technique and/or technology used to commit the fraud;
(x) action taken or proposed to be taken to avoid such incidents;
(xi) amount recovered, if any;
(xii) in case of attempted fraud, state reason for the failure of the fraud action; and
(xiii) any other relevant information.

10.6 Insurers and intermediaries shall report any attempted or actual fraud to the Seychelles Police following the company's own investigation and the Authority with a copy within thirty (30) working days from the date of detection of the fraud in the form attached.

10.7 Insurers' Compliance Officers and intermediaries shall submit quarterly progress report on fraud cases outstanding to the Authority within four weeks from the end of the reporting quarter.

10.8 The obligation of the insurers and intermediaries to report fraud to the Seychelles Police and to the Authority shall not exclude the obligation to report the case to the relevant authority under any other law.

10.9 The quarterly report should be provided to the insurers or intermediaries' Board of Director upon filing with the Authority.

11. ENFORCEMENT

The Authority shall enforce compliance to this code by exercising its powers to any person who contravenes this code or take any other measure as prescribed in the relevant law.

12. EFFECTIVE DATE

The effective date of this code is October 01st, 2018.

13. ENQUIRY

Enquiries on any aspect of this code shall be referred to the;

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