Claims Procedure Manual

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BUMACO INSURANCE
COMPANY LIMITED

Insurance Services with Certainty

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1. Introduction

Insurance business is conducted on the principle on the principle of UTMOST GOOD FAITH. The insurer trusts that all the information submitted by the insured at the time of lodging a claim is true to the best knowledge of the person presenting it. The insured also trust that the insurer will fulfill the promise and settle claims which may arise from perils insured against, and this is the real test for any insurance company when a claim arises, and the insured needs most the protection we promised. Must not be frustrated purely by technicalities which do not prejudice our contractual liability.

It is said the best form of advertisement for any insurance company is the prompt and quality services to its customers when a claim arises. Insurance Company must exercise the rule of FIRM BUT FAIR in claim settlements.

Those who have to deal with negotiations and settlement of claims must have sound of knowledge about the scope of policy cover and conditions. They should also be conversant with relevant statutes and common law.

Efficient and tactful handling of claims is very important and prompt action is necessary in investigation, negotiations and settlement of all claims.

2. Notice of Claim

Notice of a claim can be made either by telephone, fax, telex, letter, E-mail or verbally by calling in our offices. This notice is supposed to be made direct to our nearest office within a period stipulated in a particular policy e.g. for motor insurance and business protector notice is supposed to made within 48 hours from the occurrence of the event.

Notice made verbally or by telephone shall be immediately put in writing by the recipient of that notice.

3. The Claim File

The next step after receipt of a notice of a claim is to open a file. The claim file must be open within one hour on the time of notice and must contain all the necessary information e.g. policy number, period of insurance, name of insured, sum insured, type of cover, details of accident or loss etc.

4. The Claims Register.

The next step in a file has been opened is to register the claim in a claims register and allot a number known as **Claim Number**. Registration must be done within one hour from the time of notice.

5. The Claim Form

The claimant irrespective of notifying the claim on time also is required to fill and sign a claim form. This form must be dully filled and signed. The information revealed in a claim form helps to establish if insurance is / was in force at time of the event and if the loss is falling within the scope of cover. Provide provision for outstanding then enter the particulars in the computer.

6. Verification of Cover

On receipt of a claim form verify insurance cover. The purpose of verification of cover is to establish if the loss is covered under the policy. Verification shall center on period of insurance, subject matter of insurance, scope of cover, warranties and endorsements, limit of indemnity and premium payment **if the loss is not covered close the file as no claim and notify insured. Verification of cover must be done within 48 hours from the time a claim is received by the office.**

7. Verification of a loss

If cover has been verified also verify the loss that is establish if an event really happened or not, or if the insured suffered a loss and to what extent. Verification of a loss must be done within 48 hours of the occurrence of the event. In order to verify loss you will need the access to all or some of the following documents:-

i. Motor material damage claims;

Documents required are PF 90, VIR (PF 93) PF 115 copy of registration card, estimates of repairs, drivers license, sketch map of the scene of accident, route permit if applicable identification of the subject matter, income tax declaration (for loss of use claims) and court judgment (if necessary).

ii. Documents required are PF 3, PF 90, PF 115 or court judgment, medical report, 2 claimant photographs (postcard size), Fare ticket (for passengers), Proof of income, age and dependants, Proof of ownership (for lost items), proof of cost incurred (for medical expenses, and transport) X- ray film, a letter stating the amount being claimed.

iii. Motor Fatal claim

Documents required are PF 90, PF 115, Proof of income, proof of dependants, and proof of age, death certificate and letter of administration or probate, claimant photograph (post card size), a letter on the amount being claimed.

iv. Theft Clams:

Documents required are preliminary and final police reports, court judgment, Proof of loss (e.g. books of accounts and invoices) Proof of ownership and PF90 (for money in transit if lost by accident)

v. Fire Claims:

Documents required are fire masters report (fire brigade report) TANESCO engineers report Police report, bill of quantities and proof of loss (e.g. Books of account and invoices).

vi. Personal accident injury claims:

Document required are medical report, X ray film, proof of cost incurred for medicine and proof of accident (event) PF 90 if it was a motor road accident.

vii. Personal accident fatal claim;

Proof of accident (event), death certificate and letter of administration or probate, photograph of the claimant (post card size) PF 90 if it was a motor road accident.

viii. Liability claims:

Documents required are: - Proof of liability, proof occurrence of an event, identity of the injured person or damaged property.

ix. Marine cargo claims (import/ Export)

Documents required are:- Original or copy of shipping invoices, together with shipping specification and / or weight notes, Original Bill of landing and / or other contract of carriage, Survey report or other documentary evidence to show the extent of the loss or damage, loading account and weight notes at final destination, correspondence exchanged with the carriers and other third parties regarding their liability for the loss or damage, A claim debit note indicating the amount being claimed.

x. Inland cargo claims

Documents required are: - Consignment note/ way bill, Delivery note and endorsement made thereon as to damage or shortage, Accident report PF 90 in case of road accident, a claim debit note, Driver and turn boy statement in case of road accident, Final reply from carriers, Supplier invoices or purchase receipts.

xi. Property loss or damage claims (cause other than fire)

Documents required are: - Proof of the occurrence of an event, proof of loss, bill of quantities or estimates of repairs, metrology report and engineers report.

Note: If there is no loss or the loss fall within the excess close the file as no claim.

8. Verification of Documents

The documents furnished by the claimant must be verified if are genuine. Verification must be done within 14 days from the time of receipt if one or more documents are not genuine make a proposal to repudiate a claim.

9. Check Reinsurance arrangements.

After verification of cover and the loss the next step shall be to check if there is a Reinsurance arrangement, if any give notice to reinsurer.

10. Appointment of Surveyors or loss adjusters:

Simple and straight forward losses of small amounts are usually settled on the basis of a claim form and sometimes supported by a survey report submitted by a staff handling claims. However other claims are settled on basic – report submitted by a surveyor or loss adjuster. The surveyor or loss adjuster is required to do the following:-

i. To investigate into the cause of loss;
ii. To ascertain the extent of loss;
iii. To advise the insured on loss minimization measures and protection of salvage.
iv. To advise the insurer on disposal of salvage and
v. To submit detailed report on the above and other aspects relating to the loss. Preliminary report must be submitted within 14 days of date of appointment and final report to be submitted within 2 months of the loss occurrence.

Note: Where the cover is facultatively or 100% reinsured or subject to claims control clause the appointment of loss adjuster shall be done by reinsurers.

11. Negotiation

Not all property losses are paid as a result of an adjustment but some are settled through negotiations. Negotiate with the client if there is no disagreement on insurable interest, policy coverage or amount of loss and negotiate if the issue is negotiable and the client is ready for negotiation.

12. Bodily Injury and fatal claims:

For bodily injury and fatal claims, quantum of damages are arrived at by use of decided case laws of which injuries are similar or related to injuries sustained by the person claiming for damages. Adjustment is made on severity of injuries, inflation, age, income and dependants.

13. Personnel accident and workmen's compensation claims:

Medical report is the bases of assessment of benefits payable for personal accident and workmen's compensation injury claims. Injuries have been divided in four categories that's Permanent Total Disability (PTD), Permanent Partial Disability (PPD), Temporary Total Disability (TTD) and Temporary Partial Disability (TPD). Check in the medical report the injuries sustained then check the benefits payable for such injuries in the policies and check the warranties and endorsement attached to the policy then recommend the benefits payable.

14. Decision Making

Decision on the amount of claim payable is done according to financial powers. Hence approval sheet which summarizes all particulars of the claim and the recommendations to pay, or reject the claim is made.

Decisions for ex-gratia payments, repudiation or rejection of a claim are done only by the Head Office claims committee.

15. Discharge Voucher

If a claim has been approved for payment a discharge voucher is issued immediately to the claimant. It is required to be signed by the insured and witnessed by a magistrate or advocate.

16. Credit Note.

If a discharge voucher has been signed and returned to the office issue immediately a credit note and sign it. The signed credit notes shall be sent to account for issue of cheques.

17. Claims paid register.

If a cheque has been issued the details must be entered in a claims paid register within one hour from the time the cheque is receiving in the office and the cheque should be sent to the original claims handling center for dispatch to the claimant. Claims paid must be accordingly marked in the claims intimation register and for claims with policies involving insurance arrangement payment advise must be communicated to insurers for necessary recovery.

18. **COMESA Yellow cards claims.**

    i. Obtain a completed accident report form and a copy of yellow card from the yellow card holder.
    ii. Proceed with normal and usual investigations of the accident and evaluations of any possible claim.
    iii. Notify the issuing agency of the details of the accident for onward transmission to the insurer concerned.
    iv. Proceed with investigations and negotiations with third parties with a view of a settlement of a claim.
    v. Send of issuing agency full written reports giving details of the nature and extent of material damage, bodily injuries and / or death medical expenses and of proposed settlement of a claim.
    vi. The handling agency is authorized to settle a claim which does not exceed $3000. For claims exceeding $3000 authority must be obtained from the issuing agency before proceeding to payment of claim. For medical expenses claim the handling agency is authorized without prior reference to the issuing agency to settle medical expenses claim irrespective of the settlement of $3000 but not exceeding the minimum of limit of indemnity of $100 per any one person per accident.

Claims handling fees:

The handling agency is entitled to fees to accrue to its own account as follows:

    i. An amount equal to 3% of the settlement amount of each claim subject to minimum of $100 and a maximum of $1000
    ii. A flat amount of 100 $ for any claim.

19. General average claims:

After the announcement in the paper of the General average declaration or on receipt of formal notice from shipping companies the following steps must be carried out.

    i. Open file and attach the formal notice of general average received.
    ii. Call of policies from insured who have cargo on board the vessel who are insured by the corporation.

iii. Await demand notes for expenses incurred either directly by ship owners or through insured parties e.g. cost of salvaging the vessel or rescue operational and repairs, cash deposit paid etc.

iv. After scrutinization of various demands and if some are found to be in order prepare general average guarantee or pay cash deposit to ship owner in respect of various clients insured by the corporation. The guarantee is made through general average forms ask the insured to sign same forms before being countersigned by the corporate officer.

v. Appoint lawyers for protection of interest of cargo owner and underwriters,

vi. Appoint surveyors for determinations of loss/ claims at the final part of discharge,

vii. Await average adjuster's report from adjusters from ship owners or the arbitrators.

viii. Ascertain the amount or contribution by each client.

ix. Compare the owner of contribution and the cash deposit paid to determine whether there are recoveries or additional payments.

x. On receipt of the average adjusters report compare the contributory values of individual insured cargoes with insured value and settle claims using survey report;

xi. Write a letter to ship owners indicating the amount of recovery if any (as per advices from lawyers)

20. Types of Frauds in non life:

Broadly frauds can be classified under two heading, i.e. within insurance industry and outside industry. Under the first category, i.e. within industry, the following types occur as a result of company's staff/ agent involved in:

i. Granting insurance cover without bringing to books the premium there on unless and until claim is made by the owner.

ii. Providing insurance cover after accident to enable owner to profit by claim made.

iii. Allowing in collusion with owner to recover more than what owner is entitled under insurance.

iv. Not disposing off/ accounting salvage or other recoveries which would otherwise reduce the loss amount.

v. Making fictitious claims with forged claim form, claim bill and other supporting documents to benefit for his own account by such claims.

Other category generally applies to claimants under insurance cover which can be considered department wise.

i. Fire: Malicious and deliberate intention to set fire particularly whn market is falling or old items are involved, making exaggerated claim taking advantage of bonafide accident, offering loss salvage value particularly specialized items which are not easily marketable to have benefit to claim and salvage.

ii. Motor: Making different claims with same accident relying on one set of evidence such as photographs, etc., Falsifying repair bill/ suppliers invoice without effecting repairs or purchasing parts. Making claims for accident after is sold without disclosing sale.

iii. Personnel Accident: Preferring claim even though person disabled or dead is different from insured person.

iv. Inland Transit: Utilizing bogus lorry receipt as proof of goods sent and making claims for non- delivery, without goods being actually sent, sending worthless goods in containers without sufficient packing so that a destination, contents are damaged or emptied and claims preferred for total loss, sending used and fragile goods which may not with stand long journey and transshipment resulting in damage on delivery total loss for replacement on insurance cover for exaggerated value.

v. Computer Insurance: Fraud on this insurance is phenomenon of the age we live in. This means wrongful convention of assets under control of computer system by insertion of fraudulent data/ alteration of data etc., changing financial analysis and confidential information by virtue of which insurance claims are made

vi. Maritime frauds fall under the following categories: Scuttling vessels where value of cargo is disproportionately higher than value of ship; vessel nearing end of its useful life is taken out to sea on trading voyage; fraudster seeking out cargo often selecting from developing countries. Buyers' pays for same as soon as soon as valid papers like letter of credit, etc. are produced. On high seas, cargo will be removed to other vessels and sold elsewhere and crew transferred. Thereafter vessel is scuttled. There is no shortage of market for cheap cargo across world. Owners claim for insured value of ship which is generally more than market value and also benefited by sale of stolen goods, Documentary frauds relate to letter of credit and charter party, these documents are

forged and negotiated obtained payment; charterer takes vessel on the time charter collecting freight charges collecting freight charges and then disappears leaving cargo to its own face and in many cases not meeting even wages of crew, etc.