



ClaimCenter Application Guide

RELEASE 8.0.2

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Product Name: Guidewire ClaimCenter

Product Release: 8.0.2

Document Name: ClaimCenter Application Guide

Document Revision: 20-May-2014

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About ClaimCenter Documentation

The following table lists the documents in ClaimCenter documentation.

Document	Purpose
<i>InsuranceSuite Guide</i>	If you are new to Guidewire InsuranceSuite applications, read the <i>InsuranceSuite Guide</i> for information on the architecture of Guidewire InsuranceSuite and application integrations. The intended readers are everyone who works with Guidewire applications.
<i>Application Guide</i>	If you are new to ClaimCenter or want to understand a feature, read the <i>Application Guide</i> . This guide describes features from a business perspective and provides links to other books as needed. The intended readers are everyone who works with ClaimCenter.
<i>Upgrade Guide</i>	Describes how to upgrade ClaimCenter from a previous major version. The intended readers are system administrators and implementation engineers who must merge base application changes into existing ClaimCenter application extensions and integrations.
<i>New and Changed Guide</i>	Describes new features and changes from prior ClaimCenter versions. Intended readers are business users and system administrators who want an overview of new features and changes to features. Consult the "Release Notes Archive" part of this document for changes in prior maintenance releases.
<i>Installation Guide</i>	Describes how to install ClaimCenter. The intended readers are everyone who installs the application for development or for production.
<i>System Administration Guide</i>	Describes how to manage a ClaimCenter system. The intended readers are system administrators responsible for managing security, backups, logging, importing user data, or application monitoring.
<i>Configuration Guide</i>	The primary reference for configuring initial implementation, data model extensions, and user interface (PCF) files. The intended readers are all IT staff and configuration engineers.
<i>Globalization Guide</i>	Describes how to configure ClaimCenter for a global environment. Covers globalization topics such as global locales, languages, date and number formats, names, currencies, addresses, and phone numbers. The intended readers are configuration engineers who work with locales and languages.
<i>Rules Guide</i>	Describes business rule methodology and the rule sets in ClaimCenter Studio. The intended readers are business analysts who define business processes, as well as programmers who write business rules in Gosu.
<i>Contact Management Guide</i>	Describes how to configure Guidewire InsuranceSuite applications to integrate with ContactManager and how to manage client and vendor contacts in a single system of record. The intended readers are ClaimCenter implementation engineers and ContactManager administrators.
<i>Best Practices Guide</i>	A reference of recommended design patterns for data model extensions, user interface, business rules, and Gosu programming. The intended readers are configuration engineers.
<i>Integration Guide</i>	Describes the integration architecture, concepts, and procedures for integrating ClaimCenter with external systems and extending application behavior with custom programming code. The intended readers are system architects and the integration programmers who write web services code or plugin code in Gosu or Java.
<i>Gosu Reference Guide</i>	Describes the Gosu programming language. The intended readers are anyone who uses the Gosu language, including for rules and PCF configuration.
<i>Glossary</i>	Defines industry terminology and technical terms in Guidewire documentation. The intended readers are everyone who works with Guidewire applications.

Conventions in This Document

Text style	Meaning	Examples
<i>italic</i>	Emphasis, special terminology, or a book title.	A <i>destination</i> sends messages to an external system.
bold	Strong emphasis within standard text or table text.	You must define this property.
narrow bold	The name of a user interface element, such as a button name, a menu item name, or a tab name.	Next, click Submit .
<code>monospaced</code>	Literal text that you can type into code, computer output, class names, URLs, code examples, parameter names, string literals, and other objects that might appear in programming code. In code blocks, bold formatting highlights relevant sections to notice or to configure.	Get the field from the <code>Address</code> object.
<code>monospaced italic</code>	Parameter names or other variable placeholder text within URLs or other code snippets.	Use <code>getName(first, last)</code> . <code>http://SERVERNAME/a.html</code> .

Support

For assistance with this software release, contact Guidewire Customer Support:

- At the Guidewire Resource Portal – <http://guidewire.custhelp.com>
- By email – support@guidewire.com
- By phone – +1-650-356-4955

part I

Introduction

Introduction to ClaimCenter

ClaimCenter is a web-based enterprise software application designed to manage the process of reporting, verifying, and making payments on claims against a policy. It manages the claims process from first notice of loss through execution of financial transactions, including the payment and setting of reserves. This insurance claims management system also manages claims information and coordinates the claims process to ensure compliance with corporate policies and claims best practices. ClaimCenter functionality includes:

- **Group-based ownership of claims and claim subobjects** – Enables assignment of objects to users based on the group they are in, as well as user access to an object based on who owns the object.
- **Claim maturity** – A set of rules that automatically manage the claim's maturity level. Particular attention is paid to whether the claim can be paid out or not and whether activities are prevented if the claim is not yet payable.
- **Claim financials** – Enables management of the finances involved in a claim. Financials include setting aside money for expected payments (reserves), issuing payments (checks), tracking recovery opportunities, and requiring approval for financial activity in excess of a given user's authority.
- **Address book integration** – Enables sharing of vendor contact information across claims. If PolicyCenter is installed and integrated, you can also manage client contact information in a central address book database. Guidewire provides an address book application called ContactManager that can be integrated with ClaimCenter. For more information, see “Integrating ContactManager with Guidewire Core Applications” on page 45 in the *Contact Management Guide*.
- **Workspace to manage claims process** – Adjusters and supervisors use a workspace to manage the claims process, whether they are connected to or disconnected from the corporate network. Many routine tasks are automated.
- **Distributed collaboration** – ClaimCenter manages distributed participants such as fraud investigation units, auto repair shops, and claimants.
- **Activity coordination** – Adjusters and supervisors manage activities on open claims being managed by a group of adjusters at any given time. ClaimCenter tracks critical activities and coordinates the distribution of work on a claim across people inside and outside the organization.
- **Worker and claim management** – ClaimCenter ensures that supervisors are aware of claims and activities in their groups in real time.

This topic includes:

- “Claim Management Process” on page 26
- “ClaimCenter Users” on page 27

Claim Management Process

ClaimCenter guides you through these types of activities:

- **First Notice of Loss (FNOL)** – You can enter initial claim information directly into ClaimCenter through the New Claim wizard or enter it into an external system and import that information into ClaimCenter. External systems include call centers or a third-party, outsourced system.
- **Claim Setup** – After you enter claim information into ClaimCenter, the system runs business rules to segment and assign the claim. The business rules also assign initial activities for handling the claim. This initial work-plan of activities establishes initial priorities in conformity with best practices and provides adjusters with a starting point for their work.
- **Claim Management - Investigation and Evaluation** – You can plan, investigate, and evaluate steps in the claim management process. Adjusters can record their investigative notes, collaborate with other adjusters and internal experts, and view high priority or overdue claims.
- **Payment and Recovery** – Use ClaimCenter to track claim reserves, payments, and any salvage or subrogation activities.
- **User Management** – Administrators can create groups and teams of users, and provide them and other users with passwords, permissions, and authority limits.
- **Catastrophe Management** – You can assign catastrophes to claims as well as search and assign those claims to catastrophes after claim creation.
- **Fraud** – ClaimCenter contains several mechanisms that help identify potential fraud.
- **Litigation and Negotiation** – The Plan of Action section of a claim is useful for identifying strategies in negotiating a claim.
- **Property and Vehicle Assessment** – ClaimCenter contains an assessment section that stores and evaluates assessment information in one location.
- **Subrogation** – ClaimCenter handles subrogation in auto and property claims.

ClaimCenter Users

ClaimCenter has several types of users who address the claim's process. The following table lists typical ClaimCenter users and their roles in the base configuration.

Users	Typical activities
Customer Service Representatives (CSRs) or FNOL technicians	<ul style="list-style-type: none">• Create and work on claims, bulk invoices, and new exposures.• Typically collect basic information prior to establishing that coverage exists.
Adjusters	<p>There can be several adjusters and types of adjusters that work on a claim, each with various roles and responsibilities. For example, one can be the claim owner, another can own several exposures or activities, and another adjuster can have the role of <i>subrogation owner</i>. Adjuster activities can include:</p> <ul style="list-style-type: none">• Creating, editing, and closing claims• Working on exposures, activities, and matters• Editing policies• Working on bulk invoices• Transferring checks• Creating evaluations• Generating manual payments• Working on payments, recoveries, and recovery reserves
Managers	<ul style="list-style-type: none">• Members of a group who are responsible for occasionally knowing about or doing work that is assigned to another member of the group.• Can access any object that any member of the group can access.• View summary information on the Team tab about objects assigned to users in a group.• A group can <i>have zero, one, or many managers</i>.
Supervisors	<ul style="list-style-type: none">• Assigned to one or more groups, supervisors are responsible for ensuring that the group's work is completed as efficiently as possible. They must have the <i>supervisor</i> role, which contains the permissions appropriate to doing the work of a supervisor.• Listed as the supervisor for one or more groups.• Access any object that any member of the group can access.• View summary information about objects assigned to users in a group.• Assign Pending Assignment claims. The Pending Assignment link on the left pane in the user interface is visible only to group supervisors.• Attend to escalated activities or transactions that are pending approval.• Can remove flags from a claim.• A group must have one and only one supervisor.
Reinsurance Managers	Manage the reinsurance reportable thresholds and reinsurance processes.
Litigation specialists	Typically, the in-house legal staff that works on legal matters.

Users	Typical activities
Subrogation specialists	<ul style="list-style-type: none">• Review and evaluate complex collision liability claims to identify subrogation potential.• Recover monies paid for damages from responsible parties such as uninsured or underinsured motorists and other carriers.
Salvage specialists	<ul style="list-style-type: none">• Assist insureds in processing their total loss claim, including mailing or collecting all necessary paperwork and issuing any necessary payments.• Issue settlements to lien holders and insureds.• Monitor the sale of salvage, and post proceeds to the claim file.• Coordinate the sale of all property assigned to the carrier as a result of settlement of a physical damage and a total loss claim.• Review all incoming salvage paperwork for accuracy

Claims Overview

To insurance carriers, a *claim* is a collection of all the information related to an accident or loss of some kind. A ClaimCenter claim is analogous to a physical claim file that collects and records in one place all the information relating to the claim. Unlike a physical file, a ClaimCenter claim also records and tracks the progress of all work involved in handling the claim.

This topic briefly introduces you to the features of ClaimCenter.

This topic includes:

- “Claim Contents” on page 30
- “Claim Summary Screens” on page 31
- “Activities” on page 32
- “Workplan Screen” on page 32
- “Loss Details Screens” on page 33
- “Incident Tracking” on page 35
- “Exposures Screen” on page 35
- “Reinsurance Screen” on page 36
- “Parties Involved Screens” on page 36
- “Policy Screen” on page 42
- “Financials Screens” on page 42
- “New Claim Wizard” on page 43
- “Notes Screen” on page 44
- “Documents Screen” on page 44
- “Plan of Action Screens” on page 44
- “Services Screen” on page 45
- “Litigation Menu Link” on page 46
- “History Screen” on page 46
- “FNOL Snapshot Screens” on page 46

- “Calendar Screens” on page 47

Claim Contents

Every claim is a collection of the following screens and sections of screens:

- **Summary** – Lists the most salient information about the claim. See “Claim Summary Screens” on page 31.
- **Workplan** – Shows initial activities and grows to include all activities created for the claim. See “Workplan Screen” on page 32.
- **Loss Details** – A description of the types of losses, including vehicles, properties, injuries, and the causes of the losses. These screens also include claim associations, damage assessments, subrogation, catastrophes, and fraud detection information. See “Loss Details Screens” on page 33.
- **Exposures** – Screens correlating policy coverages with claimants. In a workers’ compensation claim, the exposure screens are specific to this type of claim, like **Medical Details**, **Time Loss**, and so on. See “Exposures Screen” on page 35.
- **Reinsurance** – If there is reinsurance for the policy, these screens show a summary of financial records for reinsurance. See “Reinsurance Screen” on page 36.
- **Parties Involved** – All people, companies, users, vendors, legal venues and so on involved with the claim.
- All information related to the **Policy** associated with the claim. This includes general information such as the policy number, policy type, and insured parties as well as information on associated endorsements and aggregate limits. See “Parties Involved Screens” on page 36.
- **Financials** – An auditable record that includes checks, transactions, reserves, payments, recoveries, and recovery reserves. See “Financials Screens” on page 42.
- **Notes** – All notes entered for the claim. See “Notes Screen” on page 44.
- **Documents** – All documents that have been added to the claim. See “Documents Screen” on page 44.
- **Plan of Action** – Plans for evaluations and negotiations, useful for settling complex claims without resorting to legal action. See “Plan of Action Screens” on page 44.
- **Services** – Includes information on all service requests associated with the claim and communicated to vendors. See “Services Screen” on page 45.
- **Litigation** – A list of legal matters and pending litigation related to the claim. See “Litigation Menu Link” on page 46.
- **History** – A record of all claim events. See “History Screen” on page 46.
- **FNOL Snapshot** – Saved First Notice of Loss (FNOL) data that encapsulates the initial data entered for the claim. See “FNOL Snapshot Screens” on page 46.
- **Calendar** – Current and upcoming events and activities. See “Calendar Screens” on page 47

Clicking the **Claim** tab takes you to the **Summary** screen, accessible from the sidebar by navigating to **Summary** → **Overview**.

Other Aspects of Claims

ClaimCenter uses the following associated features to enable you to create and use claims:

- ClaimCenter tracks its users, how they work together in groups and queues, and how they receive work. This tracking is useful because a claim is seldom handled by only one person. See “Users, Groups, and Regions” on page 437.
- ClaimCenter assigns work by creating owners for claims, exposures, and other parts of a claim. It can use attributes, such as a location, proximity information, and user characteristics, to make these assignments. See “Work Assignment” on page 197.

- The **New Claim** wizard facilitates the collection of all information when a claim is first reported. See “Claim Creation” on page 77.
- ClaimCenter creates descriptions of each event concerned with the claim, and keeps them in separate Incidents. An *incident* can be a general description of the loss, or center around each individual auto, piece of property, or injured individual.
- Claims make use of complex financial features, such as multiple currencies and bulk invoices. See “Multiple Currencies” on page 335 and “Bulk Invoices” on page 353.
- Create, track, and manage requests for claim services to be provided by vendors. See “Services” on page 375.
- Rate and select vendors based on their ratings by using service provider performance reviews. See “Service Provider Performance Reviews” on page 165.
- Use the archiving feature to reduce the size of the active claims database and make it more manageable. See “Archiving” on page 123.
- Work with the security features for contacts and many aspects of claim information. See in “Security: Roles, Permissions, and Access Controls” on page 447.
- Use business rules and workflows to define your own business model. See “Introduction to Business Rules” on page 13 in the *Rules Guide*.
- View statistics for each user, including how many claims and activities have been recently opened and closed. Supervisors can see these statistics for their teams as well. See “Dashboard” on page 411.
- With administrative permissions, find users, edit permissions, set claim metrics, manage catastrophes, and perform other administrative functions. See “Administering ClaimCenter” on page 469.
- Work with users, parties involved in claims, companies and vendors, and legal venues. ClaimCenter can integrate with ContactManager to provide full, centralized contact management for vendors and claim contacts. See the “Administering ClaimCenter” on page 469.

Claim Summary Screens

In the base configuration, the default view of a claim is the **Summary** screen, which you see when you open a claim. You can also navigate in the sidebar to **Summary** → **Overview** to open this screen.

In addition to the **Summary** overview screen, there are **Claim Status** and **Claim Health Metrics** screens that enable you to quickly surmise the condition of the claim. Navigate to **Summary** → **Status** or to **Summary** → **Health Metrics** to open these screens. See “Claim Status Screen” on page 397 and “Claim Health Metrics” on page 392.

The **Summary** overview screen provides common information that applies to all exposures in the claim. Initially, all work to verify policy coverage and the basic facts of the incident is centralized with a single adjuster. Eventually, the work for investigating separate exposures is often divided among specialists, making the information provided on the **Summary** screen useful for seeing who is responsible for which areas. The **Summary** screen shows the facts of the incident and related policy information, including limits that apply across all payments for a single incident.

The claim **Summary** screen has the following sections:

- **Claim Headline** – **Basics**, **Financials**, and **High Risk Indicators** that apply to the claim. See “Claim Headline” on page 32.
- **Loss Details** – A summary of information about the losses reported for the claim, including the loss date, when the loss was reported, the location, and a description of the loss.
- **Services** – A list of current vendor service requests associated with the claim.
- **Exposures** – The type, coverage, claimant, adjuster, status, and financial summary information for each exposure.
- **Parties Involved** – A list of contacts related to the claim and the roles those contacts have for the claim.

- **Planned Activities** – A list of the most urgent claim activities that need to be completed by users working on the claim.
- **Litigation** – A list of all legal matters related to the claim.
- **Associated Claims** – Other claims that have the same insured, claimant, or damaged property or vehicle.
- **Latest Notes** – The notes most recently entered about the claim.

Viewing Details of Summary Screen Sections

In general, to view details of each **Summary** screen section, click the menu link with a similar name in the sidebar menu, on the left side of the screen. The screens for some sections are listed under other menu links. To see Planned Activities, use the **Workplan** menu link. To see Associated Claims, navigate to **Loss Details → Associations**.

For example, the **Workplan** screen shows more detail about each activity than **Planned Activities**, including:

- **External** – Whether the activity is completed by someone employed by the carrier or not.
- **Ext Owner** – The name of the outside, external owner of the activity.
- **Assigned By** – The ClaimCenter user who assigned the work.
- **Assigned To** – The ClaimCenter user who must complete the work.

See also

- “Workplans and Activity Lists” on page 224

Claim Headline

The claim **Summary** screen provides a picture of the most important aspects of a claim’s overall condition. Using a combination of summary text and icons, it provides details that answers questions such as:

- **Basics** – How long has the claim been open? Is this within an acceptable range? What happened?
- **Financials** – What is the total incurred amount of this claim? How much has the carrier paid? Has the deductible for the claim been paid, if applicable?
- **Risk Indicators** – What are the risks associated with this claim? Answers can include if the claim is in litigation or has been flagged.

Additional claim details are also visible such as loss details, exposure statuses, and recent notes entered by claim handlers. The claim headline is one way to monitor the status of the claim and is part of the ClaimCenter Claim Performance Monitoring strategy. See “Claim Performance Monitoring” on page 391.

Activities

Activities are the tasks to be performed in handling a claim. Examples include inspecting a vehicle, reviewing medical information, negotiating with the claimant, and making payments. ClaimCenter tracks all activities. Supervisors use activities to identify problem claims and to assign workloads based on the number of activities of each team member. For example, an adjuster with many overdue or escalated activities might be overworked and need to have activities reassigned to another adjuster. See “Working with Activities” on page 217 for details.

Workplan Screen

The Workplan includes all activities. It does not matter whether they are completed or assigned to a specific user. The Workplan screen provides a view of what remains to be done and a history of what has been done with a date. The entries on this screen are activities identical to those on the adjuster’s activities list, except that they are collected to show all activities specific to a given claim.

Click **Workplan** in the sidebar to view and manage activities. To view or edit the details of an activity, exposure or involved party, select the corresponding subject, which is underlined.

See “Workplans and Activity Lists” on page 224.

Loss Details Screens

The **Loss Details** screen of ClaimCenter displays the information typically gathered during the first call from a claimant. It also contains various sections of standard claim information. To modify the information listed, click **Edit**.

Note: In the workers’ compensation line of business, the **Medical Details** pages contain medical information that is relevant to the claim.

On the **Loss Details** screen, you can work with some of the following features:

- **Assessments** – Select a vehicle or property incident listed on the **Loss Details** screen and then click the **Assessments** card for the item you clicked. See “Assessments” on page 149.
- **Catastrophes** – When you edit the **Loss Details** screen, **Catastrophe** is a field in the **Loss Details** section. To associate the claim with a catastrophe, select one from the **Catastrophe** drop-down menu. See “Catastrophes and Disasters” on page 155.
- **Subrogation** – The **Loss Details** screen is often where you start a subrogation. Click **Edit** and then set the **Fault Rating** field either to **Other party at fault** or to **Insured at fault**. If you set it to the latter, set the **Insured’s Liability %**, which then displays just below, to less than 100%. See “Subrogation” on page 275.

You can also open the following screens under the **Loss Details** menu link in the sidebar:

- **Claim Associations** – Navigate to **Loss Details** → **Associations** to open this screen. See “Claim Associations” on page 33.
- **Special Investigation Details** – Navigate to **Loss Details** → **Special Investigation Details** to open this screen. See “Fraud—Special Investigation Details” on page 34.

Claim Associations

Claims are not always completely independent. One claim can be related to others, and it is often useful to associate such claims with one another. For example:

- **Many claims can result from the same root cause** – For example, after a catastrophe or damage to a roadway occurs, a carrier might receive multiple claims due to the same underlying event.
- **Claims can have the same person as the insured and the claimant** – The same auto incident can affect the insured’s auto and another vehicle or property that is covered by the same insurance company. Both drivers can file first person or third person damage claims, or both.
- **Multiple claims from the same claimant could represent fraud** – An SIU team might want to associate all claims made by the same person as part of their investigation.
- **The same incident can result in multiple claims** – For example, if the carrier insures both a hotel and a restaurant in the hotel, a fire can cause two related claims.
- **The same incident can result in parent and child claims** – For example, an insured can have both an auto and umbrella policy with the same carrier, and can file claims under both policies for the same incident.
- **Litigation can involve related claims** – Associating claims based on the same incident can assist lawyers in looking for different sets of facts.

Open a claim and navigate to **Loss Details** → **Associations** to associate one claim with others. The screen shows a table of claims that are associated with each other. For each claim, it shows:

- **Title** – A unique name that you give to a group of associated claims. For example, if your association is for all claims involving one particular vehicle, you might use the vehicle name.

- **Type** – The kind of association, from the `ClaimAssocType.ttx` typelist. You can edit this typelist in Guidewire Studio to add your own associations. In the base configuration, the typelist provides association typecodes like the following:
 - **General** – A placeholder for your own category of association.
 - **Event-related** – One event, such as catastrophe or multi-car accident, associates all the claims.
 - **Parent/child** – A group of policies associate the claims. The master policy might be an umbrella, and there can be child claims from related auto and injury policies.
 - **Prior claims** – An association of all claims by the same claimant, or concerning the same vehicle.
 - **Reinsurance-related** – Claims related by reinsurance.
- **Description** – A free-form text entry box associated with the association of this claim.
- **Claims** – The list of all claims having the name of that association.
 - **Primary** – Select one claim in each association as the main one. ClaimCenter does not further use this information.

The Associations section provides a button bar with the following buttons:

- **New Association** – Create a new association between claims.
- **Delete** – Remove the checked claims for the association.
- **Find Association** – Search for existing claims by claimant, number, or loss date, or search for an association by name.

Working with Claim Associations

To create a new association with the current claim

- With the claim open, navigate to **Loss Details** → **Associations**, click **New Association**, and then click **Add** to add a claim. Use the search icon in the **Claim** field to locate each claim, and click **Select** in the search results for the claim. Then enter a new or existing **Title**, **Type**, and **Description**, optionally check **Primary** for one of the claims, and then click **Update**.

To delete a claim from an association, but not the entire association

- Navigate to **Claim** → **Loss Details** → **Associations**. Select an association. Then click **Edit**. In the list of claims, select the check box for the claim you want to remove from the association. Click **Remove**, and then click **Update**.

When an association contains just two claims, you cannot delete one because an association must contain at least two claims. If you delete the **Primary** claim, you must mark another claim Primary to enable the delete.

To delete an entire association, not just a file from the association

- Navigate to **Claim** → **Loss Details** → **Associations**. Select the check box for the association you want to remove, and then click **Delete**.

To find an association

- Navigate to **Claim** → **Loss Details** → **Associations** → **Find Association**. On the **Association Search** screen, you can search by association title, claim number, loss date, insured name, or organization name.

Fraud—Special Investigation Details

Fraudulent claims are a continuing problem for all who handle them, and identifying suspicious claims can be difficult. Too often, flagging a suspicious claim is left to ad hoc processes that might be different for each adjuster. ClaimCenter provides a mechanism to help you determine when to further investigate a claim.

With the claim open, navigate to **Loss Details** → **Special Investigation Details** and fill out the questionnaire. See “Claim Fraud” on page 141.

Incident Tracking

ClaimCenter tracks *incidents*, such as issues or accidents, that can result in claims. Some examples include:

- You are in an automobile accident and have filed a claim with your insurance company.
- Your customer slips and falls at your store but has not yet filed a claim. You contact your insurance carrier anyway so that the incident is recorded with them.

For more information, see “Incidents” on page 235.

Exposures Screen

An *exposure*, one of the liability items of a claim, associates a claimant with a particular policy coverage.

Each exposure on a claim relates one coverage to one claimant. Different exposures on a claim always have a different combination of a claimant and coverage. For example, an auto accident claim would typically have an exposure for the owner of each vehicle damaged, for each person injured, and for each owner of damaged personal property.

This association of claimant and coverage is central to the way ClaimCenter organizes and processes claims. ClaimCenter uses exposures as the basic unit of potential liability and tracks financial details by exposure or subsets of exposures—cost types and cost categories.

The **Exposures** screen enables you to **Assign**, **Edit**, and **Close** exposures and create reserves for them.

The following columns can be enabled in the **Exposures** screen:

- **#** – A unique number identifying the exposure in the claim.
- **Type** – The type of exposure, such as Vehicle or Bodily Injury
- **Coverage** – The related coverage type for the exposure, such as Collision, Medical payments, or Liability - Bodily Injury and Property Damage.
- **Claimant** – The name of the claimant for the exposure, not necessarily the same as the claimant for the overall claim.
- **Adjuster** – The adjuster in charge of processing the exposure, not necessarily the same as the adjuster for the overall claim. Individual exposures in a claim can be assigned to different people. While there is always one main adjuster in charge of the whole claim, there can be different people managing individual exposures of the claim.
- **Status** – The status of the exposure, such as Draft, Open or Closed.
- **Remaining Reserves** – The related reserve liability amount allocated for the exposure.
- **Future Payments** – The amount planned to be paid out for the exposure.
- **Paid** – The amount already paid out for the exposure.

The **Exposures** screen also has a button bar that provides the following buttons for processing exposures:

- **Filter** – Show the exposure list by all claimants or by individual claimant.
- **Assign** – Assign ownership of the exposure to someone else.
- **Refresh** – Show the latest list of exposures.
- **Close Exposure** – Mark the selected exposure as closed.
- **Create Reserve** – Create a new reserve for the selected exposure.

Reinsurance Screen

The **Reinsurance** menu link is available if there is reinsurance for the policy associated with the claim.

ClaimCenter provides visibility into reinsurance agreements and financials to users in the Reinsurance Manager role or with **view** permissions. To access the **Reinsurance Financials Summary** screen, open a claim and click **Reinsurance** in the sidebar.

The **Reinsurance Financials Summary** screen helps identify agreements applied to a claim, their ceded reserves, and their reinsurance recoverables. For more information on this screen, see “Working with Reinsurance Agreements and Transactions” on page 430.

Parties Involved Screens

Parties involved are all the people and organizations associated with the claim. Involved parties are divided into two categories, contacts and users. The **Parties Involved** menu link, available in the sidebar when a claim is open, by default opens the **Contacts** screen. You can work with users by clicking the **User** menu link. The two screens are:

- **Contacts** – People, companies, vendors, or legal venues associated with the claim. Contacts do not directly use ClaimCenter. Use this screen to add contacts to the claim, remove them from the claim, and update contact information.
- **User** – Anyone interacting with ClaimCenter is a user. Claim users either have work assignments on the claim or have user roles on the claim. Use this screen to manage the users who work with the claim.

Contacts Screen

The **Contacts** screen lists all the contacts associated with the claim and shows the role each contact has on the claim. With the claim open, you get to this screen by clicking **Parties Involved** in the sidebar. For example, the contacts can include the insured, the claimant, the people involved in an accident, experts, witnesses, and vendors associated with the accident, like an auto repair shop. To associate a contact with a claim, each contact must have at least one role on the claim.

The upper part of this screen is a filtered list of contacts. The lower part provides a detailed view of one selected contact.

The upper part of this screen provides a list of contacts with the following columns:

- **Name** – The name of the contact related to the claim.
- **Roles** – The relationship of the person to the claim, such as claimant or witness, from the **ContactRole.ttx** typelist.
- **Contact Prohibited?** – A Boolean field indicating whether you can communicate with the contact.
- **Phone** – Telephone number of the contact.
- **Address, City, State, ZIP Code** – Address information for the contact.

The upper part of the screen provides the following field and buttons:

- **Filter** – Use this drop-down list to limit contacts shown. Choices include:
 - **Claim** – Covered parties on the claim
 - Contacts related to an exposure of the claim
 - **Primary roles** – Contacts in primary roles like Claimant, Covered Party, Insured, and Main Contact
 - **Secondary roles** – Contacts in secondary roles like Driver
 - **Litigation roles** – Contacts in litigation roles
 - **Vendors** – Contacts providing services for the claim, like auto body repair or doctor
 - **Former roles** – Contacts in roles that no longer exist.

- **New Contact** – Create a new contact. Submenus enable creation of a person, vendor, company, or legal venue.
- **Add Existing Contact** – If ContactManager or another contact management system is integrated with ClaimCenter, you can search the Address Book for a contact to add to the claim. See “Integrating ContactManager with Guidewire Core Applications” on page 45 in the *Contact Management Guide*.
- **Delete** – Remove a contact from the claim, including all its contact roles. You must first select the contact’s check box. This action does not remove a linked contact from ContactManager.

The lower part of the screen shows the details of the currently selected contact in three cards:

- **Basic** – A summary of the most important details.
- **Addresses** – The contact can have multiple ways to be contacted. This card shows them.
- **Related Contacts** – You can add any other contacts and describe the relationship in any way you like. Common uses are the spouse of a witness, the guardian of a minor, and the company representative of a contact that is a company.

The **Basics** card provides the following buttons for managing contacts, the first two of which are also on the **Addresses** and **Related Contacts** cards:

- **Edit** – Edit the contact’s information. This button is also on the **Addresses** and **Related Contacts** cards.
- **Link/Unlink** – Either link the contact to an external contact management system, such as ContactManager, or unlink it—disconnect the contact from that system. This button is also on the **Addresses** and **Related Contacts** cards.

When a contact is not linked, you see the **Link** button and a text message indicating that the contact is not linked. When a contact is linked, you see the **Unlink** button and a text message indicating the status of the contact in the external contact management system.

- Clicking the **Link** button stores the contact in the external system and changes the button to **Unlink**. Linking a contact enables ContactManager to manage the contact data. ContactManager sends updates to ClaimCenter if the data or status of the contact changes. ClaimCenter sends contact changes made in ClaimCenter to ContactManager.
- Clicking the **Unlink** button removes the link, making the contact locally stored, and changes the button to **Link**.
- **Transfer roles from other contacts** – Opens a screen for the current contact in which you can transfer claim roles from other parties on the claim and then remove those contacts from the claim. See “Merging Contact Roles” on page 41.

Users Screen

Users are people who have access to ClaimCenter, such as an employee of your company. A user has access to a specific claim if either of the following is true:

- Some work on the claim has been assigned to the user.
- A user role has been given to the user for this claim.

The **Claim → Parties Involved → Users** screen lists the ClaimCenter users that are related to the claim. For example, one person can be the primary adjuster, and another can be the subrogation owner.

The **Users** screen provides the following information for each user:

- **Name** – The name of the ClaimCenter user related to the claim.
- **Group** – The ClaimCenter business group to which the person belongs.
- **Assignments** – The exposures to which the relationship applies if the relationship does not apply to the entire claim.
- **Roles** – The relationship of the person to the claim, such as adjuster.
- **Phone, Email** – Phone number and email address of the user.

This screen also has a button bar with the following buttons for managing users:

- **Add User** – Add a new user to the claim.
- **Remove User Roles** – Remove the roles from the selected user. You can add new roles for the user in the **User Details** view.

Working with Contacts and Users

Users are people who have access to ClaimCenter. Typically they are employees of your company. In the base configuration, information about users is managed and stored in ClaimCenter and not in a contact management system. It is possible to extend ClaimCenter to integrate with your human resources database, where centralized data about users can be stored.

- You add users to and remove them from claims in a claim's **Parties Involved** → **Users** screen. See “Adding a User to a Claim” on page 40.
- You create, edit, and manage users in **Administration** tab screens. See “Managing Users” on page 473.

You can work with contact information in a claim. If ContactManager or another contact management system is integrated with ClaimCenter, you can search for existing contacts from a claim screen or in the **Address Book**.

You can create, edit, and delete contacts only in claim screens, such as the **Parties Involved** → **Contacts** screen or the **New Claim** wizard

- If you create a new vendor contact or edit a contact that is stored in ContactManager, the changes are automatically sent to ContactManager, and the contact becomes linked. The contact information might be put in pending state in ContactManager, depending on your permissions, as described later.
- If you create a new contact that is not a vendor, such as a person who is a witness, the contact is not automatically linked. You can click the **Link** button after creating the contact to send the contact data to ContactManager.

ClaimCenter generates messages informing you of the contact's link status.

Note: Some messages use the term *Address Book*, which means an external contact management system, like ContactManager, that is integrated with ClaimCenter.

The status of the contact information in ContactManager depends on your contact and tag permissions, and on the type of contact, as follows:

- Changes made to linked, non-vendor contacts are sent to ContactManager and take effect when ContactManager receives them. These changes are never made pending. Non-vendor contacts can include clients and claim contacts that are not vendors, such as witnesses.
- You are logged in as a user with contact and tag permissions, such as `abedit` and `anytagedit`. Vendor contact changes for which you have permission are sent to ContactManager. These changes are applied immediately.
- You are logged in as a user who does not have contact and tag permissions for an operation on a vendor contact. Your contact changes are sent to ContactManager, which puts the changes in Pending state. Pending contact changes must be reviewed in ContactManager by a user who has the appropriate permissions.

Note: Searching from the **Address Book** works only if you have integrated ClaimCenter with ContactManager or another contact management system. See “Integrating ContactManager with Guidewire Core Applications” on page 45 in the *Contact Management Guide*.

This topic includes:

- “Selecting a Contact or User” on page 39
- “Adding an Existing Contact to a Claim” on page 39
- “Creating a New Contact for a Claim” on page 39
- “Modifying a Contact in a Claim” on page 40
- “Adding a User to a Claim” on page 40
- “Removing a Contact or User from a Claim” on page 40

- “Merging Contact Roles” on page 41

Selecting a Contact or User

To select a contact directly from an open claim

- Navigate to Parties Involved → Contacts and then click the contact’s name.

To select a user assigned to a open claim

- Navigate to Parties Involved → Users and then click the user’s name.

Adding an Existing Contact to a Claim

You can add contacts in the **New Claim** wizard during the claim intake process, or you can add them after the claim has been created. To add contacts to an existing claim, use the **Parties Involved** → **Contacts** screen.

Note: If you want to add an existing contact, ClaimCenter must be integrated with ContactManager or another contact management system, and that contact management system must be running. See “Integrating ContactManager with Guidewire Core Applications” on page 45 in the *Contact Management Guide*.

To add an existing contact to an open claim

1. Ensure that ContactManager or another integrated contact management system is running.
2. Navigate to **Parties Involved** → **Contacts**.
3. Click **Add Existing Contact**.

The **Search Address Book** screen opens.

4. Search for the contact.

You can limit your search to include contacts that are pending creation or vendors offering specific services. If you select **Limit to vendors providing services**, the **Services** table is shown. Click **Add** to select specific services to filter by.

5. In the search results, click **Select** for the contact you want to add.
6. An edit screen opens for the contact.
7. On the edit screen, add a claim role for the contact.
 - a. Under **Roles**, click **Add**.
 - b. Click the new **Role** field and choose a role from the drop-down list.

8. Click **Update**.

The contact is added to the list of contacts on the **Contacts** screen.

Creating a New Contact for a Claim

To create a new contact, you can define a contact in the claim. Alternatively, if you have a ContactManager login, you can open ContactManager from ClaimCenter, define the contact, and then add it to the claim.

To define a new contact in the claim

1. With the claim open, navigate to **Parties Involved** → **Contacts**.
2. Click **New Contact** and select the type in drop-down menu.
3. Enter your contact’s information.
4. Under **Roles**, click **Add**, and then click the new **Role** field and choose a role in the claim.

5. Click **Update.**

To define a new contact in ContactManager

1. Click the **Address Book** tab to open the **Search Address Book** screen.

2. Click **Open Contact Manager**.

ContactManager opens. You might have to log in to ContactManager.

Note: You might have to turn off or bypass your browser's popup blocker for this action to succeed.

3. In ContactManager, click the **Actions** button and choose the type of contact you want to create.

4. After you create the contact, return to the claim, and then add the contact on the **Parties Involved → Contacts** screen. See “Adding an Existing Contact to a Claim” on page 39.

Modifying a Contact in a Claim

You can change the information for a contact directly in the claim.

1. With the claim open, navigate to **Parties Involved → Contacts**.

2. Select a contact and click **Edit**.

3. Make your changes and click **Update**.

Where the changes are saved, either only in ClaimCenter or in both ClaimCenter and your contact management system, depends on whether the contact is synchronized with the contact management system.

- If the contact is linked to the Address Book, at first you see a message saying that the contact is out of sync. However, the changes are saved in ContactManager or your contact management system. You might have to refresh your screen to see that the contact is linked with the new information.
- If the contact is not linked to the Address Book, you see a message to that effect. The contact information is saved with the claim in ClaimCenter. If you want to save it in the contact management system, you can click the **Link** button.

Adding a User to a Claim

You do not have the option of creating new users in a claim. You must add existing users from the claim screens.

To add a new user to a claim

1. With a claim open, navigate to **Parties Involved → Users**, and then click **Add User**.

2. Enter a name or partial name and click **Search**.

3. Click **Select** for the user you want to add.

4. Under **Roles**, click **Add** and then click the **Role** field and choose a role for the user in the claim.

5. Click **Update**.

Removing a Contact or User from a Claim

If a contact or user is no longer connected with a claim, you can remove the contact or user from the claim. For example, a contact with the role of nursing supervisor has completed work on medical treatment for a claimant and no longer needs to be contacted.

Removing a contact from a claim deletes only the record that ClaimCenter stores for that contact with this claim. This action does not affect information in the Address Book or in other claims that might use the same contact.

Removing a user from a claim affects only the claim roles that user had on the current claim. It does not change any other information stored for the user, like the user's roles in the company or the groups the user belongs to.

To remove a contact from a claim

1. With the claim open, navigate to **Parties Involved** → **Contacts**.
2. Select the check box for the contact and click **Delete**.

To remove a user from a claim

1. Before removing a user from a claim, if necessary, reassign all the user's work on the claim to another user.
2. With the claim open, navigate to **Parties Involved** → **Users**.
3. Select the check box for the user and click **Remove User Roles**.

Merging Contact Roles

The data on a claim regarding the contacts who are involved and how they are involved can come from different sources at different times, or from different systems. For example, the claim might show two contacts named Mike Smith. The first contact is listed as the insured and driver, and the second contact has the role of lienholder. At first, you might not know if these names are the same person. The lienholder's full name might be *Mike Smith, Senior*, and the insured and driver might be *Mike Smith, Junior*, and they are different people.

If you find that two or more contacts are the same, you can consolidate the claim contact roles into a single contact. This contact will have all the roles of the previous contacts.

Note: Merging contact roles affects the claim roles for contacts in the current claim. Merging roles does not change any other contact data, although it does result in removing one or more contacts from the claim. See “Removing a Contact or User from a Claim” on page 40. Additionally, merging contact roles is not the same as merging contacts. For information on merging contacts, see “Merging Duplicate Contacts” on page 249 in the *Contact Management Guide*.

To transfer roles to a contact

1. With a claim open, navigate to **Parties Involved** → **Contacts**.
2. In the list of contacts, click the contact to which you want to transfer claim roles, the target contact.
This contact is highlighted after you click it and you see the contact's data in the **Basics** card.
3. Click **Transfer roles from other contacts**.
The **Transfer Roles** screen opens. On this screen, you see the target contact, and you can select the contacts who will have their roles transferred.
4. Select the contacts whose roles are to be transferred and click **Select**.
The contacts you selected appear below the **Remove** button.
5. To exclude a contact that you previously selected, click the check box for the contact in this list and click **Remove**.
When you have selected all the contacts whose roles you want to transfer, you can click **Transfer Roles** to continue the operation or **Cancel** to cancel it.
6. Click **Transfer Roles** to transfer the roles to the target contact and delete the contacts whose roles are to be transferred.
ClaimCenter opens a confirmation dialog telling you the roles that will be transferred, the contact that will receive them, and the contacts that will be deleted if you continue.
7. Click **OK** to continue or click **Cancel** to return to the **Transfer Roles** screen.

Policy Screen

ClaimCenter retrieves policy information from an external policy administration system, such as Guidewire PolicyCenter. The exact policy information that you see depends on the type of claim and the application's configuration. Policy data that is imported is considered a *verified* policy. You cannot edit a verified policy itself. If there is additional information in the Policy section that is not part of the verified policy, that information is editable.

If you enter policy information manually into ClaimCenter, the policy is *unverified*. Until you import the policy from the policy system, making the policy verified, there are limitations on what you can do with the claim.

See also

- For a description of how ClaimCenter works with policies, see “Working with Policies in Claims” on page 91.
- For a discussion on how ClaimCenter can integrate with PolicyCenter, see “Policy Administration System Integration” on page 509.

Financials Screens

Financials screens show information on the financial transactions that are related to the claim. The screen can be a read-only view of transactional information imported from an external financial system, or it can be editable information managed in ClaimCenter. To access these screens, with a claim open, click **Financials** in the sidebar.

See also

- For an overview of how ClaimCenter uses financials, see “Claim Financials” on page 287.
- For information on how ClaimCenter handles multiple currencies, “Multiple Currencies” on page 335.
- For information on how to use bulk invoices in ClaimCenter, see “Bulk Invoices” on page 353.
- For information on how ClaimCenter handles deductibles, “Deductible Handling” on page 349.

Summary Screen

The **Financials → Summary** screen shows an overview of reserves, payments, recoveries, and total amount incurred for the claim. You can use the **View** filter to see subtotals grouped by exposure, claimant, coverage, and other criteria.

This screen provides the following data for each summarized item:

- **Open Recovery Reserves** – *Recovery reserves* are estimates of how much money might be recovered from others in settling the claim. Open recovery reserves are calculated by subtracting total recoveries from the total recovery reserves. See “Recovery Reserves” on page 311.
- **Remaining Reserves** – The estimate of the remaining amount that the carrier still has to pay out for the claim. See “Definitions of Reserve Calculations” on page 292.
- **Future Payments** – Amount that is scheduled to be paid at a future date. See “Payments” on page 296.
- **Total Paid** – Amount already paid out for the claim. See “Definitions of Total Incurred Calculations” on page 292.
- **Recoveries** – Amount of money collected to offset the claim payments, such as from salvage or subrogation. See “Recoveries and Recovery Reserves” on page 311.
- **Net Total Incurred** – Amount of money the company currently expects to pay for the claim. See “Definitions of Total Incurred Calculations” on page 292.

Clicking specific values on this screen drills down into more financial details. When multicurrency reserving is enabled, you can view values on this screen using fixed or market exchange rates.

Transactions Screen

The **Financials → Transactions** screen lists all the individual financial transactions for the claim and provides the following data for each transaction:

- **Type** – A filter that controls the type of transactions shown, such as reserves, payments, recoveries, or recovery reserves.
- **Amount** – The amount of money involved in the transaction.
- **Exposure** – The exposure that is associated with the payment.
- **Coverage** – The policy coverage related to the transaction.
- **Cost Type** – The cost type associated with the transaction, such as claim cost, which applies across the entire claim.
- **Cost Category** – The cost category associated with the transaction, such as medical, auto body, baggage, property repair, indemnity, and so on.
- **Status** – The status of the transaction, such as Submitted or Pending Approval.

See also

- “Transactions” on page 288

Checks Screen

This **Financials → Checks** screen lists the checks that have been generated for the claim and includes the following data for each check:

- **Check Number** – The number that identifies the check.
- **Pay To** – The payee, the person or company to whom the check is payable.
- **Gross Amount** – The amount of the check.
- **Issue Date** – The date on which the check was issued.
- **Scheduled Send Date** – The date on which the check was sent or is scheduled to be sent to the payee.
- **Status** – The status of the check, such as Issued or Pending Approval.
- **Bulk Invoice** – The bulk invoice, if any, that the check is part of. See “Bulk Invoice Checks” on page 363.

See also

- “Checks” on page 301

New Claim Wizard

To open new claims, use the **New Claim** wizard. The screens of the wizard model the manner in which a caller describes the loss, by dividing the claim into incidents. The wizard’s normal workflow conforms to the type of claim, but allows for free navigation through its many pages.

Working with the New Claim Wizard

To access the **New Claim** wizard, navigate to **Claim tab → New Claim**.

The topic “Claim Creation” on page 77 describes in detail what information the wizard requests and requires. In brief, the wizard:

- Models the natural flow of collecting First Notice of Loss (FNOL) information.
- Uses logically ordered steps, or pages.
- Has peripherally useful screens, like **Parties Involved** and **Documents**, that are not in the main wizard flow.

- Enables you to jump between steps and non-step pages.
- In its default mode, is optimized for both personal auto and workers' compensation, but can be configured for any line of business.
- Uses incidents to organize Loss Details data by vehicle, property and injury.
- Enables you to pick subflows, such as first-and-final or auto glass, to further optimize the wizard's flow.
- Provides quick navigation and data entry.
- Can be used by all levels of users.

Notes Screen

The **Notes** screen finds and displays notes entered by users as they perform work on the claim. The screen has a search area at the top and shows search results—notes—at the bottom. See “Notes” on page 251.

Documents Screen

ClaimCenter manages claim-associated documents. These documents can be either online documents, created within ClaimCenter, or hard copies. For example, you can write and send the insured a letter to acknowledge the claim. Or the claimant can email you a map of the loss location. You manage all these varieties of documents in ClaimCenter.

Use the Documents feature to:

- Create new documents, involving templates and optional approval activities.
- Store documents, both those you create and those received from other sources.
- Search for documents associated with a claim, and categorize them to simplify the searches.
- Link to external documents.
- Indicate the existence of documents that exist only in hardcopy.
- Remove documents.
- Associate a document with a single claim, exposure, or matter.
- Associate the creation of a document with an activity.
- Create and send a document while performing an activity.
- Create and send a document with rules or in workflows.

For details, see “Document Management” on page 525.

Plan of Action Screens

The **Plan of Action** screens of a claim, **Evaluations** and **Negotiations**, enable you to settle complex claims without resorting to legal action. When you click **Plan of Action** in the sidebar, the **Evaluations** screen opens by default.

- **Evaluations** – Tracks the expected claim liabilities and helps you evaluate a claim's possible, expected, and worst-case cost scenarios. It helps you track both actual claim costs and possible punitive damage costs. Knowing the potential financial exposure helps you to both negotiate a settlement and plan your response to any litigation.
- **Negotiations** – Helps you plan how you will discuss the claim when negotiating a settlement with the claimant or representatives of the claimant.

Evaluations

To open an evaluation

1. With a claim open, navigate to Plan Of Action → Evaluations.
2. Select an Evaluation from the list.

To start a new evaluation

1. With a claim open, navigate to Plan Of Action → Evaluations.
2. Click New Evaluation.

Alternatively, you can:

1. Open a claim.
2. Click Action → New → Evaluation.

Negotiations

To see a negotiation

3. With a claim open, navigate to Plan Of Action → Negotiation.
4. Select a Negotiation from the list.

To start a new negotiation

- Open a claim and then do one of the following:
 - Navigate to Plan Of Action → Negotiations and click New Negotiation.
 - Select Action → New → Negotiation.

Services Screen

The Services screen lists all service requests associated with the claim that have been sent to vendors. To open this screen, with a claim open, click Services in the sidebar. You can select a service in the list to open its detail view.

The screen displays the following data summary for each service:

- **Type** – The service request type, such as Perform Service or Quote. Represented by an icon as described at “Services List” on page 378.
- **Status** – The status of the service, such as Requested, Quoted, or Completed. Represented by an icon as described at “Services List” on page 378.
- **Service #** – Unique number generated by ClaimCenter and assigned to the service request.
- **Ref #** – Number assigned by the vendor.
- **Next Action** – The next step to be taken to complete the service request.
- **Action Owner** – The party responsible for taking the next step, usually the adjuster or the vendor.
- **Relates To** – Specifies if the service request is associated with the entire claim or with a specific incident.
- **Services** – The kind of service requested, such as appraisal or plumbing repair.
- **Vendor** – The contact that will perform the service.
- **Target** – The estimated date for the next action to be completed.
- **Quote** – Price quoted to perform the service.
- **Assigned To** – The user responsible for monitoring the work of the service provider. Typically, this user is an adjuster on the claim.

See also

- “Detail View of a Service” on page 379
- “Services” on page 375

Litigation Menu Link

For claims that involve legal action, the **Legal Matters** screen shows the legal matters that are pertinent to the claim. A *matter* is the set of data organized around a single lawsuit or potential lawsuit. A matter includes information on the attorneys involved, the trial details, and the lawsuit details.

See “Legal Matters” on page 243.

History Screen

The **History** screen provides an audit trail of actions taken on the claim. It records all the events associated with a claim, including the viewing actions, tracking whenever a claim is viewed. See “Claim History” on page 119 for a complete description of this feature.

History tracks the following for each event:

- **Type** – Indicates what happened to the claim, such as being viewed, an exposure being closed, an exposure being reopened, a flagged indicator being set, and so on. *Viewing* events record every user that opens a particular claim. These events are helpful in tracking whether an adjuster has been working on a claim enough or whether non-authorized users have been viewing claims. For a full list of what can be recorded in the history, review the **HistoryType** typelist in the ClaimCenter data dictionary.
- **Related To** – Whether the event occurred on the entire claim or a part of the claim such as an exposure.
- **User** – The user who triggered the event.
- **Time Stamp** – The date and time the event occurred.
- **Description** – A brief description of the event.

The History screen also has a button bar, containing the following buttons for managing history events:

- **Filter** – Show the history list by the type of event.
- **Refresh** – Show the latest list of history events.

See “Claim History” on page 119.

FNOL Snapshot Screens

After a claim is created in the **New Claim** wizard or imported as an FNOL into ClaimCenter from an external system, ClaimCenter preserves a snapshot of the initial claim data. Subsequent changes to the claim in ClaimCenter do not affect this snapshot, which always shows the claim data at the time it was first obtained by ClaimCenter.

Note: The `EnableClaimSnapshot` parameter in the **Snapshot Parameters** section of the `config.xml` file determines whether these snapshots are visible in ClaimCenter. See

The **FNOL Snapshot** menu link opens screens showing specific parts of a claim, Loss Details, Parties Involved, Policy, Notes, Documents and Additional Fields. In the base configuration, when you have a claim open and click **FNOL Snapshot**, the **Loss Details** screen for the snapshot opens. Each of the screens for the snapshot is described previously in this topic for the current claim. The screens are:

- **FNOL Snapshot → Loss Details** – See “Loss Details Screens” on page 33.

- **FNOL Snapshot → Parties Involved**— See “Parties Involved Screens” on page 36.
- **FNOL Snapshot → Policy** – See “Policy Screen” on page 42.
- **FNOL Snapshot → Notes** – See “Notes Screen” on page 44.
- **FNOL Snapshot → Documents** – See “Documents Screen” on page 44.

Calendar Screens

ClaimCenter provides a variety of calendars to help organize activities. The calendars show activities in monthly and weekly views. You can navigate to the **Calendar** menu link from either the **Desktop** tab or the **Claim** tab. Additionally, you can filter the activities and view activities from multiple users if you have supervisor permissions. See “Activity Calendars” on page 228.

part II

ClaimCenter User Interface

Navigating ClaimCenter

This topic describes how to access ClaimCenter and provides instructions on how to navigate the user interface.

This topic includes:

- “Logging in to ClaimCenter” on page 51
- “Setting Preferences” on page 52
- “Viewing Statistics” on page 53
- “Selecting International Settings in ClaimCenter” on page 53
- “Common Areas in the ClaimCenter User Interface” on page 55
- “ClaimCenter Tabs” on page 56
- “Saving Your Work” on page 61

Logging in to ClaimCenter

To log in to ClaimCenter, you need:

- **A web browser** – For example, Firefox, Chrome, or Internet Explorer.
- **The URL (web address) for connecting to ClaimCenter** – You can set up a Favorite link to the URL or a create a shortcut on your computer desktop that starts a web browser with that URL.
- **A user name and password** – You must have one or more roles assigned to your user name by a system administrator. Roles determine the pages you can access and what you can do in ClaimCenter.

1. Launch ClaimCenter by running a web browser and using the appropriate web address, such as:

`http://localhost:8080/cc/ClaimCenter.do`

2. Enter your **User Name** and **Password** on the login page.

If you first click **Keep me logged in** and then log in, you are logged in automatically for the next seven days whenever you navigate to the login page. To support this feature, the application must be hosted by the same application server each time you return to the page. If you log out of ClaimCenter, you will need to log in the next time you navigate to the login page.

When you click **Keep me logged in**, ClaimCenter writes a cookie to your machine. As is the case with all Internet Explorer cookies, writing this cookie can expose a security risk if other people get access to the cookie. For example, someone could copy the cookie to another machine and then be able to log in without entering a user name or password. If this security issue is a concern, you can remove this field from the login page in your ClaimCenter implementation.

When you log in, ClaimCenter displays your startup view, or landing page.

Notes: Because ClaimCenter generates pages dynamically:

- You cannot create **Favorites** to pages other than the login page,
- The **Back** button of the browser is not supported.

In the default configuration, ClaimCenter initially opens the **Activities** page on the **Desktop** tab. This page lists all open activities that have been assigned to you.

Setting Preferences

You can change your preferences, which include your password, startup view, regional formats, default country and phone region and entries in the recent claims list.

To change your password

1. If necessary, click the **Desktop** tab.
2. Select the **Actions** menu in the left pane and click **Preferences**.
The **Preferences** worksheet appears below the main work area.
3. Enter your **Old Password**.
4. Enter the **New Password**.
5. Enter the new password again in the **Confirm New Password** field.
6. Click **Update**.

To change your startup view

1. If necessary, click the **Desktop** tab.
2. Select the **Actions** menu in the left pane and click **Preferences**.
The **Preferences** worksheet appears below the main work area.
3. In the **Preferences** worksheet, select a different **Startup View**.
4. In the base configuration, **Entries in recent claims list** is empty, but you can optionally enter a number. If you leave this field empty, the number of claims shown in the list of recent claims is 10.
5. Click **Update**.

In the base configuration, ClaimCenter opens with the **Activities** page on the **Desktop** tab. This page lists all open activities that have been assigned to you. You can optionally change your default view and the number of recent entries in the claims list. For example, if you are a supervisor you might prefer to see the **Team** page first.

Note: You can also change your vacation status. See “Vacation Status” on page 265.

To change the regional format

1. If necessary, click the **Desktop** tab.
2. Select the **Actions** menu in the left pane and click **Preferences**.
The **Preferences** worksheet appears below the main work area.

3. Select a format from the **Regional Formats** dropdown.

4. Click **Update**.

To change the default country

1. If necessary, click the **Desktop** tab.

2. Select the **Actions** menu in the left pane and click **Preferences**.

The Preferences worksheet appears below the main work area.

3. Select a **Default Country**.

4. Click **Update**.

To change the default phone region

1. If necessary, click the **Desktop** tab.

2. Select the **Actions** menu in the left pane and click **Preferences**.

The Preferences worksheet appears below the main work area.

3. Select a **Default Phone Region**.

4. Click **Update**.

See also

- “**Preferences**” on page 470

Viewing Statistics

You can always see the status of your activities and claims by navigating to **Desktop** → **Actions** and selecting **Statistics**.

Selecting International Settings in ClaimCenter

In Guidewire ClaimCenter, each user can set the following:

- The language that ClaimCenter uses to display labels and drop-down menu choices
- The regional formats that ClaimCenter uses to enter and display dates, times, numbers, monetary amounts, and names.

You set your personal preferences for display language and for regional formats by using the Options  menu at the top, right-hand side of the ClaimCenter screen. On that menu, click **International**, and then select one of the following:

- **Language**
- **Regional Formats**

To take advantage of international settings in the application, you must configure ClaimCenter with more than one region.

- ClaimCenter hides the **Language** submenu if only one language is installed.
- ClaimCenter hides the **Regional Formats** submenu if only one region is configured.
- ClaimCenter hides the **International** menu option entirely if a single language is installed and ClaimCenter is configured for a single region.

ClaimCenter indicates the current selections for **Language** and **Regional Formats** by placing a check mark to the left of each selected option.

Options for Language

In the base configuration, Guidewire has a single display language, English. To view another language in ClaimCenter, you must install a language pack and configure ClaimCenter for that language. If your installation has more than one language, you can select among them from the **Language** submenu. The **LanguageType** typelist defines the set of language choices that the menu displays.

If you do not select a display language from the **Language** submenu, ClaimCenter uses the default language. The configuration parameter **DefaultApplicationLanguage** specifies the default language. In the base configuration, the default language is **en_US**, U.S. English.

Options for Regional Formats

If your installation contains more than one configured region, you can select a regional format for that locale from the **Regional Formats** submenu. At the time you configure a region, you define regional formats for it.

Regional formats specify the visual layout of the following kinds of data:

- Date
- Time
- Number
- Monetary amounts
- Names of people and companies

The **LocaleType** typelist defines the names of regional formats that users can select from the **Regional Formats** menu. The base configuration defines the following locale types:

- | | |
|-----------------------|---------------------------|
| • Australia (English) | • Germany (German) |
| • Canada (English) | • Great Britain (English) |
| • Canada (French) | • Japan (Japanese) |
| • France (French) | • United States (English) |

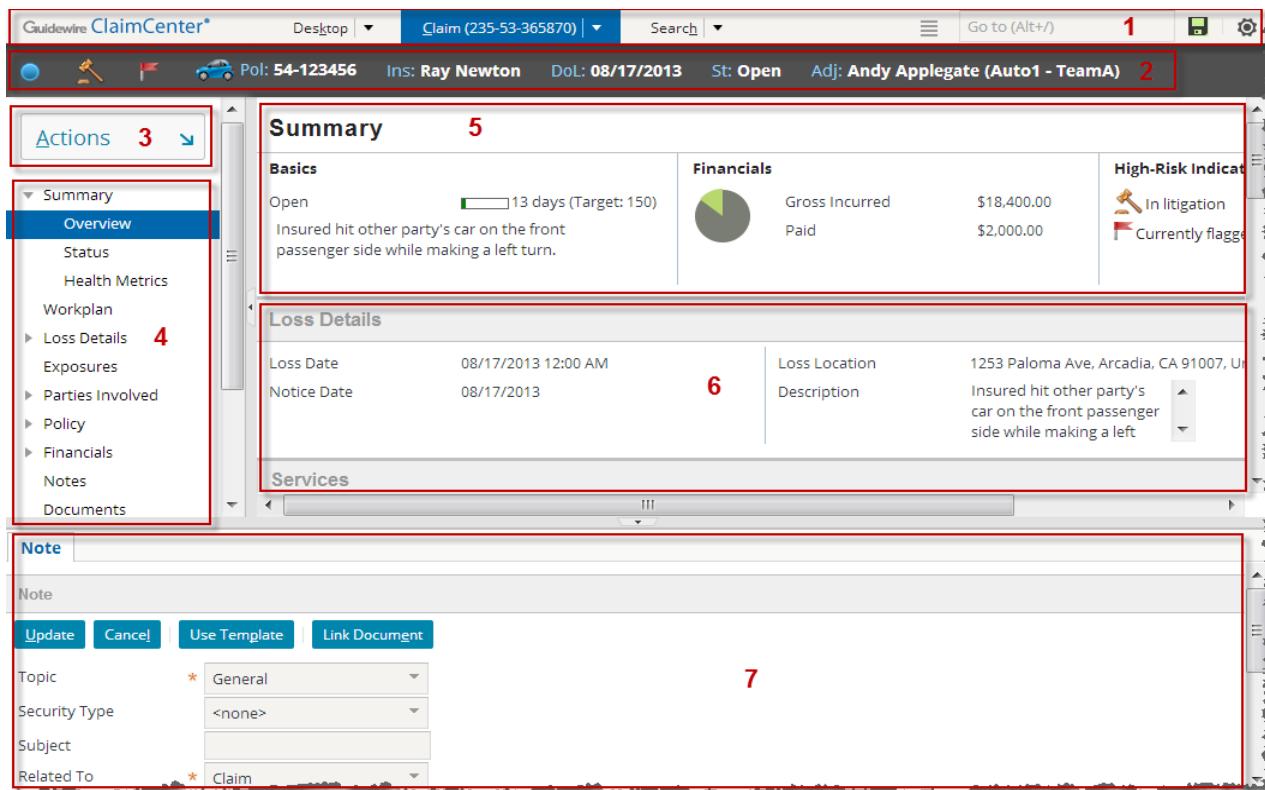
Unless you select a regional format from the **Regional Formats** menu, ClaimCenter uses the regional formats of the default region. The configuration parameter **DefaultApplicationLocale** specifies the default region. In the base configuration, the default region is **en_US**, United States (English). If you select your preference for region from the **Regional Formats** menu, you can later use the default region again only by selecting it from the **Regional Formats** menu.

See also

- “Understanding Globalization” on page 11 in the *Globalization Guide*
- “About Display Languages” on page 21 in the *Globalization Guide*
- “Working with Regional Formats” on page 67 in the *Globalization Guide*

Common Areas in the ClaimCenter User Interface

This section describes some of the common areas in a claim's user interface.



The ClaimCenter main user interface contains the following areas:

Area	Description
1	<p>The Tab Bar contains:</p> <ul style="list-style-type: none"> Tabs – The number of tabs depends on the user's permissions. For example, a supervisor sees the Team tab. If you are a colleague's backup, you see the Vacation tab. If ClaimCenter is integrated with reporting, you see Reports. QuickJump box – The QuickJump text box that displays Go to (Alt-J) is a fast way for you to navigate in ClaimCenter or search for information in specific categories. This feature checks permissions and blocks unpermitted jumps. Type the name of a command and press Enter to jump to that location in the application. Guidewire provides you with a number of predefined commands. See "QuickJump" on page 71. Unsaved Work menu – You can access your unsaved work from the Unsaved Work menu in the Tab bar. This menu is activated when you have work in a ClaimCenter screen that you have not saved. See "Saving Your Work" on page 61. Options menu – This menu contains global links including International, Help, About, Preferences, and Log Out.
2	<p>The Info Bar contains relevant information that pertains to your immediate task as seen in the main screen. Using a combination of icons and text, you can quickly see where you are and what you are looking at in the screen below. In this example, the following items are included in the Info Bar</p> <ul style="list-style-type: none"> The blue circular button means the claim is open and/or has exposures that are open. The hammer indicates that the claim has a matter. The red flag indicates that there is a condition associated with it. For information about flags, see "Flags" on page 398. The car icon indicates that this is a personal auto claim. Ray Newton is the name of the insured party. 8/17/2013 is the date of the loss. The status of the claim is Open. The adjuster is Andy Applegate, and he belongs to the Auto1-Team A group.
3	<p>The Actions menu displays choices based on the page you are on. For example, if you navigate to Desktop → Actions, you can select only Statistics, Preferences, and Vacation Status. However, if you are on the Summary page of a claim, the Actions menu offers many more options that relate to the claim.</p>
4	<p>The Sidebar provides menu links. Use it to navigate to different pages. The items in the Sidebar are contextual and can change depending on the claim object.</p>
5	<p>This section shows the title of the current page, in this case, the claim Summary. The Claim Headline below shows basic and financial information that provides a quick view of the state of the claim. If there are any issues pertaining to the claim, ClaimCenter shows the high risk indicator icons. See "Claim Summary" on page 396 for details.</p>
6	<p>The Screen Area displays most of the business information. This is where you interact with ClaimCenter.</p>
7	<p>The Workspace can display additional information while keeping the Screen Area visible, such as menus for entering a note or adding a new document.</p>

ClaimCenter Tabs

In ClaimCenter, tabs in the **Tab Bar** at the top of the screen group logical functions.

To work with a tab:

- Click the tab to see its default page. You can then choose one of the pages grouped by the tab from the Sidebar menu on the left. For example, in the base configuration, clicking the **Desktop** tab opens the **Activities** page.
- Tabs can also contain menus with shortcuts to pages on that tab. To see a menu, click the down arrow next to the tab name and select a menu item from the drop-down menu. For example, click the down arrow on the **Desktop** tab and then click **Calendar** → **My Calendar** to open your **Calendar** page.

This topic describes each ClaimCenter tab in the following topics:

- “Desktop Tab” on page 57
- “Claim Tab” on page 57
- “Search Tab” on page 58
- “Address Book Tab” on page 60
- “Dashboard Tab” on page 60
- “Team Tab” on page 61
- “Administration Tab” on page 61
- “Vacation Tab” on page 61

Note: The visibility of tabs is based on user permissions. For example, only a user who is a manager or supervisor can see the Team tab.

Desktop Tab

The Desktop tab organizes your activities, claims, exposures, pending assignments, and other items. In the left Sidebar or from the Desktop drop-down menu, the Desktop tab provides links to the following pages:

- **Activities** – Shows all activities assigned to you. For more information, see “Viewing Activities” on page 223.
- **Claims** – Shows the claims that you have been assigned. By default, the list shows all your open claims. You can use a drop-down menu to filter the list and show subsets, like claims assigned to you this week, flagged claims, or open related claims. See also “Viewing Your Assignments” on page 198.
- **Exposures** – Shows a list of exposures that you own. By default, the list shows all your open exposures. You can use a drop-down menu to filter the list and show subsets, like exposures assigned to you this week or exposures closed in the last 90 days.
- **Pending Assignments** – Visible only to supervisors, this page lists assignments that the supervisor needs to assign manually. For more information, see:
 - “Manual Assignment” on page 200
 - “Global and Default Rule Sets” on page 199
- **Queues** – Shows activities that have been queued for selection by members of your group. Use this page to select an assignment or assign it to someone else if you have permission to do that. For more information, see:
 - “Assigning Activities” on page 220
 - “Queues” on page 204
- **Calendar** – You can see the activities in a calendar format for either yourself or your supervisor. For more information, see “Activity Calendars” on page 228.
- **Bulk Invoices** – Shows bulk invoices that you can view and edit and enables you to create new ones or further process a existing bulk invoice. For more information, see:
 - “Bulk Invoices” on page 353
 - “Using the Bulk Invoice Screens” on page 355

Claim Tab

Use this tab to open a new claim, to search for existing claims by claim number, or to see a claim you already have open. Clicking to open a claim shows the claim’s **Summary** page. When you click the tab, it opens the last claim you were working with. If you were not working with a claim, clicking the tab opens a page that lets you choose whether to start a new claim or search for an existing claim.

Clicking the arrow for the Claim tab shows a drop-down menu with the selections **New Claim**, **Claim #** (search by number), and any claims you have open for edit.

See also

- “Claim Summary Screens” on page 31

Search Tab

You can use the **Search** tab to search for claims, activities, checks, recoveries, and bulk invoices.

Some fields on search pages are text fields. When you enter text into one of these fields, ClaimCenter searches for a match that starts with that text. For example, if you enter Ray in the **First Name** field, the search returns all first names that start with Ray. These names would include Ray and Raymond. However, you must enter an exact match in the **Claim Number** and **Policy Number** fields.

During a search, ClaimCenter uses only the fields in the form that have data. For example, if you search for a **Claim** and enter a **Last Name** but not a **Claim Number**, ClaimCenter omits **Claim Number** from the search.

If ClaimCenter shows a search page divided into two columns, you are required to enter at least one search criterion from the left side. The secondary search criteria, in the **Optional parameters** section, are optional.

Note: You can configure the optional parameters section, but not the primary search criteria, the fields on the left side. This limitation on configuration is for performance reasons.

This topic includes:

- “Claim Search” on page 58
- “Activity Search” on page 58
- “Check Search” on page 59
- “Recovery Search” on page 59
- “Bulk Invoice Search” on page 59

Claim Search

You can search for claims by using simple or advanced search parameters. You can also find claims using claim contacts.

Simple Search

Simple searches include searching by claim or policy number, type of person, by name, or tax ID. Type of person can include claimant, insured, any party involved, or additional insured.

Advanced Search

The advanced search has additional parameters that might be useful in finding your claim. For example, you can search by jurisdiction state, assigned group, loss dates, or flagged or high risk indicators.

Search by Contact

The **Search by Contact** option provides free-text search for claim contacts, which can make searching large databases quicker. Free-text search provides exact and inexact matching and is configurable.

See “Search by Contact” on page 64.

Activity Search

Your search for activities can include the following criteria:

- Claim number
- Assigned group or user
- Creator of the activity
- External owner of the activity
- Status
- Priority

- Overdue or late
- Pending assignment
- Description
- Dates
- By subject, derived from activity patterns

Check Search

Your search for checks can include the following criteria:

- Claim number
- Group or user that approved the check
- Creator of the check
- Check number
- Invoice number
- Payee information
- Check total
- Status
- Payee
- Dates

If multicurrency is enabled, you can search for check totals that are based only on transaction currency. This criterion limits the search to checks in the selected currency. If you specify a currency but no amount range, the search returns results with that selected currency, regardless of amount.

Recovery Search

Your search for specific recoveries can include the following criteria:

- Claim number
- Created by
- Payee information
- Amount
- Status
- Cost type, such as claim cost or expense - A&O
- Recovery category, such as salvage or deductible
- Dates

If multicurrency is enabled, you can search for recovery amounts in a transaction currency. The currency field refers to the transaction currency. If you specify a currency but no amount range, the search returns results with that selected currency, regardless of amount.

Bulk Invoice Search

The **Search Bulk Invoices** page available from the ClaimCenter **Search** tab includes the following criteria:

- Claim number
- Invoice number
- Payee information
- Check number
- Invoice approved total range

- Pay to
- Dates

If your ClaimCenter installation includes multicurrency, you can search for bulk invoices in the invoice approved total currency. The currency field refers to the transaction currency. If you specify a currency but no amount range, the search looks for bulk invoices with that selected currency but does not search on amount.

The **Desktop** view also provides a **Bulk Invoice** link. However, ClaimCenter uses the **Desktop** view for bulk invoices on which you are currently working or that ClaimCenter is processing.

Address Book Tab

You can use the **Address Book** tab to search for contacts, such as vendors, to help you with a claim. Searching for contacts works only if you have integrated ClaimCenter with a contact management system, like ContactManager.

Dashboard Tab

You can see the **Dashboard** tab if you are a manager or supervisor. This tab provides a high-level summary of ClaimCenter data. You can use it to gain an overview of claims and related financial information during a standard time period. This time period is specified using the `DashboardWindowPeriod` field in the `config.xml` file.

The information shown on the Dashboard includes the number of open claims, recent claim activity, current financial data, and summary financial data. You can view Dashboard data for your team as a whole, or you can drill down to view individual groups. When you view Dashboard statistics at the organization level, data is summarized by business group, line of business, loss type, and coverage.

In particular, the Dashboard shows you the following reports:

- **Open Claim Counts** – Information on open claims, organized by group. There is data on the number of exposures open, number of handlers, average pending, number of claims flagged and litigated, and the number in excess of the total incurred limit. You can see this limit at the bottom of the report.
- **Period Activity** – Number of claims and exposures that are new, closed, or new incident only, and matters that are new in the current period. Additionally, there is data on the average number of days taken to close a claim and the number of claims that have been reopened.
- **Open Claim Financials** – A financial summary of all currently open claims, organized by group.
- **Period Financials** – A financial summary of payments and recoveries in the specified time period, as well as payments made on claims that were closed in the same period. Payments on closed claims can date back to before the specified time period when the associated claims are recently closed.

These reports are generated by the Dashboard Statistics batch process. You can configure ClaimCenter to provide additional Dashboard reports.

Dashboard Permissions

A user in the role of manager or supervisor has the permissions needed to view the contents of this tab. Permissions that affect viewing the Dashboard are:

- **View Dashboard claim activity** – Permission to view the Dashboard claim activity page, code `edbclaimact`.
- **View Dashboard claim counts** – Permission to view the Dashboard claim counts page, code `edbclaimcounts`.
- **View Dashboard current financials** – Permission to view the Dashboard current financials page, code `edbcurrfin`.
- **View Dashboard period financials** – Permission to view the Dashboard period financials page, code `edbpdfin`.

See also

- “`DashboardWindowPeriod`” on page 81 in the *Configuration Guide*
- “`Dashboard Statistics`” on page 134 in the *System Administration Guide*

Team Tab

The **Team** tab, available if you are a manager or supervisor, opens a visual management tool that helps you manage your groups. This tool displays the number of claims, exposures, matters, and activities grouped by whether items are open, closed, flagged, new, or completed.

For more information, see “Team Management” on page 403.

Administration Tab

With administrator privileges, you have access to the **Administration** tab. You can also see this tab if you are a Catastrophe Administrator or a Reinsurance Manager, but for those roles your choices are limited to those two functions. With full administrator privileges, you can view and maintain many business elements that define how ClaimCenter is used. You can define your organization’s group structure and manage the users that belong to those groups. You can also specify permissions and roles, such as adjuster, manager, supervisor, and so on, to manage user access to certain ClaimCenter actions.

For more information, see “Administration Tab” on page 470.

Vacation Tab

This tab enables you to view work assigned to you as a backup by another user currently on vacation. It is not available if there is no vacation work assigned to you. If work is assigned to you, you can select any activities, claims, or exposures to work on.

For more information, see “Vacation Status” on page 265.

Saving Your Work

ClaimCenter includes some safeguards to protect updates that have not been saved. It automatically saves your work in wizards to the database. ClaimCenter also saves your work when you are in the **Claim** or **Administration** tabs, but not to the database. If you leave a page in one of those tabs with unsaved changes and navigate to another section of ClaimCenter, the server keeps your information in memory. You can retrieve your work from memory by using the **Unused Work** menu, which returns you to the page that has your unsaved data. You can then finish your work and save it. This feature is useful if you must navigate away from a page but need to return to it later. After you complete and save your work, ClaimCenter removes that item from the **Unused Work** menu.

If you attempt to log out without saving, ClaimCenter alerts you that your unsaved work will be lost if you continue. Autosaving is the mechanism ClaimCenter uses to save work that can be retrieved by using the **Unused Work** menu.



chapter 4

Claim Search

ClaimCenter provides three types of searches for claims:

- Simple Search
- Advanced Search
- Search by Contact

Simple and advanced searches access the ClaimCenter database to find claims. Search by contact uses a searchable index and is a free-text search that includes both exact and inexact matching. Inexact matching returns results that partially match, are synonyms, and sound like the terms in the search criteria.

This topic includes:

- “Simple Search” on page 63
- “Advanced Search” on page 64
- “Search by Contact” on page 64
- “Search by Contact User Interface” on page 65
- “Working with Free-Text Search” on page 68

Additionally, you can also search for activities, checks, recoveries, and bulk invoices. See “Search Tab” on page 58.

Simple Search

In ClaimCenter, **Simple Search** enables you to search for a claim using a group of text field entries. You can access the simple search from **Search → Claims**.

Enter one of the following to search for a claim:

- Claim Number
- Policy Number
- First Name
- Last Name
- Organization Name
- Tax ID

You must enter an exact match in the **Claim #** and **Policy #** fields. During a search, ClaimCenter uses only those fields in the form in which data exists. For example, if you enter a **Last Name** but not a **Claim #**, ClaimCenter omits **Claim #** from the search.

The search results return claims with links to view details.

Advanced Search

The advanced search screen is similar to the simple search with additional parameters that might be useful in finding your claim. For example, you can search by jurisdiction, assigned group, loss dates, and flagged or high risk indicators.

Some fields on the simple and advanced search screens are text fields. If you enter text into one of these fields, ClaimCenter searches for a match that starts with that text. For example, if you enter *Jones* into the last name field, the search returns all last names that start with *Jones*. The search results include: *Jones*, *Jonesburg*, or *Jones-Smith*. It does not find *McJones*.

If multicurrency is enabled, you can use advanced search to search for the currency, type, and amounts. The search returns claims in that currency. Note that ClaimCenter searches for claim currencies. For more information, see “Multiple Currencies” on page 335.

Search by Contact

In ClaimCenter, the **Search by Contact** option provides faster, free-text search for claims than database search, especially against very large databases. The search is faster, because it searches through text-based representations of selected data. ClaimCenter uses a custom integration with the Apache Solr search engine, the Guidewire Solr Extension, to generate a full-text search index. You can choose to enable or disable this type of search. For more information on enabling and configuring free-text search, see “Free-text Search Configuration” on page 360 in the *Configuration Guide*.

In the base configuration, **Search by Contact** is disabled. If you choose to enable **Search by Contact**, it is recommended that you remove **Simple Search** as a menu option, because **Search by Contact** effectively replaces it. Database searches only support exact and Free-text search is best suited for approximate searches, where it is possible to enter inexact, phonetic, or synonym search terms and recover accurate results. When you are searching for very specific objects in ClaimCenter, such as a check or an activity, **Search by Contact** is not recommended. Use other available search options such as **Search → Checks** instead.

The **Search by Contact** screen has fields to enter data by name, address, role, and other criteria. Search fields are not case-sensitive. For each field, there is a corresponding search index to optimize retrieval of that data. One search field may map to more than one object or property in the database. For example, entering a value in the **Name** field compares the search string against an index field that consists of concatenated **First Name** and **Last Name** or **Company Name**.

Note: Free-text search using **Search by Contact** is not integrated with a contact management or address book system, such as Guidewire Contact Manager. You search for claims using claim contacts within ClaimCenter.

The free-text search process consists of four steps:

1. Setup and enabling of free-text search for ClaimCenter.
2. Initial loading of the Guidewire Solr Extension index.
3. Continuous index updates in production using messaging.
4. Sending a search query to the Guidewire Solr Extension and receiving results.

As users make and save changes, ClaimCenter updates the Guidewire Solr Extension index dynamically.

Query and Filter Search Fields

On the **Search by Contact** screen, the fields for entering search criteria are of two types:

- **Query fields** – These are grouped under the **Search By** heading. ClaimCenter sends the query fields to the search engine. You need to enter at least one query field for the search to function accurately.
- **Filter fields** – These are grouped under the **Filter By** heading and help narrow down the results returned by the query.

Search Types and Ranking

Search fields are configured to match exactly or inexactly. An exact match of a field returns a result that matches the search string exactly. An inexact match of a field returns a result that starts with, contains, or sounds like the search string.

For example, exact and inexact matching returns the following names if you search for Rob:

- Rob – Exact.
- Robertson – Starts with.
- Robert – Contains.

ClaimCenter ranks the search results with a score that reflects the degree to which the result matches the search criteria. In the base configuration, only exact, prefix, and phonetic searches are enabled. Synonym matching for the full name is not enabled.

A configuration file defines for each search field how to rank exact matches and the various types of inexact matches. For more information, see “Configuring Free-text Search for Indexing and Searching” on page 367 in the *Configuration Guide*.

A search field may return matches from two or more pieces of information on the search object. The search ranks the matching information. When searching for claims, for example, a name search attempts to match the names of all the contacts associated with a claim.

Archived Claims Search

Free-text search using the **Search by Contact** menu option targets claims in the active database. In the base configuration, you cannot use free-text search to access archived claims.

Additional configuration would be required to create a separate index for claims in the archive database. If you do choose to add this configuration, you need to ensure that both databases are current when changes such as archiving or restoring a claim are made.

Search by Contact User Interface

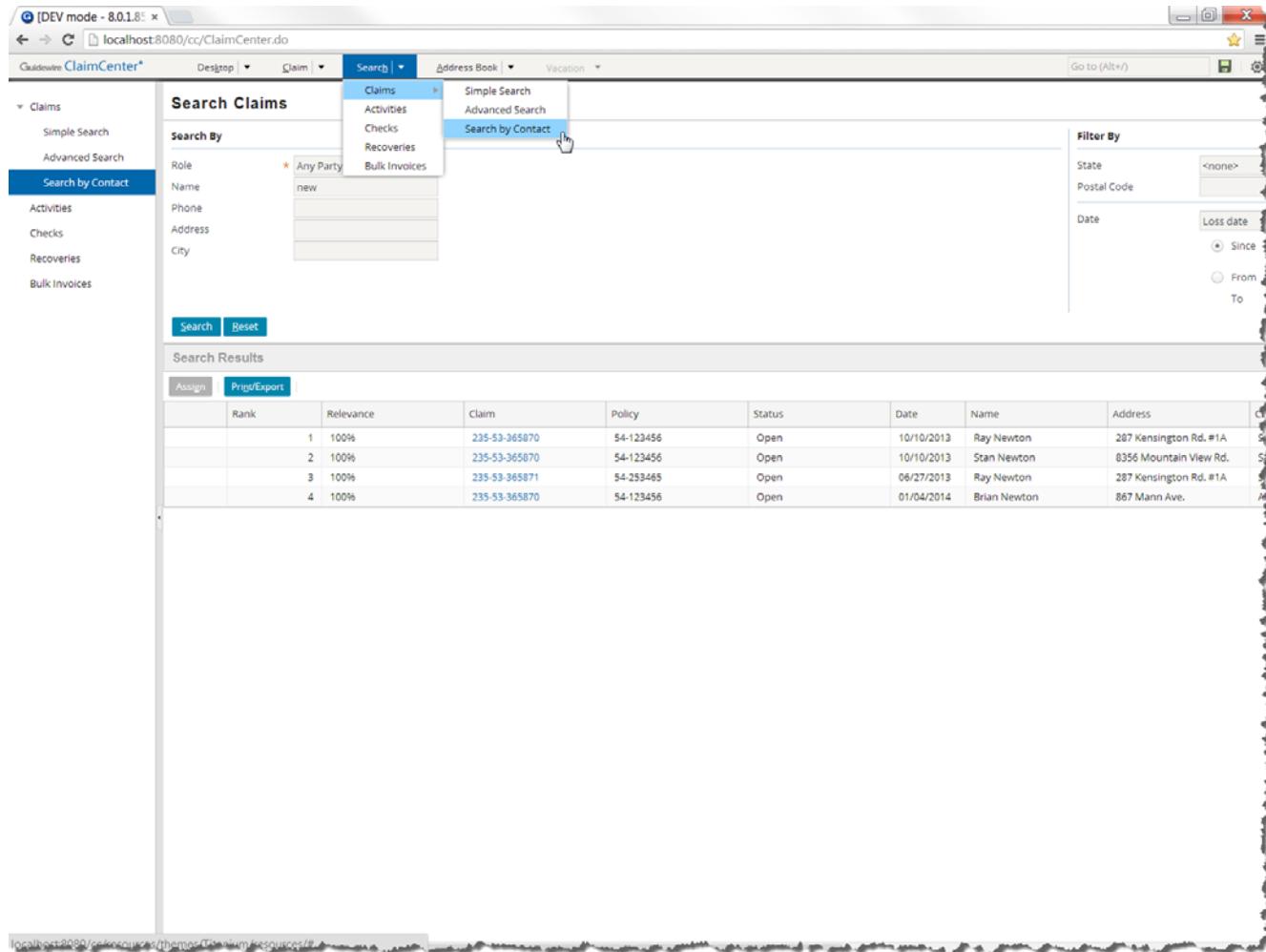
In the base configuration, **Search by Contact** searches for claim contacts in the active database and retrieves the corresponding claims.

Search by Contact has the following features:

- The **Name** search field matches a concatenated first and last name or company name.
- The **Phone** search field matches a home, mobile, or work phone number.
- The **Address** field matches the address associated with the claim.

Note: ClaimCenter also includes advanced search for additional object types. For more information, see “Advanced Search” on page 64.

Navigate to **Search → Search by Contact**, enter search criteria in the top of the screen, and ClaimCenter displays results in the bottom pane, as shown in the following figure.



Search Criteria

On the **Search Claims** screen, the following search fields appear at the top of the screen.

Field	Description	Matching	Type
Search By			
Role	Search for the role of the claim contact. Select Additional Insured, Any Party Involved, Claimant, or Insured. The default selection is Any Party Involved .	Exact	Query
Name	Search for first and last name of a person or company name. Starting with the best match, the search ranks the matching names as follows: <ul style="list-style-type: none"> • Exact • Starts with (prefix) • Sounds like (phonetic) • Contains 	Inexact	Query

Field	Description	Matching	Type
Phone	<p>Search for a matching work, home, or mobile phone number. You must enter the whole phone number. Valid telephone number formats are:</p> <ul style="list-style-type: none"> • 650-555-1234 • 650 555 1234 • 6505551234 • (650)555-1234 • (650) 555-1234 • 650.555.1234 <p>Country codes must be prefixed with +.</p>	Exact	Query
Address	<p>Search for the street address. The search ranks the results from highest to lowest as follows:</p> <ul style="list-style-type: none"> • Exact • Starts with (prefix) • Sounds like (phonetic) • Contains 	Inexact	Query
City	<p>Search for the city. The search ranks the results from highest to lowest as follows:</p> <ul style="list-style-type: none"> • Exact • Starts with (prefix) • Sounds like (phonetic) • Contains 	Inexact	Query
Filter By			
State	Search for the state. Select from a preconfigured drop-down list.	Exact	Filter
Postal Code	Search for the postal code.	Exact	Filter
Date	<p>Search for claims in one of the following date ranges:</p> <ul style="list-style-type: none"> • Loss date • Reported date • Closed date • Creation date 	Exact	Filter

The Matching column indicates whether the field matches exactly or inexactly. The Filter column indicates whether the field is a query or filter field.

You must specify at least one query field other than Role, such as Name or Phone. For more information, see “Query and Filter Search Fields” on page 65.

Search by Contact Results

On the Search by Contact screen, the following Search Results fields appear at the bottom of the screen.

Field	Description
Rank	The rank indicates the relevance of the result to the search criteria. The lowest rank corresponds to the most relevant match.
Relevance	The relevance is a percentage value that indicates the closeness of the match. The higher the relevance percentage, the better the match. A relevance of 100% represents the highest score of all the search results.
Claim	The claim number.
Policy	The policy number.
Status	The status of the claim.
Date	The date, typically the loss date, listed on the claim.
Name	The first and last name of the person or the company name returned by the search results.
Address	The street address on the policy.

Field	Description
City	The city on the address of the policy.
State	The state on the address of the policy.
Postal Code	The postal code on the address of the policy.
Phone	The primary phone number listed on the policy.
Roles	The roles held by the contact on this claim.

Name Search

The **Name** field finds matches in the contacts associated with claims, including company names. This is an inexact search field.

If you enter more than one word in the name field, the search gives a better rank to results containing both words. A match has a better ranking if the words exist in the same order. If only part of the words match, the match has an inferior ranking.

Note: The middle name is not indexed in the base configuration.

Address Search

The address search finds matches in addresses associated with claim contacts. Query fields for an address search include **Address** and **City**, and filter fields include **State** and **Postal Code**.

Working with Free-Text Search

This topic provides instructions for working with **Search by Contact**.

Prerequisites

These examples assume that you have set up and enabled free-text search for ClaimCenter. For more information about setting up free-text search, see “Free-text Search Setup” on page 85 in the *Installation Guide*. The examples also use sample data included with the base ClaimCenter installation. See “Installing Sample Data” on page 53 in the *Installation Guide*.

Search Examples

The following examples illustrate some simple claim searches.

1. Select **Search** → **Search by Contact**.
2. In **Name**, enter **robert**, then click **Search**.

The **Search Results** displays claims that contain a contact with **robert** in the first name or last name. Middle names are not indexed in the base configuration.

For example, the results contain rows for Robert Farley and Dan Robertson.

Note: Free-text search is based on matching search criteria to contacts from the index. So, a claim might appear more than once in the results for each matching claim contact.

3. In **Name**, enter a **robert**, then click **Search**.

The **Search Results** displays claims with contact names such as Allen Robertson, Robert Farley, and Alecia Cole, where the first name or the last name is a match. A name such as Allen Robertson has the highest relevance and rank.

4. In the **Name** field, enter **nuton**, then click **Search**.

The **Search Results** displays claims contacts with Newton in the name, which is a phonetic match to the entry, nuton. Example results include Ray Newton and Brian Newton.

Search Index Updates

In ClaimCenter, if you commit a change that is part of the search index, the change is updated automatically in the free-text search index, as shown in the following example.

1. Select **Search → Search by Contact**.
2. Enter Ray Newton in the **Name** field and click **Search**.
3. In the **Search Results** pane, click Claim # 235-53-365870 to navigate to the Ray Newton claim.
4. Select the **Parties Involved** menu link, and click **Brian Newton**. Edit the contact information and change his role from **Excluded Party** to **Other**. Click **Update**.
5. Return to **Search → Search by Contact** and enter newton in the **Name** field. Click **Search**.

The search results now display Brian Newton's updated role in the **Roles** column.

Note: You may have to wait a short time for the index update to occur.

QuickJump

The QuickJump box is a text-entry box for entering navigation commands using keyboard shortcuts. It is located at the upper right corner of each ClaimCenter page.

ClaimCenter is a web-based application, its complex page structure navigable with mouse clicks in specific places. The QuickJump feature provides a way to use keyboard shortcuts to navigate ClaimCenter for users who prefer typing navigation commands.

This topic includes:

- “QuickJump Overview” on page 71
- “Configuring QuickJump” on page 73

QuickJump Overview

QuickJump contains the following features:

- **Omnipresence** – Always present, in the same place on every application page.
- **Availability** – You reach it quickly by using your own two-keystroke sequence.
- **Auto-completion** – QuickJump attempts to complete the destination as you begin to type it.
- **Absolute jumps** – goto commands that always take you to the same page.
- **Jumps to a specific entity** – A claim number is sufficient.
- **Claim-dependent, chained jumps** – You can specify a main entity, like a claim, and one of its subentities, in a single command.
- **Complete configurability** – You can add and remove jumps and change what you type to make them happen.
- **Expandability** – You can add jumps to all the new pages you create in the application.
- **Intelligence** – QuickJump is context specific. For example, jumping to **New Note** within a claim associates any Note you write with that claim.

Accessing QuickJump

To put the cursor in the QuickJump text box, type the QuickJump shortcut command, which defaults to ALT /, in any ClaimCenter page. Until you jump to the QuickJump text box, the box contains the previous named shortcut. You can also use your mouse to position the cursor in the box. The QuickJump shortcut is configurable.

QuickJump to a Specific Page

You can use absolute QuickJump commands to reach certain ClaimCenter pages. Available destinations are:

- Desktop tab
- Search tab
- Address Book tab
- Administration tab
- New Claim wizard

You can also configure QuickJump to go to any other destination, any PCF file, that does not require an argument to specify it, such as the **Quick Check** wizard.

QuickJump to a Specific Entity

You can use QuickJump commands to reach an entity. The only entity-based QuickJump command provided in the base configuration of ClaimCenter is `claim`. You can add others.

For the `claim` command, entering the word `claim` and a *claim number* as its argument takes you to that claim's **Summary** page.

You can also configure QuickJump to go to any other entity, provided that it requires one or no arguments to specify, such as a bulk invoice. However, it is not possible to jump to an entity requiring more than one argument.

QuickJump to a Claim-Related Page

After QuickJump recognizes the name of a claim, it has a context and can jump directly to a subentity or other page related to that claim. If you are in a page related to a specific claim, you can QuickJump to many other pages of the claim by typing the page name in the QuickJump box. The following pages are available:

Calendar	Checks (within financials)	Documents	Exposures
Financials	Litigation	Loss Details	New Note
New Activity	New Check	New Document from template	New Document Link
New Exposure	New Recovery	New Recovery Reserve	New Reserve
Notes	Parties Involved	Plan of Action	Policy
Summary	Workplan		

These context-specific jumps are perhaps the most useful part of QuickJump. They allow rapid switching among many claim-related pages.

Chaining QuickJump Destinations Together

You can enter both an entity and subentity in QuickJump and go directly to the subentity. For example, `claim xxx workplan` jumps you to the Workplan of claim xxx. Chaining works only if the final destination is unique. Therefore, `claim xxx workplan` and `claim xxx New Note` are allowed, but `claim xxx New Exposure` and `claim xxx check` are not. The last two do not work because there are multiple exposure types and check wizards.

Localizing QuickJump

The commands QuickJump recognizes are defined in the `display.properties` file. Localization requires changing the command names in this file.

Configuring QuickJump

You can also customize the QuickJump box in Guidewire Studio to define frequently used commands, search parameters, and permissions. For the QuickJump text box to be enabled, there must be at least one configured command.

See “[Implementing QuickJump Commands](#)” on page 125 in the *Configuration Guide* for information on implementing and configuring quick-jump commands.

part III

Working With Claims

Claim Creation

The New Claim wizard is a flexible and configurable wizard that simplifies the intake of First Notice of Loss (FNOL) information to create a new claim.

The New Claim wizard:

- Models the natural flow of collecting FNOL information.
- Uses a small number of logically ordered steps.
- Captures high-level details, such as the reporter, relevant parties, and loss details in an organized way.
- Provides peripherally useful pages, like **Parties Involved** and **Documents**, that are accessible at any time, outside the main wizard workflow.
- Enables you to jump between step and non-step pages.
- Is optimized, in the base configuration, for personal auto and workers' compensation, but can be configured for any line of business.
- Uses incidents to organize **Loss Details** data by vehicle, property, and injury.
- Enables you to pick subflows, such as first-and-final or auto glass, to further optimize the wizard's workflow.

There are also other wizards, such as Auto First and Final or the Quick Claim Auto used in Personal auto, that you can use, depending on your business requirements. For example, the Auto First and Final wizard would typically be used when a claimant calls to report that the car's windshield is cracked.

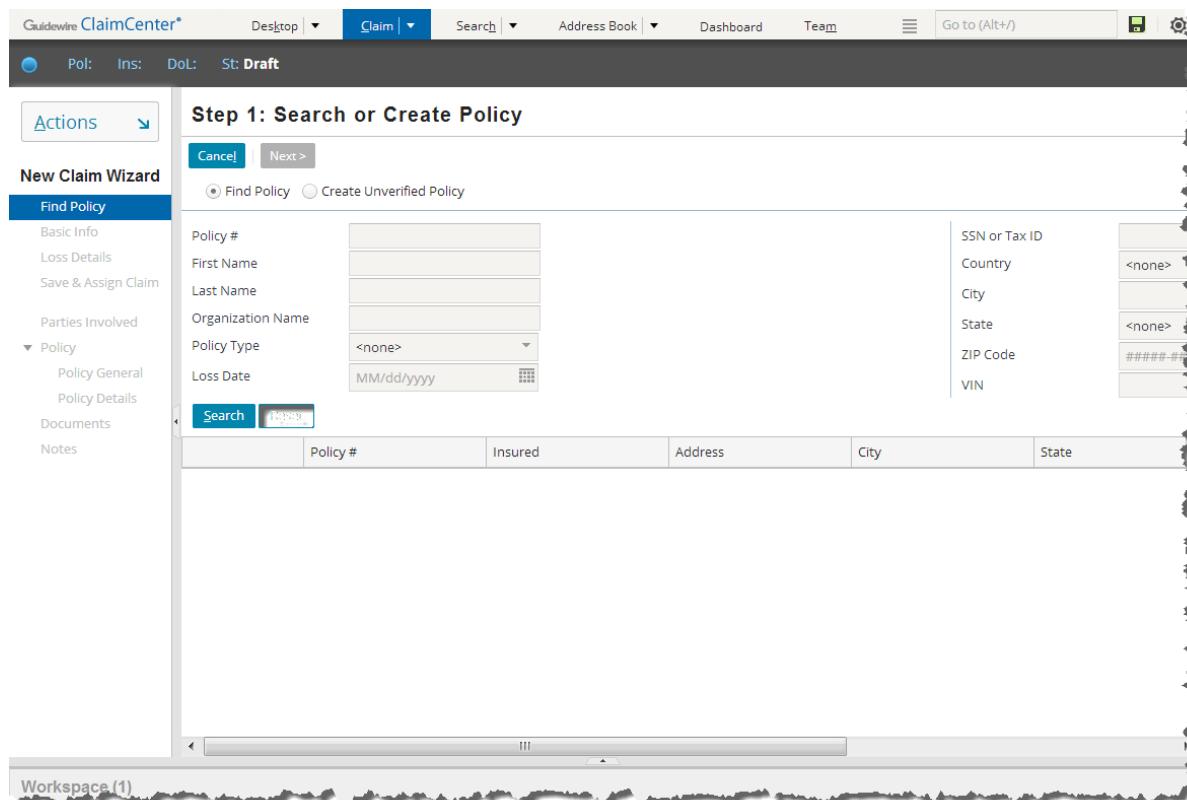
This topic includes:

- “New Claim Wizard Overview” on page 77
- “New Claim Wizard Steps” on page 80
- “New Claim Wizard and the Lines of Business” on page 87

New Claim Wizard Overview

The New Claim wizard page contains two navigation panels on the left, besides a main panel to collect data.

Access the wizard by selecting **New Claim** from the **Claim** tab.



Wizard Step Navigation Panel

The New Claim wizard provides different flows depending on the policy type that the policy search returns. For example, if the selected policy is of type Auto, the flow consists of four steps as seen in the previous graphic. The Wizard Steps navigation panel displays these steps, and you can navigate among any enabled steps. To access all the steps, including those that are not enabled, you must go through the wizard.

For personal auto and workers' compensation policy types, you can further specify a subflow, such as **Quick Claim Auto**, as a **Type of Claim** when selecting a policy. Additionally, there are subflows for homeowners and personal travel policy types, such as **Quick Claim Baggage** or **Quick Trip Cancel**. These selections also affect the flow and change the steps shown in the Wizard Steps navigation panel. See “New Claim Wizard Steps” on page 80.

Claim Action Navigation Panel

Besides the main wizard steps, you can add additional information as you create the claim. You enter this optional, claim-related information into pages that you reach from the Claim Action navigation panel. These pages include **Parties Involved**, policy-related information, **Documents**, and **Notes**. You can use this panel and the Wizard Step navigation panel together to jump quickly through the claim, but you cannot navigate to greyed-out choices. For example, you can always enter a new note, but you can attach **Documents** only after completing Step 1. See “Optional New Claim Wizard Pages” on page 86 for more details.

Claim Info Bar

The **Claim Info bar** contains information about the claim. It shows whether the claim is open or closed, the selected policy, the insured, date of loss, and the claim status. After you select a policy, an icon describing the type, auto, property or workers' compensation, appears by the policy number.

Saving Work and Retrieving Unsaved Work

The New Claim wizard stores the state of your work and returns you to work that you started but have not yet saved. The **Unsaved Work** menu shows a drop-down list of all step and claim action panels for which you have entered data but not saved.

Step one of the wizard is always selecting a policy. For you to be able pay the claim, the claim must have a verified policy. After clicking **Next**, you create a new claim and save it with draft status. The New Claim wizard does not save a claim in a more advanced status. However, each time you exit a step or claim action page by using **Next**, you save the information on that page in the draft.

After you have a draft of the claim, you can use the navigation panels to add information in any other wizard steps or claim pages. Use the **Unsaved Work** menu to return to any page you have begun but not saved by clicking **Next**.

After you click **Finish** to exit the wizard, claim validation rules run and the claim is saved in the highest status allowed by these rules.

Note: The system saves only when you click **Next**. The system does not save when you click **Back**.

Delaying Creation of a Draft Claim

To delay creating a draft claim until a later wizard step, change the `autosaveable` attribute at the end of page one of `fno1wizard.pcf` to `false`. Change this attribute to `true` in the step where you want to create the draft claim.

Multiple Draft Claims

After you have created a draft claim by completing the first page of the New Claim wizard, you cannot exit the wizard and enter it again to create another claim. After you enter the wizard again, it displays your current draft. However, this feature is configurable.

Enabling Multiple Draft Claims

To enable multiple draft claims, change the `autosaveable` attribute to `false` in all pages of the `fno1wizard.PCF` file.

After you enable multiple draft claims, you can exit the wizard at any time after creating a draft claim. When you open the wizard again, you can begin entering a new claim, instead of being required to return to your previous draft claim.

To enter the wizard again with a particular draft claim, use the **Desktop** tab to see the list of your claims. The list includes all drafts. Select any draft to return to the wizard with that draft open.

Flows of the New Claim Wizard

If you create an unverified policy, you must enter a **Policy #**, **Policy Type**, and **Type of Claim** before you exit Step 1. Requiring these entries enables the New Claim wizard to decide which flow to use. Then, after you select a flow, you can exit the step.

Capturing Incidents in the New Claim Wizard

You can use the New Claim wizard to capture incidents. A claim that contains incidents with no exposures is a claim that is recorded but not processed any further. No payments are made against it. This kind of claim can result from reported losses that are not covered by the policy or from a decision by the insured not to process the claim. Reasons not to process the claim might be that the loss amount is just slightly over the deductible or the insured does not want a rate increase. *Incident only* is an accepted industry term that implies that there is no expectation of financial liability by the carrier.

Another reason to capture incidents on a claim is that a customer service representative (CSR) might not have the permissions to create an exposure. The CSR might not know enough about the type of claim to create an exposure and, therefore, just gathers available information during the first notice of loss.

You can create incidents after a claim is created. Navigate to the claim's **Loss Details** page, and then click **Edit** and make your selection. Available incidents are located on the right side of the page.

Note: In the base configuration, there is an **Incident Only** radio button in Step 3 of the wizard. This radio button is actually a Boolean field, `IncidentReport`, on the `Claim` entity. ClaimCenter provides this radio button for optional configuration purposes. For example, you might decide to generate a report that contains a list of all claims that are incident-only. This button does not create an incident.

To learn more about incidents, see "Incidents" on page 235.

New Claim Wizard Steps

This topic describes in detail the workflow in the creation of a claim using, as an example, an auto claim. The pages for personal auto and commercial auto, and for personal and property claims are similar. Differences are noted, where applicable.

This topic includes:

- "Step One: Select or Create a Policy" on page 80
- "Step Two: Basic Information" on page 81
- "Step Three: Add Claim Information" on page 82
- "Step Four: Services" on page 84
- "Step Five: Save and Assign the Claim" on page 85
- "Completing the New Claim Wizard" on page 86
- "Optional New Claim Wizard Pages" on page 86

Step One: Select or Create a Policy

The first step of opening a new claim is ensuring that a policy exists. This step searches for an existing policy or creates an unverified policy as a placeholder. ClaimCenter searches an external system for a policy for the new claim or creates a new one, based on the current policy description. If the policy description matches the claim's current policy, the wizard's `setPolicy` method does nothing.

The wizard determines whether two policies are the same based on fields in the policy summaries. For example, you might return to the wizard's first step and select a new policy. If you click **Next** again, ClaimCenter relies on configurable logic to compare two policy summaries and determine if they are the same policy. You can configure the logic of how ClaimCenter compares the policy summaries, for example, to use additional fields such as the loss date.

You can update the claim with the actual policy later. "Verified and Unverified Policies" on page 91 describes the reasons and consequences of using each type of policy, especially as they affect claim validation.

Creating an Unverified Policy

If you select **Create Unverified Policy**, you then enter a **Loss date**, a **Policy Number**, **Policy Type**, and **Type of Claim** before you exit step one. The New Claim wizard uses the last three values to determine which flow to use. This topic describes the main Auto flow, and assumes you have chosen one of the Auto claim types.

Completing a Claim with an Unverified Policy

Some claims, such as those with Type of Claim either **Property - Quick Claim Property** or **Auto First and Final**, complete a claim even if the policy is unverified. However, you cannot specify the property or vehicle. Choose the **none selected** option from the **Select Property** or **Select Vehicle** drop-down list.

Selecting a Verified Policy

After you select **Find Policy**, you use the claim search panel to find the correct policy from a policy administration system, such as Guidewire PolicyCenter.

Policy search criterion	If searching for a name, you can also specify:
Policy #	
First and/or Last Name of policy holder	SSN or Tax ID, City, State, ZIP, and/or Country
Organization Name (of policy holder)	SSN or Tax ID, City, State, ZIP, and/or Country
Policy Type	
Loss Date	
Auto VIN (vehicle ID #)	

After you click **Search**, the results appear in a table at the bottom of the page. Use **Select** to display the correct policy. If the search finds just one result, the New Claim wizard selects it for you. You can use the **Unselect** button to override this choice and try again.

Selecting a policy shows additional details. For example, if the policy type is Personal Auto or Property, you see a history of all other claims filed against the policy, both open and closed, but not archived. Workers' compensation and commercial policies do not show a claim history because there are often many claims against these kinds of policies. After the claimant's name becomes known, ClaimCenter displays a claim history for the current claimant. You must enter additional information to complete this step.

- **Date of Loss** – Required so the New Claim wizard can evaluate if the policy is valid for the claim. You can optionally enter the **Loss Time**. The value defaults to midnight.
- **Type of Claim** – If the policy type can have more than one flow, you must select the targeted flow. See “Flows of the New Claim Wizard” on page 79.

After clicking **Next**, the claim is saved as a draft and advances to the next step.

Step Two: Basic Information

The **Basic Info** page captures information about the main contact for the claim. This page is designed to capture information about the people involved in the claim and has the following fields:

- **Reported By** – The person who called in the claim. See “Reported By” on page 82.
- **Insured** – The person or people who are insured on the policy. See “Insured” on page 82.
- **Main Contact** – The person serving as the principal point of contact for the claim. See “Main Contact” on page 82.
- **Involved Vehicles** – The vehicles that were reported as involved in the claim. See “Involved Vehicles” on page 82.

You can capture information about other relevant contacts—people, organizations, and companies—by navigating to the **Parties Involved** claim action page at any time while in the New Claim wizard.

After you go to the next step, the New Claim wizard runs a search for duplicate claims, since it already has enough information to perform a directed search.

Reported By

In the **Reported By** pane, enter how the claim was reported. Enter information about:

- **How reported** – Choices are **Phone**, **Fax**, **Mail**, **Internet**, **Walk-in**, and **None**.
- **Name** – If you click the picker icon next to this field, it tries to find the contact name you need. To add the contact yourself, choose the **New Person** option on the picker. If you choose a contact from the list shown by the picker, the page shows contact information. Some of this information, like phone numbers, but not addresses, is directly editable. An **Edit** button enables you to edit all contact information in a popup window. The picker icon restricts itself to contacts already on the claim. If you are unsure of the picker's selection, you can click the **View Contact Details** option of the picker.
- **Relation to the insured** – Choose a relationship from the drop-down list.
- **Date of Notice** – The date the claim was opened—the current date by default.

Insured

This section contains the name, address, and primary phone number of the insured. This data derives from the information in the policy associated with the claim. You cannot edit this information directly. However if you click the name, the **Contacts** page opens and you can create a new contact or make any edits.

Main Contact

The main contact is, more often than not, the person reporting the claim. This contact is set to the person reporting the claim by default. To choose another main contact, select **Different Person**, which opens the **Name** and **Relation to Insured** text boxes. Next to the **Name** box is a picker that behaves identically to the **Reported By** picker. The **Relation to the insured** field uses the same typelist for its options as the **Relation to the insured** field described previously in “Reported By” on page 82.

Involved Vehicles

This section shows the names of all vehicles listed on the policy and comes from information in the policy. Clicking the check box by any vehicle displays coverages and coverage limits of the policy. If the claim is a property claim, **Involved Properties** replace this section, and the check boxes show policy details for each property. By clicking a check box, you choose that vehicle to be the first party (insured’s) vehicle.

For commercial policies, this section does not appear, since the number of covered vehicles and properties is likely to be too large to be useful.

Step Three: Add Claim Information

Add claim information is the center of the New Claim wizard. Incidents are collections of information about a loss involving an injury or a loss to a vehicle or some property. The information is about what happened and is something that an observer could relate. To make it usable by call center operators with no insurance background, the New Claim wizard collects incident information rather than exposure information.

For more information on incidents, see “Incidents” on page 235.

The separate sections capture:

- Information on the claim cause and location.
- Incident information on vehicles, people, and property. See “Vehicles, People, and Property” on page 83.
- Contact information about others at the scene of the loss or accident. See “At the Scene” on page 84.
- A categorization of the loss. See “Categorization” on page 84.

Basic Claim Information

This section contains only the most basic claim details:

- **What Happened** – A text box for your description.
- **Date of Loss** – Not editable, from “Step One: Select or Create a Policy” on page 80.
- **Loss Cause** – ClaimCenter does not take any action based on this field. The choices come from the **Losscause** typelist.
- **Incident Only** – ClaimCenter does not take any action on this field. You can configure a rule to decide what to do with the draft claim already opened by the New Claim wizard.
- **Location** – A number of text boxes for address, city, and so on. The fields default to a new address. The **Location** drop-down list shows all the addresses obtained from the policy. Selecting one fills in the other address fields.

Vehicles, People, and Property

For an auto claim, this section initially contains only the vehicles selected by the previous step. For a property claim, this section contains selected properties. It provides additional buttons to add other incidents, based on another vehicle, a property loss, or a pedestrian injuries. If there is an injury to a person in a vehicle, you capture that information as part of a vehicle incident.

The buttons are:

- **Add Vehicle** – See “Add Vehicle Button” on page 83.
- **Add Pedestrian** – See “Add Pedestrian Button” on page 83.
- **Add Property Damage** – See “Add Property Damage Button” on page 83.

Add Vehicle Button

Each time you add a vehicle, you create another vehicle incident for the claim. Add vehicles in this step by selecting vehicles listed on the policy. These are usually first party incidents. Select these vehicles to delete them or edit the details of the incident that concerns them. You can also add any other vehicle and add its details.

The **Vehicle Basics** section displays the vehicle information, if known, from the policy. If this information is not known, or if the **Third Party** button is selected, fields appear to help you describe the vehicle. If you click **Stolen** or **Parked** in this section, the **Other Details** and **Damage** sections disappear from the page.

Besides the expected **Basic**, **Damage**, and accident (**Other Details**) sections, the **Occupants and Injuries** section displays a **Passenger Details** or **Driver Details** page. Enter contact details, including injury details, for anyone in the auto.

Use the damage section to describe the vehicle damage. This section includes a **Total Loss Calculator**, which is a series of scored questions that help you decide whether to write off the damage to the vehicle. Rules can use its score to help you decide whether the vehicle is a total loss.

Services check boxes—**Rental**, **Towing**, **Appraisal** and **Repair**—appear in each **Vehicle Incident** page. They are identical to the Services described in “Step Four: Services” on page 84.

Add Pedestrian Button

Use this button to add a person to the claim, someone not inside a vehicle. This pedestrian must be part of a vehicle incident as previously described. After clicking this button, you see the **Pedestrian Details** page.

The **Injuries** fields appear only when you select the **Injured (Yes)** button. After you save this page, a new entry appears in the **Vehicles, People & Properties** table of the main Step Three page. If no name or address is given for the pedestrian, the listing in this table is for an **Unknown Pedestrian**. If the pedestrian is injured or dead, appropriate icons precede the name. You can add a pedestrian incident only to an auto claim, not a property damage claim.

Add Property Damage Button

This button displays a **Property Incident** page each time you click it. Each time you save this page, a new row appears in the **Vehicles, People & Properties** table of the main Step Three page. You cannot add a property incident (loss) to an auto claim.

At the Scene

This section contains the following: **Witnesses**, **Officials?**, and **Police Report?** to collect information on these topics. Each time you select its **Add** button, you create a new entry in that section.

After you click **New Witnesses Add**, enter the witness' **Name**, whether there was a **Statement Obtained**, the location (**Where was the witness**), and the witness' **Perspective**. To make a new entry under **Officials?**, click its **Add** button and enter the official's **Type** and **Name**, and the **Report#** of any report made by that official. Finally, selecting **Police Report? Add**, opens the **Metropolitan Report Details** page. Enter details of the report.

Note: If ClaimCenter is integrated with Metropolitan Police Reports, this page shows data when ClaimCenter receives its accident report.

Categorization

This section of Step Three contains:

- **Fault rating** – Used by the subrogation feature. See “Working With Subrogation” on page 275.
- **Weather** – The weather at the accident, from the **Weather** typelist.
- **Catastrophe** – Entering a name associates the claim with that catastrophe. See “Catastrophes and Disasters” on page 155.
- **Special Claim Permission** – Entering a name puts the claim on that ACL. See “Data-based Security and Claim Access Control” on page 451.

Step Four: Services

An important part of receiving the first notice of a loss is providing help to those who have suffered the loss. The New Claim wizard has information about services that might be needed to start the claim resolution process for the insured, the claimant, or another party reporting the claim. Services are filtered based on the choices you made in previous steps of the New Claim wizard.

For example, for auto claims, the services provided include how to obtain:

- **Rental Car**
- **Towing Services**
- **Appraiser**
- **Auto Body Repair Shop**

Note: In the New Claim wizard, you can select services from a menu of predefined, commonly used services for your type of claim. The request type for these services is also preselected to simplify this process. Alternately, you can also choose to manually add services using the **Other Services** menu option, in which case, you can make more granular selections, including the request type.

For each service, ClaimCenter shows the related coverage and limit. For example, the **Auto Body Repair Shop** service section shows whether the vehicle has collision coverage and its deductible, obtained from the policy.

Other types of claims involve other types of providers. For example, a workers' compensation claim might offer a doctor, medical clinic, and physical therapy facility to visit. A property loss might involve an appraiser or a company involved in insurance replacements.

The following example shows Step Four of the New Claim wizard. Details of each service appear only when its check box is selected.

The picker can be configured to search based on proximity to the loss, which is already part of the claim. You can use the picker to select only **Preferred Vendors**, or vendors meeting a certain minimum standard, as determined by a ranking score.

See also:

- “Services” on page 375
- “Service Provider Performance Reviews” on page 165.

Step Five: Save and Assign the Claim

The New Claim wizard attempts to ensure that data that has just been entered is not lost. It saves the claim as a draft claim after you exit step one. The draft is saved again every time you move to another step in the wizard.

In step five of the wizard, you do the following:

- Add a new **Note** on the claim with the First Notice of Loss section.
- **Assign** the claim, either to the logged-in user filling out the wizard, by using automatic assignment, or by using a picker. The picker helps you find a user by name, group name, or proximity to a location. You also have the option of assigning the claim and exposures individually using the same methods.
- Create **Exposures**. The wizard uses the incidents entered into Step Three of the New Claim wizard to help you select:
 - **Vehicle Exposures** – Generated for each vehicle incident already entered.
 - **Property Exposures** – Generated for each property incident already entered.
 - **Injury Exposures** – Generated for each injury incident, whether entered separately, such as a pedestrian, or as part of a vehicle incident, such as a driver or passenger.
 - **Exposures based on the coverage type** – Choices reflect the coverages on the policy.

After you create individual exposures, you can assign them. This feature is more appropriate for a claim adjuster than a call center, and is optional during the New Claim wizard.

The following example shows the exposure types generated for a vehicle on the policy:

The screenshot shows the 'Step 5 of 5: Save and Assign Claim' page. On the left, a navigation panel for the 'New Claim Wizard' is visible, with 'Save & Assign Claim' selected. The main area has tabs for 'Assignment' and 'Exposures'. Under 'Assignment', the 'Assign claim and all exposures to:' option is selected, with a dropdown set to 'Use automated assignment'. Under 'Exposures', there is a table with two entries:

#	Type	Coverage	Claimant	Involving	Status
1	Vehicle	Collision	Brian Newton	1996 Toyota Corolla (2G...	Draft
2	Vehicle	Liability - Bodily Inj...	Brian Newton	1996 Toyota Corolla (2G...	Draft

Completing the New Claim Wizard

After you click **Save**, ClaimCenter runs its automatic assignment rules if you selected this method of assignment. ClaimCenter then saves the claim.

Note: If you have integrated ClaimCenter with ContactManager, after you complete the New Claim Wizard, you might notice that contacts brought over from ContactManager or PolicyCenter are marked as not synchronized. It can take some time for ClaimCenter to synchronize these contacts with ContactManager. When this process is complete, the contacts will be marked as being in sync.

For more information, see:

- “Integrating ContactManager with Guidewire Core Applications” on page 45 in the *Contact Management Guide*
- “Linking and Synchronizing Contacts” on page 191 in the *Contact Management Guide*

Optional New Claim Wizard Pages

The topic “Claim Action Navigation Panel” on page 78 describes other pages that are part of the New Claim wizard. For auto claims, these pages are always available after you have chosen a policy and finished step one.

- **Parties Involved** – A page for entering all contacts that you did not enter elsewhere. Enter other types of contacts, as well as contacts normally entered on a step page. For example, if the caller suddenly thinks of a witness name, you can enter it on this page rather than navigating back to the previous step.
- **Policy General** – This page and the one that follows provide editable information on the selected policy. Editing policy information makes the policy no longer verified. See “Working with Policies in Claims” on page 91.
- **Policy Details** – The **General** page is the policy overview. The **Details** page shows the vehicles or property that are covered, what coverages they have, and the coverage limits. Workers’ compensation claims do not show the **Policy Details** option, since these policies never list vehicles or properties, only coverages that apply to the insured.

- **Documents** – Use this page to review existing documents and add, link, or indicate the existence of a new document to the claim. It is the same page you reach in ContactManager when you select **Documents**. It is available after you complete step one.
- **Notes** – Use this page to add a new note.

New Claim Wizard and the Lines of Business

This topic describes the differences in the New Claim wizard with the different lines of business in the base configuration.

Policy Type	Loss Type	Flows (steps) defined in default wizard
Businessowners (BOP)	General liability, Property	main (9), quick claim property (2)
Commercial auto	Auto only	main (6), quick claim auto (2), first and final (2)
Commercial property	Property	main (9), quick claim (2)
Farmowners	General liability	main (5)
General liability	General liability	main (5)
Homeowners	Property	main (5)
Inland marine	Property	main (8), quick claim (2)
Personal auto	Auto only	main (5), quick claim (2), first and final (2)
Personal travel	Travel	main (4),quick claim baggage (2), quick trip cancel (2)
Professional Liability	General liability	main (5)
Workers' compensation	Workers' compensation	main (5)

New Claim Wizard and Commercial Auto LOB

In commercial lines of business, it is common for there to be a significant number of Risk Units on a policy. In a Commercial auto policy, for example, a full fleet of trucks might be listed on the policy. In ClaimCenter, all the vehicles are retrieved, and you can select the ones that pertain to the claim.

Specific Features in the Commercial Auto New Claim Wizard

The following table lists specifics in the wizard steps:

Wizard Step	Description
Find Policy, step 1	Select your policy or create an unverified policy.
Affected Properties, step 2	Select the vehicle that is affected from this list of vehicles from the policy.
Basic Info, step 3	Provide the contact information.
Loss Details, step 4	Provide loss information. Add incidents, such as those affecting vehicles, pedestrians, or property damage. You can add any existing witnesses, officials, or police reports.
Services, step 5	Assign additional services, such as rental, towing, appraisal or autobody repair.
Save and Assign Claim, step 6	Assign the claim specifically to an adjuster or through automated assignment.

New Claim Wizard and Commercial Property LOB

The claims intake process for commercial property claims works as follows:

Wizard Step	Description
Find Policy, step 1	Select your policy, or create an unverified policy.
Affected Properties, step 2	Select the property that is affected from the list of policy properties.
Basic Info, step 3	Provide contact information.
Loss Details, step 4	Provide loss information. Add incidents, such as those affecting properties or people. You can assign a catastrophe to the claim in this step as well as add any existing Metropolitan Reports.
Exposures, step 5	Optionally, create exposures in this step from the Actions, New Exposure menu.
Parties Involved, step 6	Provide contact details of the people involved in the claim.
Documents, step 7	If there are no documents, then this step is skipped.
Save & Assign Claim, step 8	Assign the claim to specifically to an adjuster or through automated assignment.
Save Claim, step 9	Review the claim before saving.

New Claim Wizard and Homeowners LOB

The claim intake process for homeowners claims is usually faster than intake for auto claims. For example, a Customer Service Representative (CSR) might take 10 minutes to gather data for a homeowners claim, while gathering auto claim information might take up to 45 minutes. As a result, the New Claim wizard uses only four steps.

The wizard provides:

- Damage mitigation by using Services early in the process. Dispatching services early in the claim process can prevent issues from escalating. An example is a pipe leak, which can escalate to damaged contents and mold issues.
- Questions for capturing detailed damage information on the claim.
- Automatic incident creation upon selection.

Specific Features in the Homeowners New Claim Wizard

The following table lists specifics in the wizard steps:

Wizard Step	Specific Feature
Find Policy, step 1	Claims History – You can see immediately if there are other related claims, their status and loss dates, and who was assigned to them. Finding information at this level could alert an adjuster or CSR of potential fraud.
Basic Info, step 2	ClaimCenter pulls the coverage limits on the policy into the claim for you.
Loss Details, step 3	This step captures claim loss details, property incidents, and liability incidents, besides additional information. There is only one Property incident per claim, but for Liability incidents, there can be multiple incidents. Property incidents include Dwelling, Personal Property, Other Structures, and Living Expenses. Selecting a damage type of Fire or Water expands the page so that you can capture additional details and ask the right questions about the damage. This step also captures any witnesses, officials, or reports.
Services, step 4	This page is where you assign services. If done early in the claim process, assigning services can help keep damages to a minimum.
Save and Assign Claim, step 5	You can create new exposures during this step by clicking the New Exposure button. When you are finished, save the claim and assign to an adjuster or use automated assignment.

See also

- “Homeowners Line of Business” on page 169 for additional information.

Configurable Risk Units

Step two of the New Claim wizard for commercial auto and commercial property displays the list of either vehicles (RiskUnit objects) or properties that are contained in the policy. From this list, you make your selection of the property or vehicle to be included in the claim.

This process is configurable, enabling you to configure other loss types and display different types of RiskUnit objects. Examples can include configuring locations for a workers’ compensation claim or changing the RiskUnit objects to show coverages in a homeowners claim.

Working with Policies in Claims

Every claim is a claim against a single insurance policy. The policy associated with a claim determines what the claim covers. The coverages on the claim map to the exposures on a claim. It is the coverage limits that bind or limit the payments on a claim. This topic explains the relationship between policies and claims.

This topic includes:

- “Verified and Unverified Policies” on page 91
- “Validating Policies” on page 92
- “Working with Policies in ClaimCenter” on page 92
- “Searching for Candidate Policies” on page 92
- “Creating an Unverified Policy” on page 93
- “Retrieving the Correct Policy” on page 93
- “Editing a Policy Copy in ClaimCenter” on page 94
- “Refreshing the Policy Snapshot on a Claim” on page 94
- “Replacing a Policy on a Claim” on page 98
- “Adding Coverages to a Policy” on page 98
- “Configuring Policy Menu Links” on page 100
- “Verifying Coverage” on page 101
- “Aggregate Limits” on page 103
- “Policies and the Data Model” on page 105
- “Claim Policies and the Policy Administration System” on page 106

Verified and Unverified Policies

ClaimCenter depends on an external system to provide and *verify*—vouch for the authenticity of—the claim’s policy. Usually, ClaimCenter is integrated with a policy administration system, which provides policies that are guaranteed to be real and accurate, or *verified*. If that system does not provide ClaimCenter with a verified policy, you can enter policy information to open the claim. You can also edit a verified policy. However, the

policy you create or edit in this way is always *unverified*. A claim with an unverified policy passes validation only at the *New Loss* level, but not at the *Ability to Pay* level. To make payments and complete a claim, ClaimCenter requires that the claim have a verified policy.

Validating Policies

Every claim must be associated with a policy when it is first created. ClaimCenter validation rules verify that when a claim is first created, it is associated with a policy, which can be an unverified policy. Allowing unverified policies enables a novice call center employee to start the claim process. As claim processing progresses to making payments, the policy validation rules provided in the base configuration do not look for a verified policy, although you can create rules that do.

Working with Policies in ClaimCenter

You can perform the following actions on policies with Guidewire ClaimCenter:

Task or action	Description
Search for a policy	You can search for policies by entering information that helps ClaimCenter search for a policy in a policy administration system. This system can be either Guidewire PolicyCenter or an external policy administration system. The search, if successful, returns a list of possible policies from which you can make a selection.
Retrieve a policy snapshot	You can retrieve a snapshot of an existing policy. Selecting one of the candidate policies returned by a policy search associates that policy with the claim. This operation retrieves full policy information, correct as of the -claim loss date.
Create an unverified policy	You can create a new, unverified, policy. If you want to open a claim without knowing about the policy, enter possible policy information. It is not necessary to know the correct policy number.
Edit an existing policy	You can change actual policy information or add extra policy information that is local to ClaimCenter. If you edit an existing policy, ClaimCenter no longer considers the policy to be verified.
Refresh policy information	You can replace the policy information on a claim with a new copy of the policy information pulled from a policy administration system.
Replace a policy on the claim	You can replace the policy associated with a claim with a different policy.
Add coverages to a policy	You can add coverages to a policy.

Searching for Candidate Policies

The initial step of the ClaimCenter New Claim wizard requires that you provide a policy number. You can either search for an existing policy or create a new, unverified, policy.

To search for a policy:

1. Select **Find Policy** in the **Search or Create Policy** page of the New Claim wizard.
2. Enter search information, such as the insured's name and address, the VIN number of the vehicle, or the policy number.

If successful, the integrated policy administration system returns a list of all policies that match your search criteria. The summary for each policy contains information about the policy along with information about any claims against this policy.

If you click a policy number in the list, you see a Policy Details page that shows a list of all vehicles or properties insured under the policy. ClaimCenter truncates the list of vehicles or properties if the policy contains a large number of them.

If ClaimCenter truncates the list:

- ClaimCenter attempts to retain the correct vehicle or property in the returned list by using the search criteria.
- ClaimCenter generates a warning message to indicate that truncation occurred.

ClaimCenter stores the totals for these lists in the `Policy.TotalVehicles` and `Policy.TotalProperties` properties.

Note: To suppress these warning messages, in Guidewire Studio you can open `config.xml` and set the configuration parameters `IgnorePolicyTotalPropertiesValue` and `IgnorePolicyTotalVehiclesValue`.

To select a verified policy for a new claim

1. Navigate to the New Claim wizard in the Claim tab.
2. Click **Find policy**.
3. Enter the policy number.
4. Click **Next** to continue with the New Claim wizard.

To search for a claim by its policy

1. Navigate to **Claims** in the Search tab.
2. Enter the policy number.
3. Click **Search**.

Creating an Unverified Policy

If you do not have sufficient information to retrieve a snapshot of an existing policy, you can create an unverified policy. Later, you can associate the claim with an actual verified policy.

To create a new, unverified, policy

1. Navigate to **New Claim** in the Claim tab.
2. Click **Create Unverified Policy** and enter the requested information and a policy number. The policy number does not have to be valid at this point. It is possible to change the policy number at a later date.
3. Click **Next**.

Retrieving the Correct Policy

After ClaimCenter returns one or more policies that match your search criteria, select the appropriate policy from the list. The external policy administration system retrieves and transfers a snapshot of the entire policy, valid on the date of loss to ClaimCenter. Retrieval occurs automatically as you select a verified policy.

Editing a Policy Copy in ClaimCenter

Because any edit to a verified policy changes it to unverified in ClaimCenter, you have an incentive not to make changes to the policy. To both keep a policy verified and enable you to edit its information, ClaimCenter uses additional fields that are attached to the policy.

These additional fields:

- Are internal to ClaimCenter.
- Are independent of the verified data.
- Survive a policy refresh or replacement.
- Are editable without fear of policy de-verification.

You must have a role that has the Make Policies Editable permission to be able to enter an unverified policy or to edit a verified policy.

To modify a policy copy in ClaimCenter

1. Select a Claim.
2. Select the Policy menu item and click **Edit**.
3. Make your edits.
4. Click **Update** to save your work.

Note: Clicking **Edit** immediately de-verifies the policy, even if you make no edits. You can click **Refresh** to verify the policy again.

Refreshing the Policy Snapshot on a Claim

Each claim contains a snapshot of the policy associated with that claim. In working with policies, you can perform a number of tasks:

Policy Refresh	Update the snapshot of the policy directly from the integrated policy administration system. See "Policy Refresh" on page 94.
Policy Select	Choose an entirely different policy to associate with a claim.

Note: Refreshing a policy from the policy administration system always gives you a verified policy.

Policy Refresh

Refreshing a policy replaces the policy snapshot with the latest version of the policy from the policy administration system, effective on the date of loss. In this process, ClaimCenter does the following:

- Retrieves a new snapshot of the policy from the policy administration system.
- Replaces the policy snapshot with the new policy and rewrites the connections between the policy and the claim. This process is called *relinking*.

There are several reasons that you might want to refresh the policy attached to the claim:

- The loss date was wrong when the claim was created, and the wrong policy was retrieved and used in the snapshot.
- There was a mistake on the policy in the policy administration system when the claim was created. For example, there was an incorrect contact. This mistake has been fixed and the policy needs to be updated.

- There was a risk unit or coverage missing on the policy. It is possible that the wrong risk unit was chosen during claim creation or that the policy lacked a risk unit that needed to be covered. The error has now been corrected in the policy administration system.
- A policy change has been made that is effective for the date of loss, and this change has rendered the policy snapshot obsolete.

What ClaimCenter Replaces During a Refresh

When a policy is refreshed, only information from the policy administration system is updated. For example:

What ClaimCenter updates	What ClaimCenter does not update
<ul style="list-style-type: none">• Coverages• Coverage limits• Policy contacts• Claim contacts – Updated if they have policy roles like insured, covered party, and similar roles.	<ul style="list-style-type: none">• Aggregate limits• Reinsurance agreements• Claim contacts – Not updated if they have claim roles only, like reporter, witness, and similar roles.

Refreshing a policy replaces the current policy information. In a refresh, ClaimCenter preserves only the policy fields marked as internal. ClaimCenter also preserves information related to claim contacts and the parties involved. For example, in the base configuration, refreshing a policy does not update witness or claimant information because this claim information is not present in the policy administration system.

Policy refresh checks to see if any of the aggregate financial values have changed. If this is the case, ClaimCenter recalculates those values.

Policy Refresh Wizard

You initiate a policy refresh by clicking the **Refresh Policy** button in the **Policy: General** page of a claim. Depending on your line of business, the wizard takes a path enabling you to:

1. Select the policy.
2. Make the risk unit selection for commercial auto and commercial property only.
3. Compare policy information on the **Policy Comparison** page.

The comparison page shows the differences and any errors or warnings. Errors prevent refresh from completing. If there are warnings only, then you can still complete the refresh.

Policy Comparison Page

After you click **Policy Refresh**, ClaimCenter displays a side-by-side comparison of the current policy and the new policy in the **Policy Comparison** page.

- The *current policy version* is the snapshot of the policy that is already on the claim.
- The *new policy version* is the snapshot of the policy returned by the policy administration system upon requesting a policy refresh. This version is the latest version of the policy from the policy administration system effective for the date of loss.

The **Policy Refresh** page contains:

- An area at the top for errors and warnings that can occur during a refresh. An error blocks a refresh. A warning draws attention to a potential problem.
- A tree representing differences between the policy snapshot and the latest policy retrieved from the policy administration system. The tree shows policy entities and properties.

- Two columns on the right, one labeled **Current Policy**, the other labeled **New Policy**. The policy snapshot on the claim is the current policy version. The copy of the policy that the policy administration system returns is the new policy version.
- A button bar that contains **Cancel** and **Finish** buttons.

Resolving Issues

If ClaimCenter encounters an error condition, such as an incompatible change, during policy refresh, the error prevents the refresh.

The following list describes the policy refresh behavior in the ClaimCenter base configuration:

Retrieved policy changes	Policy refresh changes in ClaimCenter
Contact no longer present on the policy as insured, and is added as an excluded party	The insured becomes the former insured. ClaimCenter adds the contact as an excluded party.
Coverage added	ClaimCenter shows the refreshed policy with the coverage.
Coverage incident or exposure limits changed or the limit currency changed	ClaimCenter updates the coverage limits on the policy. ClaimCenter provides a warning if the limit decreases.
Effective date or the expiration date changed on the coverage	ClaimCenter shows a warning.
PIP aggregate limits lowered	ClaimCenter shows a warning.
Policy currency changed	<ul style="list-style-type: none"> If the currency is editable, ClaimCenter provides a warning. If the currency is read-only, ClaimCenter blocks the refresh with an error.
Policy period changed	ClaimCenter shows a warning.
Risk unit added to policy, such as a vehicle	ClaimCenter adds the risk unit to the claim. It is possible to modify an incident to use the new risk unit, such as a vehicle.
Risk unit coverage removed that is used by an exposure	<ul style="list-style-type: none"> If the exposure is still open, ClaimCenter blocks the refresh. The user must close the exposure first to continue.
	<ul style="list-style-type: none"> If there are non-reserving transactions on the exposure, or the net incurred is greater than 0, ClaimCenter blocks the refresh. If the exposure is closed, meaning that there are no transactions except reserves, and the net incurred is zero, ClaimCenter allows the refresh.
Spelling of an insured's name changed	The action is dependent on the matching logic:
	<ul style="list-style-type: none"> If the contact is uniquely identified, ClaimCenter treats the change as a name change. If no unique identification is present, the default behavior in the base configuration is to use the name as an identifier by using fallback matching criteria. ClaimCenter considers this change to be the addition of a new contact.
Workers' comp class code removed	You can configure this behavior.
	ClaimCenter blocks the refresh with an error.

Configuring the Policy Comparison Page

In the **Policy Comparison** page, it is possible to configure the following:

- The objects and properties that ClaimCenter lists in the policy comparison tree.
- The order and labels of objects and properties listed in the policy comparison page.
- The messages that ClaimCenter generates if it detects an issue during policy refresh.

See also

- “Policy Refresh Overview” on page 539 in the *Integration Guide* for details on the `IPolicyRefreshPlugin` plugin interface. ClaimCenter provides this plugin interface in the base configuration to define the interactions between ClaimCenter and policy refresh code.

Configuring the Policy Comparison Page

It is possible to configure the following items in the policy comparison tree shown in the **Policy Comparison** page:

- Entity and property labels
- Entity and property display order

See “Policy Refresh Overview” on page 539 in the *Integration Guide* for details.

Configuring Policy Refresh Messages

ClaimCenter can show messages during policy refresh as it encounters certain conditions. These messages can be any of the following:

Error	An error identifies a problem severe enough that ClaimCenter does not allow the policy refresh. If ClaimCenter identifies an error condition, it disables the Finish button in the Policy Comparison page.
Warning	A warning identifies a possible problem, but ClaimCenter still allows the policy refresh.

ClaimCenter lists all messages in order of severity. In other words, ClaimCenter lists all errors first, followed by warnings.

In the base configuration, ClaimCenter provides error or warning messages for the following:

- Missing class code
- Changed currency value
- Changed policy period
- Missing property item to which the claim refers

It is possible to configure all message types, which means that you can do the following:

- Modify the text of a message.
- Modify the conditions under which ClaimCenter generates a message in the base configuration.
- Remove a base configuration message.
- Add additional messages to those in the base configuration.

See “Policy Refresh Overview” on page 539 in the *Integration Guide* for details.

Selecting a Policy

In the **Policy: General** page, clicking **Select Policy** opens a policy search page. Use policy select to replace a claim's policy snapshot with a different policy from the policy administration system. For example, you can use policy refresh to:

- Search for and select a different policy to associate with the claim. It is possible, due to various factors, that the wrong policy was chosen initially.
- Replace an unverified policy that was entered manually with a verified policy. You might have created an unverified policy, for example, if you did not know the number of the specific policy to associate with the claim. When you know the policy number or other policy information, you could search for the correct verified policy to associate with the claim. For information on unverified policies, see “Verified and Unverified Policies” on page 91.

If you select a new policy to associate with the claim, ClaimCenter can relink the information on the claim to the new policy.

Replacing a Policy on a Claim

You can replace a policy on a claim instead of refreshing the current policy. Contacts, claim contact, and interested party information are treated as if the policy was refreshed. The claim similarly undergoes a new validation. In addition, policy replacement nulls most other policy-related claim information. For example, vehicle information from a former policy listed in one of the claim's exposures is no longer be present in the claim after replacing the policy.

Policy replacement can cause exposures to become invalid. If the replacement policy does not have the coverage needed for an exposure, that exposure cannot remain a part of the claim. ClaimCenter does not remove such exposures, but they fail validation.

To replace a policy

1. Select a Claim.
2. Select Policy menu action and click Select Policy.
3. Click OK to re-select in the popup.

You do not need to click Update.

Alternately, you can return to the first page of the New Claim wizard and select a new policy.

Adding Coverages to a Policy

It is possible to add a coverage to a policy that you select in ClaimCenter. A coverage provides protection from a specific risk. Coverages always attach to a coverable, which is an exposure to risk that a policy can protect against. You typically divide coverables into property coverables and liability coverables:

- **Property coverables** – Things with physical attributes, such as height, weight, value, construction type, age, and similar attributes.
- **Liability coverables** – Operations represented typically by class codes, such as coal mining or personal automobile operation.

You can divide coverages into the same two types as well, property and liability. For example, on an auto policy:

- A collision property coverage protects the vehicle owned by the insured.
- A liability coverage protects the driver for damage done to a vehicle owned by someone else. Liability coverage provides insurance for the operation of the vehicle. It does not provide insurance for the car, bus, or snowmobile.

Under what circumstances do you need to add a coverage to a policy in ClaimCenter? Suppose, for example, that the ClaimCenter version of the policy does not contain the correct endorsements and coverages that were in effect on the policy before an incident took place. In many cases, you must add these coverages before you can continue with claim processing.

IMPORTANT ClaimCenter does not push any changes in coverages that you make in ClaimCenter back to the policy administration system. The policy administration system is the system of record for policies, not ClaimCenter.

To add a policy-level coverage

1. Open a claim.

2. Navigate to the **Policy** link on the left-hand side of the page.
3. Click **Edit**.
4. At the bottom of the page, click **Add** in the area labeled **Policy-level Coverages**.
5. Choose the coverage type from the drop-down list.
6. Enter the other values as needed.
7. Click **Update**.

Adding Coverage Terms

A coverage term is a value that specifies the extent, degree, or attribute of a coverage. Using a coverage term, you can:

- Specify the limits or deductibles of a coverage.
- Specify the scope of a coverage.
- Specify a selection or an exclusion that is specific to a particular coverage.

A coverage can have zero, one, or many coverage terms.

If you select **Policy** → **Coverage Terms** → **Add**, ClaimCenter opens a page in which you can define a coverage term.

ClaimCenter divides coverage terms into the following types:

- Classification
- Financial
- Numeric

ClaimCenter provides an entry page for each coverage term type. Each page contains common fields and additional type-specific fields. The following table lists the fields that are common to all coverage term types:

Field	Description
Subject	<p>Drop-down list of coverage terms that are available for the chosen coverage type.</p> <p>For example, if you select a coverage type of Comprehensive for a Personal Auto claim, ClaimCenter provides you with the following choices for the Subject field:</p> <ul style="list-style-type: none">• Comprehensive deductible• No deductible for glass <p>ClaimCenter defines the available choices in typelist CovTermPattern.</p>
Applicable To	<p>Drop-down list of coverage terms that restrict what the chosen coverage type actually covers. The kinds of restrictions available for selection depend on the coverage type.</p> <p>For example, if you select a coverage type of Collision for a Personal Auto claim, ClaimCenter provides the following choices for the Applicable To field:</p> <ul style="list-style-type: none">• Accident• Bodily injury• Bodily injury/property damage <p>ClaimCenter defines the available choices in typelist CovTermMode1Rest.</p>

Field	Description
Per	<p>Drop-down list of coverage terms that indicate that this coverage term applies to a subset or a subtype of the coverage. For example, if you select a coverage type of Collision for a Personal Auto claim, ClaimCenter provides the following choices for the Per field:</p> <ul style="list-style-type: none"> • Annual aggregate • Each accident • Each common cause • Per claim • Per item • Per occurrence • Per person <p>ClaimCenter defines the available choices in typelist CovTermMode1Agg.</p>
Type	Read-only label that identifies the coverage term type. ClaimCenter generates this label from typelist CovTerm.

The following table lists the fields that are specific to each coverage term type:

Type	Type-specific fields
Classification	<ul style="list-style-type: none"> • Code – Policy administration systems often use classification codes to segment or categorize a large set of items. For example, there are jurisdictional class codes that divide a geographical region into smaller areas, each with a specific code. There are also medical class codes that assign every conceivable medical condition a specific code. The code that you enter must match a valid class code used in the policy administration system. • Description – Optional text field for additional information.
Financial	<ul style="list-style-type: none"> • Amount – A non-negative currency amount.
Numeric	<ul style="list-style-type: none"> • Value – A numeric value. • Units – The associated units for that value. Available choices include days, hours, money, or percent, for example.
ClaimCenter defines the available choices in typelist CovTermMode1Val.	

To add a coverage term to a policy

1. Open a claim.
2. Navigate to the **Policy** link on the left-hand side of the page.
3. Click **Edit**.
4. Select a coverage at the bottom of the page in the area labeled **Policy-level Coverages**.
5. Click **Add** in the area labeled **Coverage Terms**.
6. Select the coverage term type:
 - Classification
 - Financial
 - Numeric
7. Fill in the fields on the **Coverage Term** definition page appropriately for that coverage term type.

Configuring Policy Menu Links

It is possible to configure how ClaimCenter displays policy information. Specifically, you can configure the **Policy** screen of a claim to display aggregate limits, lists of insured properties, endorsements, and vehicles.

ClaimCenter defines the possible options within the Policy screen in the **PolicyTab** typelist.

See also

- “Configuring Policy Behavior” on page 461 in the *Configuration Guide*
- “Specifying Policy Menu Links” on page 471 in the *Configuration Guide*

Verifying Coverage

ClaimCenter leverages your organization’s best practices in reviewing the claim’s characteristics. ClaimCenter helps you create exposures that make sense and warns or prevents you from creating exposures that do not. After you create a new exposure, ClaimCenter looks for inconsistencies between a policy’s coverages and the loss party, the loss cause, other existing exposures, and the claimant’s liability.

For example, the following exposure examples do not have sensible relationships between an exposure’s coverage and its loss party, loss cause, other existing exposure, or liability:

- Comprehensive coverage for the auto of a third party—an incompatible loss party.
- Collision coverage for a stolen auto—the wrong loss cause for the coverage.
- Collision coverage for an auto damaged by a windstorm. A collision exposure cannot be created if an exposure based on comprehensive coverage for that auto already exists.
- Coverage for a third party’s auto when the first party is not at fault. The insured has no liability, so there is no need to create an exposure.

In the base configuration, the Coverage Verification feature checks for all these types of incompatibilities. You can define the incompatibilities to check for, except for an incompatible loss party. In that case, you cannot create an exposure. In the other cases of incompatibility, you can create new exposures, but ClaimCenter displays a warning message.

Loss Party

Every exposure in ClaimCenter must be either a first party or a third party exposure. Some exposures, like injuries covered by an auto liability coverage, must always be third party. Other coverages, such as Medical Payments, can cover only a first party.

The **LossPartyType** typelist categorizes exposures by loss party. If you have selected the loss type to be first party, ClaimCenter displays only the coverages categorized for first party loss types. If you have selected third party, ClaimCenter displays only the third party exposure types in this typelist. The categories in this typelist are based on the **CoverageSubtype**, rather than the **ExposureType** typelist.

Because ClaimCenter restricts you to certain combinations of loss party and coverage subtype, you cannot create an incorrect combination, and ClaimCenter never warns you that you have. You cannot edit the table of prohibited combinations, and there are no rules that affect the application’s behavior.

Your typelist can contain exposures categorized as both first and third party, and you must manually edit this file.

Loss Cause

A **LossCause** typically applies to some, but not all, **CoverageTypes**. Examples include:

- **Theft, Fire, and Vandalism** – Appropriate loss causes for comprehensive, but not collision coverages.
- **Collision with Motor Vehicle or with an Animal** – An appropriate loss cause for a collision coverage, but not a comprehensive coverage.

Some coverages, such as Medical Payments, do not have a strong relationship to loss cause. If your business rules specify that certain combinations are prohibited, you can modify your configuration to include them. See “Viewing and Editing Loss Causes and Coverages” on page 102.

ClaimCenter maintains a table of loss cause and coverage pairs that administrators can edit. After creating a new exposure with a pair of values in the table, ClaimCenter displays the following warning:

Warning: This exposure's coverage is not expected due to the claim's Loss Cause: [Loss Cause name]

Note: You can also use LossCause to create rules that govern conditional questions in question sets, to open a subrogation review, or take other ClaimCenter actions.

Viewing and Editing Loss Causes and Coverages

To view this table of inappropriate pairings of loss causes and coverages, navigate to **Administration** → **Coverage Verification** → **Invalid Coverage for Cause**. If you click **Edit** in this table, you can add or delete inappropriate loss cause and coverage pairs to conform with your business rules. For more information, see “Coverage Verification Reference Tables” on page 491.

Incompatible Exposures

Some exposures might not exist when other exposures already exist on the claim. For example:

- If a collision exposure exists on a claim, there is no comprehensive exposure.
- If a medical payments exposure exists on a claim, there is no extraordinary medical payments exposure.

ClaimCenter maintains a table of incompatible exposure pairs that users with administrator privileges can edit. After creating a new exposure with a pair of values in the table, ClaimCenter displays the following warning, but you can still create the exposure:

Warning: This exposure's coverage conflicts with at least one existing exposure: [exposure name]

Viewing and Editing Incompatible Exposures

To view this table of inappropriate exposure pairs, navigate to **Administration** → **Coverage Verification** → **Incompatible New Exposure**.

Click **Edit** to add or delete inappropriate exposure pairs to conform with your business rules. Use the drop-down menu to select exposure names. To remove a table entry, select its check box and click **Remove**. Click **Update** to save your changes.

See “Coverage Verification Reference Tables” on page 491.

Liability

Some exposures require the insured to be at fault and are not needed otherwise. For example, if the insured is entirely at fault, an uninsured motorist exposure is probably incorrect.

ClaimCenter maintains a table of pairs of incompatible exposure and the insured’s liability pairs. Administrators can view and edit this table. After creating a new exposure with an incompatible liability as defined in this table, ClaimCenter shows the following warning, but you can still create the exposure:

Warning: This exposure's coverage is not expected due to the claimant's fault rating: [rating value]

Viewing and Editing Liabilities Incompatible with Exposures

To view and edit the table of inappropriate pairings of fault rating and exposure navigate to: **Administration** → **Coverage Verification** → **Possible Invalid Coverage due to Fault Rating**.

If you click **Edit**, then you can add or delete inappropriate pairs to conform with your business rules. Using a drop-down menu, you can choose exposure names or fault ratings. To remove a table entry, select its check box and click **Remove**. Click **Update** to save your changes. See “Coverage Verification Reference Tables” on page 491.

Coverage Verification

The Coverage Verification feature contains tables of incompatible pairs. Methods scan them and determine if the end user is to receive a warning if a potentially invalid Exposure has been selected.

Coverage verification	Table of incompatibilities	Method to read table
Loss Party incompatible with exposure	none	none
Loss cause	InvalidCoverageForCause	invalidCoverageForCause
Incompatible exposures	IncompatibleNewExposure	incompatibleNewExposure
Liability incompatible with exposure	InvalidCoverageForFaultRating	invalidCoverageForLiability

Note: The Reference Table framework is at the configuration layer. The same techniques described can be used to administer any reference tables added by an implementation.

Aggregate Limits

An *aggregate limit* is the maximum financial amount that an insurer is required to pay on a policy or coverage during a given policy period. An aggregate limit can apply to a policy, a specific coverage, a coverage subtype, a group of coverages, or an account. The purpose of using aggregate limits is to enable ClaimCenter to track the financial transactions made on a claim, and warn you if a preset limit is exceeded.

An aggregate limit effectively caps the insurer's total liability for a specified time. The cap applies regardless of the number of claims made against the relevant policies or the number and variety of exposures represented in the claims. At the highest level, an aggregate limit can apply to a policy or an account. A limit that applies to a single policy establishes a maximum total liability for all of the claims made against that policy. A limit that applies to an account establishes a maximum liability for all claims made against all the policies belonging to that account.

In the base configuration, ClaimCenter displays a warning if the aggregate limit is exceeded by the creation of a reserve or payment. This is simply a warning, and you can still continue to create the reserve or make the payment. You can change this configuration in rule TXV08000 in the Transaction Validation rule set. See “Transaction Set Validation Rules” on page 161 in the *Rules Guide*.

Policy Periods

Policy periods play an important role in aggregate limits. ClaimCenter uses policy periods to do the following:

- **To connect aggregate limits to either accounts or individual policies** – ClaimCenter associates aggregate limits with policy periods, and policy periods identify the policy or policies to which the aggregate limit applies.
- **To distinguish between policy versions** – Policies are typically in effect for a single year or portion thereof. Each year the policy in effect is a different version of the policy, with different effective dates.

See also

- “Understanding Aggregate Limits” on page 461 in the *Configuration Guide*

Adding Aggregate Limits

In a ClaimCenter claim, navigate to Policy → Aggregate Limits to create and view aggregate limits.

Define a new aggregate limit by specifying the following:

- **Applies To** – Applicable account or policy.

An aggregate limit can apply either to an account or to an individual policy, as follows:

- If the policy is part of an account, any aggregate limit you define on that page applies to the account as a whole, rather than to the individual policy.
- If the policy is not a member of an account, aggregate limits defined on that policy's **Aggregate Limits** screen apply only to that policy.

Note: When you add a new aggregate limit, the default selection is **Policy**.

- **Aggregate Type** – Aggregate limit or deductible.
- **Amount** – Aggregate limit amount.
- **Count Towards Limit** – Financial transactions to include in the aggregate limit, based on their cost types and cost categories. These options can be configured in the aggregate limits configuration file, `aggregateLimitUsed-config.xml`.
- **Coverages** – Optionally, one or more coverage types, coverage subtypes, and covered items. You can add coverages with coverage type only or coverage type and subtype or a combination of coverage type, subtype, and covered item.

Adding Coverages

When you create a new aggregate limit, you can optionally add coverage. Each coverage can be a combination of any of the following fields:

- Coverage Type – Displays a preconfigured list of types relevant to the policy type. For example, if you select a commercial property policy, the following Coverage Type selections might be available:
 - Building Coverage
 - Business Income Coverage
 - Business Personal Property - Separation of Coverage (Stock)
 - Business Personal Property Coverage
 - CPBlanket Coverage
 - Extra Expense Coverage

Note: If you choose to add a coverage to an aggregate limit, the Coverage Type is mandatory.

- Coverage Subtype (optional) – Displays a preconfigured list of potential subtypes dependent on the selected Coverage Type. For example, if you select Building Coverage, the following Coverage Subtype might be available:
 - Building Coverage
- Covered Item (optional) – Displays a preconfigured list of potential items that can be covered. The choices in the list are also dependent on the choice of covered type and subtype. For example, if you select Building Coverage as the coverage type and subtype, the following Covered Item might be available:
 - Property #1

See Also

- “Defining Aggregate Limits” on page 463 in the *Configuration Guide*

Archiving Claims with Aggregate Limits

In ClaimCenter, you can archive a claim, even if it has aggregate limits associated with it. On the other hand, new policy-level and account-level limits cannot be created for a claim that has been archived.

When a new aggregate limit is created, ClaimCenter checks if there are existing archived claims in the policy period contributing to the limit.

If there are archived contributing claims for a given policy, the following conditions apply:

- You can change the limit amount, as needed.

- You must specify at least one coverage, including a covered item and a coverage type, for the new aggregate limit. It cannot be defined as a general, policy-wide limit.
- You can create aggregate limits only on coverage types, covered items, and risk units if they are not being used in an archived claim. ClaimCenter displays an error if you attempt to create an aggregate limit on a coverage type, covered item, or risk unit used in an archived claim.
- You can add a coverage as long as it does not match any coverages with transactions used on archived claims.
- You can delete a coverage or the entire aggregate limit.

You can run the aggregate limits batch process, `AggLimitCalc`, as usual, and it calculates the limits incurred for all contributing claims, including archived ones.

Viewing Aggregate Limits

Navigate to **Policy → Aggregate Limits** to see a list of all aggregate limits created on the policy. To view claims contributing to an aggregate limit, click the amount in the **Realized** column. The **Realized by Claim** panel now shows a list of all claims contributing to the selected aggregate limit with the amounts contributed per claim.

Viewing Aggregate Limit Details

In the **Aggregate Limits** screen, click the aggregate type in the **Applies To** column or the amount in the **Realized** column to view the details of an aggregate limit.

The **Aggregate Limit Details** screen includes the following additional information on the aggregate limit:

- **Realized**—The used amount by coverage.
- **Remaining**—The remaining available amount by coverage.

Viewing Contributing Claims

In the **Realized by Claim** pane, you can view the claims contributing to the aggregate limit by Claim Number. Additionally, claim contributions are broken down into the following details:

- **Realized**—The amount used by the claim based on the aggregate limit definition. The calculation used for the **Realized** amount of each contributing claim is available by using the virtual property, `AggregateLimit.FinancialsCalculationDescription`. For policy aggregate limits, ClaimCenter also displays the calculation used in this pane.
- **Net Incurred Contribution**—Sum of all open reserves and total payments minus recoveries that apply to the aggregate limit.
- **Net Paid Contribution**—Sum of all payments minus recoveries that apply to the aggregate limit.

See “Understanding Aggregate Limits” on page 461 in the *Configuration Guide*.

Note: Clicking on a claim number will take you to the claim’s **Financials Summary** screen and away from the **Aggregate Limit Details** screen.

See also

- “Defining Aggregate Limits” on page 463 in the *Configuration Guide*
- For more about policy periods, see the section “Configuring Policy Periods” on page 466 in the *Configuration Guide*.

Policies and the Data Model

Every policy is distinguished by a `PolicyType` typelist, which is the primary way to categorize policies. Main policy types include personal and commercial auto, personal and commercial property, homeowners, liability,

workers' compensation, and so forth. Each typecode in this typelist contains the allowed categories of these other typelists:

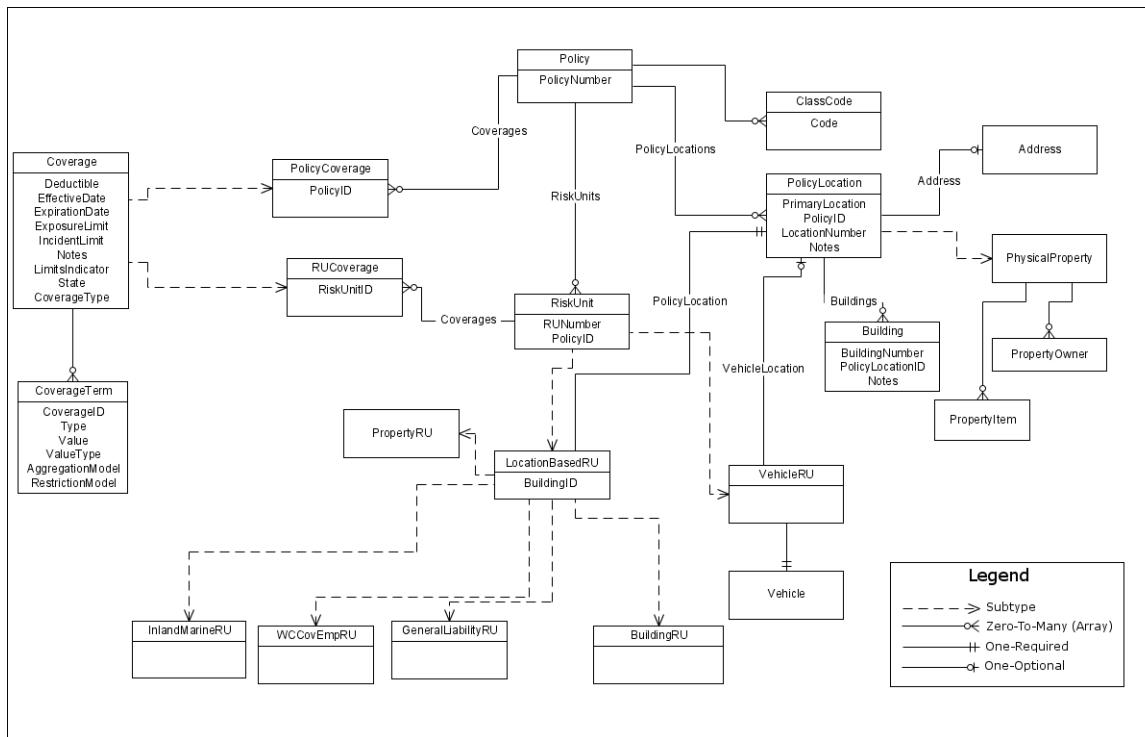
- **LOB Code** – Each policy type is associated with one line of business, as defined in the `LOBType` typelist; a policy type filters this typelist.
- **Coverage Type** – Each policy type is associated with one or more coverage types defined in the `CoverageType` typelist, such as collision, comprehensive, or towing. A policy type also filters this typelist.
- **Internal Policy Type** – Another way to categorize policies. The only allowed values are business and personal. A policy type filters the `InternalPolicyType` typelist.
- **Policy Tabs** – A typelist that describes the possible menu links of the **Policy** screen in a claim. These include **Aggregate Limits**, **Endorsements**, and **List of Insured Vehicles and Properties**. You specify these typecodes to customize the **Policy**. The policy type also filters this `PolicyTabs` typelist.

Policies in ClaimCenter and PolicyCenter

ClaimCenter and PolicyCenter can be integrated so that you can issue a policy in PolicyCenter and then create claims against that policy in ClaimCenter.

In ClaimCenter, the policy object is mostly an informational snapshot. It lists the coverages, limits, and covered items or risks that determine the type of claim and payments you can make on it for a given date. PolicyCenter, however, stores multiple versions of each policy to keep track of all modifications, cancellations, reinstatements, and so on made over time to the policy. In addition, the PolicyCenter model is structured to support all the different options an agent or underwriter has when putting together a policy.

The following example is a diagram of the ClaimCenter data model of Policy:



Claim Policies and the Policy Administration System

ClaimCenter integrates with policy administration systems including PolicyCenter.

See also

- “Policy Administration System Integration” on page 509 for details.
- “Enabling Integration between ClaimCenter and PolicyCenter” on page 97 in the *Installation Guide*.
- “Claim and Policy Integration” on page 511 in the *Integration Guide*.

Accounts and Service Tiers

Account managers can generate specific directions on how to handle a claim. These directions can be in the form of an automatic email, text on the claim screen, or an automatic activity. These special handling instructions can be based on accounts and predefined groups of policies called *service tiers*. They are common in, but not exclusive to, commercial lines of business. For example, a large carrier can request special handling for their claims.

This topic explains how you can:

- Set up and manage accounts.
- Link the claim to the account.
- Set up and manage policy service tiers.

This topic includes:

- “Accounts” on page 109
- “Account Manager Permissions” on page 110
- “Working with Accounts” on page 110
- “Service Tiers” on page 112

See also

- “Special Handling” on page 113.
- “Configuring Special Instructions” on page 583 in the *Configuration Guide*.

Accounts

While the concept of an Account is common across the Guidewire InsuranceSuite, the data modeling of Account is different in ClaimCenter as compared to PolicyCenter. An account represents an organization or person that has one or more policies. A single person or organization can be associated with multiple accounts. An account can have zero, one, or many policies.

In ClaimCenter, for most policies, the account is represented by the `AccountNumber` field on the `Policy` entity. The `Account` entity is only intended to be populated to take advantage of the application’s Special Handling capabilities.

Account Entity

In ClaimCenter, accounts are stored in the Account entity.

The Account entity, created upon claim creation, has the following key fields:

Field	Description
AccountHolder	Foreign key to the Contact entity. Points to the account holder. You can see information from the address book about the account holder in the ClaimCenter user interface.
AccountNumber	The alphanumeric account number comes from the policy administration system or PolicyCenter.
SpecialHandling	Foreign key to AccountSpecialHandling, which is a subtype of SpecialHandling. This field contains any special handling instructions and notification triggers that apply to any claims from policies associated with the account.

Accounts and Policies

Accounts can be associated with zero or more policies. The 40-character AccountNumber text field on both the Policy entity and the Account entity is used to associate policies and claims. To find associations between accounts and policies, you can make a query that returns Policy and Account entity records that have matching AccountNumber fields.

Note: There is no foreign key that links accounts and policies. The data model was designed this way to keep the account out of the claim graph. The *claim graph* is the set of all entities owned by the claim. It is used to archive and purge both the claim and data that is unique to the claim. Keeping the account out of the claim graph prevents it from being purged or archived with a claim.

Account Manager Permissions

The Account Manager is the administrator of accounts in ClaimCenter. In the base configuration, the Account Manager role has the permission to set up account information on the **Administration → Special Handling → Accounts** page.

Account Permissions

The Account Manager role has the following permissions:

Permission	Code	Description
Manage Account	accountmng	Permission to add, edit, or delete accounts.
View Account	accountview	Permission to view accounts.

In the base configuration, this role has been added to the Super User user with the login, su.

Working with Accounts

On the **Administration → Special Handling → Accounts** screen, users with the Account Manager role can perform the following account-related tasks:

- Add an Account by specifying an Account Number and an Account Holder.
- Edit an Account by changing one or both of its Account Number or Account Holder fields.
- Delete an Account.

- Add, modify, or delete **Special Handling** instructions, including:
 - Automated notifications
 - Automated activities
 - Other instructions

Defining Accounts

To define an existing account, click the account number on the **Administration → Special Handling → Accounts** screen to open the **Detail** tab for that account.

Click **Edit** to edit the following fields:

- **Account Number** – The account number must correspond to the value of the **AccountNumber** field of a verified policy. You must find it and enter it manually, rather than browse to it, since it designed not to be directly linked to **Policy.AccountNumber**. See “**Account Entity**” on page 110 for more information.

You can find the policy’s account number by:

- Clicking an applicable claim’s **Policy** link to access the **Policy: General** screen where the policy account number is listed under the **Insured** header.
 - Finding it in a policy administration system or paper copy of the policy.
- **Account Holder** – In the data model, this is the **Account.AccountHolder** field. The value of this field is set to a valid contact. Browse for a contact and add the name.

Once the **Account Holder** is defined, you can click the name to access the contact details. If the contact information is linked to the **Address Book**, any changes made to the contact’s information in the **Address Book** are updated and can be viewed in the claim.

WARNING Refreshing a policy updates the policy snapshot’s account information, specifically the **AccountNumber**. If the account number is changed due a refresh, the policy snapshot for that claim is automatically disassociated from accounts having the old **AccountNumber**. The policy snapshot is also automatically associated with any other accounts that have the new **AccountNumber**. Other policies where the same account number changed on the policy must be refreshed at the same time. If they are not, the group of policies in the account becomes incomplete or distributed over more than one account.

To add an account

1. In **Administration → Special Handling → Accounts**, click **Add Account**.
The **New Account** screen shows.
2. Enter the **Account Number**.
3. Find the **Account Holder** by browsing to a contact in the **Address Book**.
4. Click **Update**.

To edit an account

1. In **Administration → Special Handling → Accounts**, click the account number of the account to be edited.
In the **Detail** tab, click **Edit**.
2. Modify the **Account Number**, if needed. Change the **Account Holder**, if needed.
3. Click **Update**.

To delete an account

1. In Administration → Special Handling → Accounts, select the check box next to the account to be removed. You can delete one or more accounts.

2. Click Delete.

ClaimCenter warns you that if you delete the account, it may affect existing policies that reference the account.

Click OK.

Service Tiers

Special handling can be applied to predefined groups of policies called *service tiers*. A service tier represents the customer service associated with a claim and categorizes policies by their level of importance. Policies can be set up to be associated with a policy tier, such as platinum or gold, and you can define a set of special handling instructions for each tier. These additional steps are implemented during claim processing for all claims associated with policies in a service tier.

For example, if a policy is at the Bronze service tier, an associated claim might receive an activity to follow up with a letter to the insured within 48 hours. If the policy is at the Silver tier, you might follow up with an activity to contact the insured with a letter mailed within 24 hours. Finally, if the policy was at the Gold tier, you might follow up with an activity to have the adjuster contact the insured through a phone call within 24 hours.

In the base configuration, two service tiers are provided as samples – Platinum and Gold. The Silver service tier is available, but not activated. The **Policy:General** screen displays service tier information, if any. Service tiers are represented by the typelist attribute, **CustomerServiceTier**, on the **policy** entity.

Adding Service Tiers

You can activate an existing service tier by adding it in the Service Tiers screen.

Note: The service tier must be included in the **CustomerServiceTier** typelist in order to be available in the ClaimCenter Administration menu. See “Adding Service Tiers” on page 584 in the *Configuration Guide*.

To activate a service tier

1. In Administration → Special Handling → Service Tiers, select Add Service Tier.

2. In the New Service Tier screen, select the Name of the service tier. The drop-down list only displays preconfigured service tiers that have not been activated.

3. Select Update.

Deleting Service Tiers

You can deactivate a service tier by removing it in the Service Tiers screen.

To delete a service tier

1. In Administration → Special Handling → Service Tiers, select the service tier to be deleted. Only active service tiers are shown.

2. Select Delete.

3. ClaimCenter displays a warning that this might impact existing policies that reference the service tiers. Select OK to confirm.

Special Handling

In the case of critical customer accounts or for a certain segment of customers, ClaimCenter can be configured to include enhancements during claims processing, collectively referred to as *special handling*.

Special handling enhancements can be of three different types:

- Automated notifications
- Automated activities
- Other instructions (claim headline comments)

Special handling instructions are triggered by two kinds of events:

- Changes in claim indicators
- Changes in financials, such as when financial thresholds are exceeded (triggered on financial transactions only)

Automated Notifications

Special handling notifications are emails that are sent typically to involved parties who are not ClaimCenter users, such as underwriters or brokers. These emails can be created and sent automatically when a claim indicator or financial indicator event trigger is fulfilled.

Email notifications can be sent to single or multiple recipients and are, in appearance, similar to other emails sent in ClaimCenter. Emails can be sent to email addresses or to a person with a specific role on the claim.

Automated Activities

Special handling activities are generated to notify users to perform certain tasks when a claim indicator or financial indicator event trigger is fulfilled.

Other Instructions

Other instructions for special handling are free text comments that can be accessed from the claim headline. These are usually informative in nature.

Examples of Special Handling

- The account manager for a commercial auto policy carrier creates an automated notification, which is triggered when an insured party files a claim with a fatality. When this happens, ClaimCenter automatically sends an email to the carrier's broker, alerting them to the event.
- A department manager sees an activity to write up a Large Loss analysis if certain claims have a loss over a certain threshold.
- The account manager decides to create a set of instructions that will appear on a claim screen but do not need an activity or email notification sent. In this example, an account tends to handle a high volume of claims that involve litigation, but there might not be a specific name in the contact list to notify. So the text might state who the point of contact is along with the contact's email and phone number. It could also state that investigations must not take place during peak hours, and then define what those hours are.
- In a set of instructions, the claim triggers the litigation indicator, meaning that the claim is now in litigation. The adjuster must print all the claim screens and mail them to the account's law firm. The instructions indicate the contact person's name and mailing address.

Special handling instructions can be associated with policies on a specific account or a predefined policy group or *service tier*. The following sections describe these options in detail.

Adding Special Handling Instructions

Typically, special handling instructions are executed for claims generated against policies on large, high-value accounts. Special handling instructions can be assigned to accounts or service tiers. Accounts are identified by the account number in the **Administration → Special Handling → Accounts** screen. Service tiers can be selected in the **Administration → Special Handling → Service Tiers** screen.

You can add an automated notification, an automated activity, or other instructions.

Working with Automated Notifications

ClaimCenter can be instructed to create automatic notifications based on claim indicator events or financial events.

To create an automated notification for a Claim Indicator event

1. Navigate to **Administration → Special Handling → Accounts** or **Administration → Special Handling → Service Tiers** and select an account number or a service tier. The **Detail** screen opens.
2. Click the **Special Handling** tab.
3. In the **Automated Notifications** table, click **Add → Create automated notification for Claim Indicator Event**.
The **New Automated Notification** screen opens.
4. Select a policy type, such as **Commercial Property**, if you need to limit the claim indicator trigger to a specified policy type. The default is **All Policy Types**.
5. Select the type of indicator that you want to be notified of. The following indicators can be used as triggers on the claim:
 - Coverage in Question – The claim's coverage is in question.
 - Fatalities – The claim involves one or more fatalities.
 - Flag Details – The claim is flagged.
 - Large Loss – The claim involves a large loss. The claim's Net Total Incurred value is greater than the Large Loss Indicator value.
 - Litigation – The claim's litigation status is Open.
 - SIU – The claim is under special investigation.

6. Select Turns On or Turns Off.

You can turn the event trigger on or off. For example, you might want to be notified if, for some reason, the litigation indicator is turned off. A notification is then sent to the manager to check on the resolution.

7. Search and select the Email Template to use for your notification. Enter a topic or keyword to filter the results, and click Search.

Note: The default template is Claim Indicator Automated Notification. The **Keywords** field defaults to the values for this template `automatednotificationhandler`, `ClaimIndicatorTrigger`.

8. Enter the Notification Type. Select single or multiple email recipients or Contact based on claim role.**9. Enter the email address of the person or persons to receive the notification, or enter the claim contact role. If a role is selected, ClaimCenter retrieves the email address of the claim contact.****10. Click Update.**

In the base configuration, you can see a copy of the generated email in the **Documents** section. You can disable this through configuration. Email templates are created and edited in Studio. Refer to “Creating an Email Template” on page 139 in the *Rules Guide*.

To create an automated notification for a Financial event**1. Navigate to Administration → Special Handling → Accounts or Administration → Special Handling → Service Tiers and select an account number or a service tier. The Detail screen opens.****2. Click the Special Handling tab.****3. Under Automated Notifications, click Add → Create automated notification for Financial event.**

The **New Automated Notification** screen opens.

4. Select a policy type, if you need to limit the financial trigger to a specific type of policy. The default is All Policy Types.**5. Select the type of Threshold. The threshold type, along with the threshold amount, forms the basic condition for the notification. When the claim amount reaches the threshold amount value for the specified threshold type, the special handling instruction is created.**

Select one of the following:

- Net Total Incurred
- Net Total Paid
- Total Paid

Note: See “Claim Metric Limits” on page 502 for more information on how these threshold values are calculated in ClaimCenter.

6. Enter a Threshold Amount.

The email is created and sent out when the claim amount reaches this value.

7. Search and select the Email Template to use for the notification. Enter a topic or keyword to filter the results, and click Search.

Note: The default template is Financial Automated Notification. The **Keywords** field defaults to the values for this template, `automatednotificationhandler`, `FinancialThresholdTrigger`.

8. Enter the Notification Type. Select single or multiple email recipients or Contact based on claim role.**9. Enter the email address of the person or persons to receive the notification, or enter the claim contact role. If a role is selected, ClaimCenter retrieves the email address of the claim contact.****10. Click Update.**

Working with Automated Activities

Automated activities are created and generated in a similar way to notifications, but the result is an activity instead of an email. Activities are defined in activity patterns, and you need administrator permissions to create activity patterns. See “Understanding Activity Patterns” on page 225 for details.

To create an automated activity for a Claim Indicator event

1. Navigate to Administration → Special Handling → Accounts or Administration → Special Handling → Service Tiers and select an account number or a service tier. The Detail screen opens.
 2. Select the Special Handling tab.
 3. Under Automated Activities, click Add → Create automated activity for Claim Indicator Event.
The New Automated Activity screen opens.
 4. Select a policy type, if you need to limit the trigger to a specific type of policy. The default is All Policy Types.
 5. Select the type of indicator that you want to be notified of. The following indicators can be used as triggers on the claim:
 - Coverage in Question – The claim's coverage is in question.
 - Fatalities – The claim involves one or more fatalities.
 - Flag Details – The claim is flagged.
 - Large Loss – The claim involves a large loss. The claim's Net Total Incurred value is greater than the Large Loss Indicator value.
 - Litigation – The claim's litigation status is Open.
 - SIU – The claim is under special investigation.
 6. Select Turns On or Turns Off.
 7. Select an activity pattern. Choices in the base configuration are:
 - Consult Account regarding fatality
 - Produce claim strategy narrative
 - Review all Special Handling instructions
 - Review denial decision with Account Manager
 - Review matter-related Special Handling instructions
 - Review negotiation strategy with Account

Note: An activity pattern must be configured for special handling. See “Configuring Activity Patterns for Special Handling” on page 586 in the *Configuration Guide*.
 8. You can optionally choose to Override Email Template. Browse to select an email template if there is no default one associated with the activity pattern, or you can override the default email template on the activity pattern. In the generated activity, there is an option to Send email that the person viewing the activity can use. No email is generated automatically.
 - Note:** The Keywords field defaults to automatedactivityhandler, ClaimIndicatorTrigger.
 9. Click Update.
- ### To create an automated activity for a Financial event
1. Navigate to Administration → Special Handling → Accounts or Administration → Special Handling → Service Tiers and select an account number or a service tier. The Detail screen opens.
 2. Select the Special Handling tab.

3. Under **Automated Activities**, click **Add → Create automated activity for Financial Event**.
The New Automated Activity screen shows.
4. Select a policy type, if you need to limit the financial trigger to a specific type of policy. The default is **All Policy Types**.
5. Select the type of **Threshold**. The threshold type, along with the threshold amount, forms the basic condition for the notification. When the claim amount reaches the threshold amount value for the specified threshold type, the special handling activity is generated.
6. Enter a **Threshold Amount**.
The activity is generated when the claim amount reaches this value.
7. Select an activity pattern. Choices in the base configuration are:
 - **Consult Account regarding fatality**
 - **Produce claim strategy narrative**
 - **Review all Special Handling instructions**
 - **Review denial decision with Account Manager**
 - **Review matter-related Special Handling instructions**
 - **Review negotiation strategy with Account**
8. You can optionally choose to **Override Email Template**. Browse to select an email template if there is no default associated with the activity pattern, or you can override the default email template on the activity pattern. In the generated activity, there is an option to **Send email** that the person viewing the activity can use. No email is generated automatically.
Note: The **Keywords** field defaults to `automatedactivityhandler, FinancialThresholdTrigger`.

9. Click **Update**.

Working with Other Instructions

You can create detailed instructions, special handling **Other Instructions**, that are included in the claim headline. These appear as read-only text on claims that are generated on policies in the account and can be viewed by clicking **View Other Instructions**.

These instructions can be generated when specific claim events occur, such as when a new claim is created or when a claim goes into litigation. These claim event triggers for other instructions are grouped under **Instruction Category**. The **Instruction Type** that you set depends on the selected **Instruction Category**.

To create other instructions

1. Navigate to **Administration → Special Handling → Accounts** or **Administration → Special Handling → Service Tiers** and select an account number or a service tier. The **Detail** screen opens.
2. Click the **Special Handling** tab.
3. Under **Other Instructions**, click **Add**.
The **Other Instruction** screen opens.
4. Select a policy type, if you need to limit the instructions to a specific type of policy. The default is **All Policy Types**.
5. Set the **Instruction Category** from the drop-down list. These claim events, such as when a new claim is created or when a claim goes into litigation, cause instructions to be generated.
6. Set the **Instruction Type**. This depends on the **Instruction Category**.
7. Enter **Comments**, if any. Click **Update**.

Importing Special Handling Instructions

With administrative permissions, you can import account and special handling data by navigating to **Administration** → **Utilities** → **Import Data** and then choosing the file to import. See “Importing and Exporting Administrative Data from ClaimCenter” on page 115 in the *System Administration Guide*.

IMPORTANT If you import an account and special handling XML file, ClaimCenter creates instances of the entities defined in the file. Do not delete these instances in a production environment, because doing so will prevent ClaimCenter from starting.

Exporting Special Handling Instructions

With administrative permissions, you can export account and special handling data by navigating to **Administration** → **Utilities** → **Export Data**. Then, choose **Special Handling** in the **Data to Export** field. The exported XML file contains all account information and associated special handling instructions, if any.

See “Importing and Exporting Administrative Data from ClaimCenter” on page 115 in the *System Administration Guide*.

Claim History

Each claim has a non-editable **History** screen that provides an audit trail of a claim's actions. ClaimCenter records events associated with a claim, including minor events, such as each time a claim is viewed. To access a claim's history, open the claim and click **History** in the sidebar.

The **History** screen has a count of the history items at the top. There can be multiple pages if there are a lot of items. Below the title bar are the following controls:

- **Drop-down list on left** – Filter the history list by the type of event, chosen from this drop-down list.
- **Refresh** – Show the latest list of history events for the last filter used.

This topic includes:

- “Content of a Claim History” on page 119
- “Adding History Events” on page 121

Content of a Claim History

You open the **History** screen by opening a claim and clicking **History** in the sidebar. Claim history displays in a sortable list view. The list view has the following columns:

- **Type** – The claim event causing the history entry. Events include the claim's being opened or viewed, an exposure's being closed or reopened, a stopped check, and so on. Late in this topic is a full list of the events that are recorded.
- **Related To** – Whether the event relates to the entire claim or one of its parts, such as an exposure or reserve line.
- **User** – Person who caused the event.
- **Event Time Stamp** – Date and time the event occurred.
- **Description** – Brief description of the event. You can add your own entries through the use of rules that create custom history events. See “Adding History Events” on page 121 for more information.

Following are the types of history events supported in the base configuration, as shown in the HistoryType type-list:

History event type	Description
Activity due date changed	The due date of an activity was changed.
Activity escalation date moved	The escalation date on an activity was changed.
Approval or Rejection	An item or transaction on this claim was approved or rejected.
Archived	Claim was archived.
Assigned	The claim or one of its exposures was assigned.
Catastrophe warning	The claim was identified as being eligible for inclusion as a listed catastrophe.
Check deleted	A check was deleted.
Check stopped	A check was stopped.
Check transferred	A check was transferred to another claim, but not otherwise changed.
Check voided	A check was voided.
Closed	The claim or one of its exposures or matters was closed.
Custom	A custom history event occurred. Custom history events are defined in the CustomHistoryType typelist.
Flagged	An indicator status was changed.
Imported	A claim or exposure was imported.
Litigated	A lawsuit was filed against the claim.
Opened	A new claim or exposure was opened.
Policy edited	A policy was edited, and thus marked as unverified.
Policy selected or refreshed	A different policy was used for the claim, or the existing policy was refreshed.
Reopened	The claim or one of its exposures or matters was reopened.
Retrieved	An archived claim has been retrieved from the archive.
Viewed	The claim or one of its exposures was opened and viewed by a user.

Claim Viewing History

Viewing is an event that notes each time the claim is opened. This event is helpful in tracking whether an adjuster has been working on a claim or if non-authorized users have been viewing claims.

Financial Transaction History

The history of a claim does not include specific transaction events. However, all actions requiring approval do become part of this history, so all financial events requiring approval are present. You can include other financial events in the history by creating custom history event rules.

The claim itself keeps a record of all transactions and checks. To view them, see “Viewing a Summary of a Claim’s Existing Transactions” on page 315.

Another type of financial action that becomes a part of the history is when a check is denied downstream. If the check’s related payment has closed an exposure or claim, the reopening that occurs is noted in the history. See “Downstream Denials of Recoveries and Checks” on page 322.

Claim History of a Policy

ClaimCenter displays another kind of history upon claim creation in the New Claim wizard. After you search for a policy, adjusters can view the policy’s claim history. See “Selecting a Verified Policy” on page 81 for the details of this history.

Adding History Events

Although you cannot rewrite the claim history, you can add to it. You can write rules in Guidewire Studio to monitor the claim and determine if a specific change has occurred. The rules can then write an entry into the History screen. For an example, see the [ClaimPreupdate rule CPU13000 - Catastrophe History](#).

You can add your own types of events to the `CustomHistoryType.ttx` typelist, and then create rules that add the event to the history. The following table lists the event types in `CustomHistoryType` in the base configuration.

Custom history Event type	Description
Auto: No Fault rating	Claim exception: fault rating is not set on auto claim.
Create recovery bill	Create an invoice to bill for a recovery.
Data change	Any claim data has changed.
Email sent	An email was sent.
Exported to mainframe	Integration: New claim exported to mainframe.
Exposure with no reserves	Claim exception: no reserve is set for an exposure.
Guidewire catastrophe rules	There was a change to catastrophe values.

Archiving

The Archiving feature in ClaimCenter enables you to move aged, closed claims from the ClaimCenter database to an archive data store from which they can be retrieved.

This topic includes:

- “Archiving Overview” on page 123
- “ClaimCenter Preparations for Archiving” on page 125
- “Archiving Item Writer Batch Process” on page 126
- “Claims and Claim Entities that are not Archived” on page 127
- “Searching for Archived Claims” on page 129
- “Retrieving Archived Claims” on page 131
- “Purging Archived Claims” on page 133
- “Configuring Claim Archiving” on page 133
- “More Information on Archiving” on page 133

Archiving Overview

In ClaimCenter, you generally archive a claim if preserving access to the claim’s information fulfills a business need, such as litigation or proof of regulatory compliance. Claims that have this type of enduring future use are often archived. If they do not serve such a purpose, they are typically purged instead. Archived claims can be retrieved and activated again.

Note: Archived claims are not stored in the database in the base configuration of ClaimCenter. A claim to be archived is converted to XML and stored as a document. You must implement your own storage mechanism for archived claims.

A claim must be closed before it can be archived. Even if a claim is closed, it might not qualify for archiving. For more information, see “Claims and Claim Entities that are not Archived” on page 127.

Because archived claims have a potential future business use, it is important that they be searchable and accessible for review or reactivation. ClaimCenter keeps a summary of archived claims in its database and enables you to search for them and retrieve them if needed.

You can retrieve the claim from the archiving data store into the current ClaimCenter database. For example, you might need to:

- View more than just the summary information of the archived claim.
- Work on the claim.

After you retrieve an archived claim, it behaves like any other closed claim in ClaimCenter.

Archiving Components

In the base configuration, ClaimCenter supports archiving with the following three components:

- **Archiving Item Writer Batch Process** – Converts aged, closed claims from the ClaimCenter database to XML documents and then moves them to an archiving data store for long-term retention.

The archive batch process performs the following steps:

- Reads Guidewire internal and user-defined rules to skip or exclude certain claims that are otherwise eligible for archiving based on their closed status and age.
- Calls a class, `ClaimInfoArchiveSource`, that implements the `IArchiveSource` plugin interface to store the claim's XML representation in the archiving data store.
- Writes summary information to `ClaimInfo` and other Info entities to enable searching on the archived claims.

See “Archiving Item Writer Batch Process” on page 126.

- **Archive Search Interface** – Finds summary information about archived claims by using the following entities:

- `ClaimInfo`
- `ClaimInfoAccess`
- `ClaimInfoSearchView`
- `ClaimInfoCriteria`
- `ContactInfo`
- `LocationInfo`

See “Searching for Archived Claims” on page 129.

- **Archive Retrieval Process** – Retrieves archived claims from the data store and puts them back in the ClaimCenter database for display and use in the ClaimCenter application.

This process relies on the `ClaimInfoArchiveSource` class to interact with the archiving data store. The data that was originally written to the Info entities during the archive batch process is deleted when the claim is successfully retrieved and stored.

You can use the `ClaimInfoArchiveSource` and `ArchiveSource` classes as templates to write your own class to retrieve archived claims. For example, you might want to leave the archived claim in the archiving data store or remove it.

Note: If you create your own class, you must register it as a plugin in the `IArchiveSource.gwp` plugin registry.

Deciding Whether or Not to Enable Archiving

Archiving in ClaimCenter is not enabled in the base configuration because not all ClaimCenter installations benefit from archiving. The main reason to archive claims is to improve ClaimCenter performance in high volume systems or in ClaimCenter systems deployed on lower-capacity hardware.

If the hardware used in your ClaimCenter deployment is adequate to handle your claim volume, you might see no advantage in archiving. In this case, it might make sense to keep all claims in the active ClaimCenter database.

until they no longer serve any business need, and then purge them. You do not have to create and maintain a separate archiving data store.

After evaluation, if you find that you need to use archiving, you can enable and implement archiving as documented in:

- “Configuring Archiving for Development Testing” on page 52 in the *Installation Guide*
- “Enabling Archiving or Disabling Archiving Work Queue” on page 101 in the *Installation Guide*
- “Archiving Integration” on page 575 in the *Integration Guide*

ClaimCenter Preparations for Archiving

ClaimCenter uses the archiving framework to:

- Set the boundary of the entire claim so that all its relevant objects can be correctly identified and archived during the archive batch process.
- Define the summary information that is written to the ClaimCenter database to enable locating this archived claim later.

Defining the Claim Boundary

The boundary of the claim for purposes of archiving is defined by its domain graph. In ClaimCenter, the domain graph is also known as the claim graph, and its root entity is the `Claim` object.

The claim graph starts at the entity `Claim` and proceeds outward to all entities that:

- Implement `Extractable`
- Are directly or indirectly owned by the `Claim` entity through foreign key relationships

Entities included in the claim for archiving purposes are the policy snapshot, incidents, exposures, notes, calendars, activities, matters, and the claim’s access control lists (ACLS).

As ClaimCenter creates a claim, it also creates a `ClaimInfo` entity instance, which implements the delegate `RootInfo`. The `ClaimInfo` instance remains in the active database after ClaimCenter archives the claim.

See also

- “The Domain Graph” on page 239 in the *Configuration Guide* for an explanation of what the domain graph is and how to use it.
- “Domain Graph Parameters” on page 53 in the *Configuration Guide*.

WARNING Incorrect configuration of the domain graph can prevent the application server from starting.

Defining Claim Summary Data

ClaimCenter uses claim summary data to search for and review archived claims without retrieving them. Claim summary data is written to the ClaimCenter database when the claim is archived. It is deleted from the ClaimCenter database if the claim is retrieved.

Claim summary data is written into `ClaimInfo` and entities associated with `ClaimInfo`. The entities include the root entity `ClaimInfo`, as well as `ContactInfo`, `LocationInfo`, `ClaimInfoAccess`, and `CoverageLineMatchDataInfo`.

`ClaimInfo` and these other associated entities serve multiple purposes:

- They contain enough information to retrieve the original claim, such as the `ClaimNumber`.

- They enable searching for the archived claim.
- They enable you to see summary information about an archived claim.

These purposes can overlap. For example, `ClaimNumber` in `ClaimInfo` is useful for all three purposes. The `PolicyNumber` in `ClaimInfo` is useful for searching and summary information. The `LocationInfo` entity is used only for summary information.

A `ClaimInfo` entity instance retains all links to bulk invoices, aggregate limits, and claim associations. This linkage permits a retrieved claim to remain connected to these multi-claim entity instances, which are outside the domain graph and therefore always in the ClaimCenter database.

When a claim is archived, the `CoverageLineMatchDataInfo` entity keeps track of coverage lines with transactions. This tracking is useful for preventing the creation of additional coverage lines that might match these transactions while the claim is still archived.

You can extend these Info entities. An example would be if you have added new entities and want information on them to be available when the claim is archived.

See also

- “Info Entities and their Part in Search” on page 129
- “Archiving Claims with Aggregate Limits” on page 104

Archiving Item Writer Batch Process

The archive batch process, Archiving Item Writer, and its work queue operate on closed, aged claims and do two things with a claim’s data:

- Store the entire claim in the archiving data store.
- Retain enough of the claim’s information in the ClaimCenter database to make it possible to find the archived claim and retrieve it.

Note: In the base configuration, this batch process is not visible in the `Server Tools` tab. You must set the `ArchiveEnabled` configuration parameter in `config.xml` to `true` and restart ClaimCenter to see it.

ClaimCenter archives claims based on the value of `Claim.DateEligibleforArchive` and other claim data described later in this topic. For the archive batch process, if the value of `DateEligibleforArchive` is in the past, the claim qualifies for initial evaluation. The `ClaimClosed` rules in the base configuration set this value when the claim is closed. The value is the sum of the date the claim is closed plus the value of the `DaysClosedBeforeArchive` configuration parameter in the `config.xml` file. See “Archive Parameters” on page 36 in the *Configuration Guide*.

You can write `ClaimClosed` rules to set `DateEligibleforArchive` to a different value.

To process these eligible closed claims, run the archive batch process in one of two ways:

- Configure the scheduler to run the process at defined intervals. For more information, see “Configuring Distributable Work Queues” on page 128 in the *System Administration Guide*. See also “Scheduling Batch Processes and Work Queues” on page 143 in the *System Administration Guide*.
- Use the `Server Tools` page to start a single run of the Archiving Item Writer batch process. Alternatively you can run the batch process from the command line by navigating to `ClaimCenter/admin/bin` and entering `maintenance_tools -password password -startprocess archive`. For general information, see “Running Batch Processes and Work Queues” on page 126 in the *System Administration Guide*. See also “Archiving Item Writer” on page 130 in the *System Administration Guide*.

Running the batch process causes ClaimCenter to do the following:

1. Queue the claims that are active for which `DateEligibleForArchive` is in the past and the `ExcludeFromArchive` flag is not set on the claim’s `ClaimInfo` entity instance.

The Archiving Item Writer performs a simple query to find all initially eligible claims based on the `DateEligibleForArchive`. Claims marked as excluded from archiving are not returned.

2. The Archiving Item Writer does a series of verifications to determine which eligible claims to reject. These verifications, which are not configurable, include:

- Verifying the date again and skipping it for this iteration if the date is no longer eligible.
- Rejecting any claim with any active messages or workflows and skipping it for this iteration.

Note: Skipped claims might be eligible again the next time the Archiving Item Writer runs. Excluded claims are removed from eligibility until their `ExcludeFromArchive` fields are cleared.

3. Rules in the `Archive → DefaultGroupClaimArchivingRules` rule set mark claims that must not be archived. These rules can mark claims either to be skipped for the current run of the batch process or to be excluded from all future runs of the batch process. You can configure these rules. In the base configuration, these rules cause claims to be skipped that:

- Are not closed. Claims that were reopened since the archive process started.
- Are linked to a bulk invoice item with a status of Draft, Not Valid, Approved, Check Pending Approval, or Awaiting Submission.
- Have open activities.
- Have vendor reviews that are incomplete or not yet synchronized with ContactManager.
- Have transactions that have yet to be escalated or acknowledged.

4. Use the claim graph to tag entities in claims that pass the exclude and skip rules.

5. Convert tagged entities on each claim to an XML stream.

6. Write data to the XML archive file and the Claim Center database as follows:

- a. Call a plugin implementing the `IArchiveSource` interface to store XML in the archive file.
- b. Delete the claim from ClaimCenter, creating a Claim Archived History record on the claim.
- c. Write data to Info entities, including any additional data defined in the `IArchiveSource` plugin implementation.

In the base implementation, ClaimCenter calls the method `updateInfoOnStore` on the plugin implementation `gw.plugin.archiving.ClaimInfoArchiveSource`. You cannot edit this class, but you can use it and the `ArchiveSource` classes as guidelines for your own class. If you want different behavior, you must write your own class that implements `IArchiveSource` and register the class in the `IArchiveSource.gwp` plugin registry.

You can also extend the existing Info entities or create new ones to preserve more information in the ClaimCenter database than can be stored in `ClaimInfo`, `ContactInfo`, and `LocationInfo`.

7. Generate a `ClaimInfoChanged` event to indicate whether archiving succeeded or failed.

8. Write information on the archive batch process to the data store and to ClaimCenter logs. Some of the ClaimCenter log data is viewable from the `Server Tools` page.

Claims and Claim Entities that are not Archived

In the base configuration of ClaimCenter, there are a number of entities associated with claims that cannot be archived. Additionally, it is not possible to archive all claims. There are internal conditions that cannot be configured that prevent a claim from being archived. Finally, there are rules that mark claims to be excluded or skipped. These rules can be configured.

Entities That Cannot Be Archived

In the base configuration of ClaimCenter, it is not possible to archive the following entities:

- BulkInvoice
- ClaimInfo
- ClaimAssociation
- AggregateLimit
- PolicyPeriod

Non-configurable Exclusions from Archiving

In the base configuration, the following conditions are evaluated internally and prevent ClaimCenter from archiving a claim or a claim entity. These conditions are not configurable.

Condition	Description
Claims with pending messages	The pending messages table must be empty. It cannot contain messages that have been sent. It is unlikely that an old, closed claim will be in this condition. If it is, the archiving batch process skips this claim and tries later, until it finds that there are no more active messages.
Claims that are part of an unfinished workflow	It is not possible to archive a claim that has an active workflow.
Previously excluded claims	Claims already marked as excluded are not processed for archiving.
Claims for which DateEligibleForArchive is null or in the future	You can set the DateEligibleForArchive field and make settings that affect its value. However, you cannot configure ClaimCenter to archive a claim when this value is null or has a date that has not yet occurred.

Configurable Exclusions from Archiving

In the base configuration, the following conditions are evaluated in the **DefaultGroupClaimArchivingRules** rule set and the claims are marked to be skipped during archiving. These rules are configurable.

Condition	Description
The claim is open.	A claim cannot be archived if it was reopened between the time the claim was queued for archiving and the time the archive batch process processes it. The rule ARC01000 - Claim State Rule marks such claims to be skipped during archiving.
The claim is linked to a bulk invoice item with a status of Draft, Not Valid, Approved, Check Pending Approval, or Awaiting Submission.	A claim cannot be archived when it is linked to a bulk invoice item with one of these statuses. Archiving the claim might force the user to retrieve the claim when the item is ready to be escalated. The In Review and Rejected statuses do not prevent archiving, since an invoice item can retain those statuses long after its bulk invoice is escalated and cleared. This behavior is defined in the rule ARC03000 - Bulk Invoice Item State Rule.
The claim has open activities.	Claims with open activities are not archived. If a claim were archived with open activities, those activities would disappear from the owner's Desktop and would not be found or closed unless the claim was retrieved. The rule ARC04000 - Open Activities Rule marks claims with open activities to be skipped during archiving. This rule is run in case an activity was opened between the time a claim was queued for archive and the time the archive batch process processes it. The rule skips the claim. Guidewire recommends that you not modify this rule.

Condition	Description
The claim has vendor reviews that are incomplete or not yet synchronized with ContactManager.	Claims with incomplete or unsynchronized vendor reviews cannot be archived until the reviews are completed and synchronized. The rules ARC05000 - Incomplete Review Rule and ARC06000 - Unsynced Review Rule mark these claims to be skipped during archiving.
The claim has transactions that have not been escalated or acknowledged.	Claims with unescalated or unacknowledged transactions cannot be archived until the transactions are escalated or acknowledged. The rule ARC07000 - Transaction State Rule marks these claims to be skipped during archiving.

Searching for Archived Claims

Archiving claims, instead of simply purging them, enables you to review or reopen the claims to accomplish a business purpose.

The ClaimCenter claim search pages at **Search tab** → **Claims** enable you to locate claims that have been archived. ClaimCenter provides a search against archived claims on both the **Simple Search** and the **Advanced Search** pages. The search query elements on these pages use fields that are written to ClaimCenter Info entities at the time of claim archiving.

- **Simple claim searches** – The query fields in the **Simple Search** page are a subset of those found in **ClaimInfo** entity, **ContactInfo** entity, and other Info entities. Using these fields, **Simple Search** can find both active and archived claims. **Simple Search** shows active claims in the search result set in the **Simple Search** page and provides a link to the **Advanced Search** screen for viewing archived claims.
- **Advanced claim searches** – The query page for active claim searches can contain fields that are not on Info entities. The query page for archived searches has fields that are only on the Info entities. The **Source** drop-down list enables you to search for either active or archived claims.

Info Entities and their Part in Search

In ClaimCenter, when a claim is archived, a set of summary information about the claim is stored in entities called Info entities. These entities and their creation are described in “Defining Claim Summary Data” on page 125. The data stored in these entities determines:

- How search queries are formed against archived claims.
- Who can view a given archived claim in a search results set.

It is useful when designing your archiving implementation to establish the reasons that you want to retrieve claims from the archive. These reasons determine the set of query fields you provide on the ClaimCenter **Simple Search** and **Advanced Search** screens. The fields you provide will determine whether you need to extend the provided Info entities or create new ones.

For example, you might need to revisit some legal issues with catastrophe claims. To do so, you create fields on Info entities that enable finding archived claims filed in connection with catastrophes. You can extend the **ClaimInfo** entity to include these fields. Optionally, you might want to create a whole new **CatastropheInfo_Ext** entity to make this information available for search and display.

You can also use Info entities to limit who can see particular claims in a search query results set. The **ClaimInfoAccess** entity determines who can view each archived claim in the search results. For instance, some archived catastrophe claims with associated fraud investigations might have access restricted to only the Fraud Manager or the Fraud Management group.

Simple Claim Searches

In a simple claim search, Search tab → Claims → Simple Search, you cannot specify whether to search for active or archived claims. ClaimCenter always searches for both types. The application displays summaries only for the active claims it finds.

If ClaimCenter finds an archived claim when you perform a simple search, you see a link directing you to the Advanced Search screen. You can do one of two things with an archived claim listing:

- If you are certain that the claim is the one you want, click **Retrieve from Archive** to retrieve it.
- If you are not certain that the claim is the one you want, click the claim link. Doing so opens the **Archived Claim Summary** screen, in which you can view summary information for the claim.

Note: In a simple search for archived claims, you cannot search for additional insured or any party involved. These search criteria are defined in the `ClaimSearchNameSearchType.tti` typelist.

Performing a Simple Claim Search

Following are the available search criteria for simple claim searches.

- Claim number
- Policy number
 - first name
 - last name
 - organization name
 - tax ID

Note: You cannot perform a simple search by loss date or notice date.

To perform a simple claim search

1. Navigate to Search tab → Claims → Simple Search.
2. Enter at least one search criterion on the **Search Claims** screen and then click **Search**.
The search results show summaries of active claims only.
3. To view summaries of the archived claims found, click **View archived claims**. ClaimCenter displays the **Advanced Search** screen.
4. In the lower section of the screen are the **Search Results**. You can:
 - Click the claim to view its details on the **Archived Claim Summary** screen.
 - Select a claim and click **Retrieve from Archive** to retrieve the claim.

Advanced Claim Searches

In an advanced claim search, Search tab → Claims → Advanced Search, if you select **Archive**, your search criteria are limited to archived claims. Alternatively, you can use the **Search for Date** field. You must enter either a date or a range of dates for this field.

To perform an advanced claim search

1. Navigate to Search tab → Claims → Advanced Search.
2. In the **Source** field, select the type of claim to search for, **Active Database** or **Archive**. In this example, select **Archive**.
Unlike simple searches, an advanced search displays each claim found.
3. In the lower section of the screen are the **Search Results**. You can:

- Click the claim to view its details on the **Archived Claim Summary** screen.
- Select a claim and click **Retrieve from Archive** to retrieve the claim.

Finding Archived Claims without Searching

You can enter the number of an archived claim, **Claim #**, in the **Claim** tab drop-down list. You can also select an archived claim by entering its number in the **QuickJump** box. However, if you select an archived claim in this way, you must retrieve the claim from the archive before you can work with it.

Retrieving Archived Claims

After you have located an archived claim and reviewed its search results or summary page, you might still need to retrieve the full claim for further review or work.

To retrieve a claim, click the **Retrieve from Archive** button available on the **Advanced Search** or **Archived Claim Summary** screen. Enter a comment about the retrieval and click **Retrieve from Archive** again.

Note: You must enter a comment before you can retrieve the claim.

When you retrieve a claim, ClaimCenter does the following:

- Reassigns the claim.
- Generates an activity for the user assigned to the claim.
- Generates a note on the claim.
- Generates a **ClaimChanged** event used by the claim history generation and reporting systems.

The retrieved claim is identical to a claim that has never undergone the archiving process, except that:

- The history for the claim shows that ClaimCenter archived and retrieved the claim.
- Metadata about the archiving status of the claim has changed in the **ClaimInfo** entity and on the **Claim** entity itself.
- Custom code in your **IArchiveSource** plugin implementation might have made further changes to the claim after it was restored to the ClaimCenter database.

Permissions Needed to Retrieve a Claim

The **ClaimInfoAccess** entity controls when a user sees any given claim. Archiving permissions further determine whether the **Retrieve from Archive** button is visible or is enabled or disabled for a particular user. To retrieve an archived claim, you must have both view and edit permissions on the claim. If the claim has an access control list (ACL), you must qualify according to the ACL to be able to retrieve the claim.

Archived Claim Retrieval Process

The archived claim retrieval process executes as a single database transaction, including adding the history record, note, and activity at the very end of the process. In detail:

1. The user clicks the **Retrieve from Archive** button available on the **Advanced Search** or **Archived Claim Summary** screen.
2. The archived claim retrieval process locates the **ClaimInfo** entity for the selected archived claim and passes it to the registered class that implements the **IArchiveSource** plugin.
3. The class that implements the **IArchiveSource** plugin interface, by default **ClaimInfoArchiveSource**, retrieves the archived claim from the data store and saves it in memory as a serialized XML document.
4. The archived claim retrieval process clears the **ClaimInfo** and other Info entities of all data except metadata describing the retrieval.

5. The archived claim retrieval process runs upgrade steps on the XML representation of the claim as necessary to bring it up to the current data model version.
6. The class that implements the `IArchiveSource` plugin interface, by default `ClaimInfoArchiveSource`, makes user-defined changes to the `ClaimInfo` entity and other Info entities before committing the claim to the database.

These changes typically consist of deleting fields populated by `ClaimInfoArchiveSource` when the claim was archived. The `ClaimInfo` entity is the only Info entity that persists. If any changes to `ClaimInfo` are made, then a `ClaimInfoChanged` event is generated.
7. The archived claim retrieval process re-creates the claim in the ClaimCenter database, and then:
 - a. Resets `Claim.DateEligibleforArchive` by using the current date plus the value set in the `config.xml` configuration parameter `DaysRetrievedBeforeArchive`.
 - b. While restoring the claim, the class that implements the `IArchiveSource` plugin interface is called to make any user-defined changes to the `Claim` entity and its foreign keys. This class, by default `ClaimInfoArchiveSource`, can also delete the claim from the archiving data store at this time. This class can also perform any other type of document or metadata cleanup required in the archiving data store.
 - c. The claim is assigned as described in “Reassigning Retrieved Claims” on page 132.
 - d. After the claim has been restored, the archived claim retrieval process creates a note and an Archived Restored History record. See “New Note Generation in Retrieved Claims” on page 133.
 - e. The archived claim retrieval process also creates activities by using the activity pattern set in the `RestorePattern` configuration parameter in `config.xml`. ClaimCenter creates at least two activities and assigns one to the current user and one to the assigned user for the claim. See “New Activity Generation in Retrieved Claims” on page 132.
8. You can now view and work with the claim as usual in the ClaimCenter user interface.

Reassigning Retrieved Claims

All retrieved claims must be assigned, just as all newly created claims are. The `AssignClaimToRetriever` parameter in the `config.xml` file determines claims assignment. If you want to reassign retrieved claims to the user who retrieves them, set this parameter to `true`. The default is `false`, which assigns a retrieved claim to the group and user who owned it at the time ClaimCenter archived the claim.

If it is not possible to reassign to the original user, ClaimCenter assigns the retrieved claim to the supervisor of the group. If ClaimCenter cannot reassign the retrieved claim to the original group, ClaimCenter assigns the claim to `defaultowner`.

The default owner in the base configuration has no roles and is in the root group. Its purpose is to provide an owner for claims that ClaimCenter cannot reassign to anyone.

IMPORTANT Do not delete the default owner from the application. If you do, there can be problems assigning retrieved claims if the retrieved owner is not a member of a group.

New Activity Generation in Retrieved Claims

Retrieving a claim creates at least two activities by using the activity pattern defined in the `config.xml` parameter `RestorePattern`. These activities notify the claim owner and the retriever of the claim that this retrieved claim is again available in the ClaimCenter user interface. If the owner of the claim is inactive, ClaimCenter sends a notification to the inactive user's supervisor.

The activity can also enable its recipient to reassign the activity. Reassigning the activity might be necessary if the retrieve process assigns an activity to a user who no longer exists or no longer has permission to see the

claim. If you have configured the activity to do so, it can contain an **Assign** button at the top of the activity screen. Use this button to reassign the activity to someone else.

New Note Generation in Retrieved Claims

Retrieving a claim generates a new note that is attached to the claim. This note contains the comment that you enter after clicking **Retrieve from Archive**. If you retrieve a claim using the `-restore` maintenance tool command, Guidewire recommends that you enter the body of the note in the `-comment` option of the command. If you use an API call, you also add a comment to create the new note.

Purging Archived Claims

You can purge claims from the archive. When you do so, you also remove the claim's `ClaimInfo` entry from the ClaimCenter database, and you can no longer find the claim when you search for claims. The only way to get a purged claim back into ClaimCenter is to retrieve it from a backup.

ClaimCenter notifies the archive that an archived claim record is to be deleted by calling the `delete(RootInfo)` method on the class that implements the `IArchiveSource` plugin interface. This class is `ClaimInfoArchiveSource` in the base configuration. The `delete` method is actually defined in the class `ArchiveSource`, which `ClaimInfoArchiveSource` extends.

Note: When a claim contributing to an aggregate limit is purged, it ceases to contribute to any aggregate limit on the policy period.

For more information, see “Purging Unwanted Claims” on page 50 in the *System Administration Guide*.

Configuring Claim Archiving

For information on how to configure archiving for your business practices, see the following:

- See “Archive Rule Set Category” on page 40 in the *Rules Guide* for a discussion of the Archive business rules.
- See “Configuring Archiving” on page 578 in the *Configuration Guide* for a discussion of the various configuration points associated with archiving.
- See “The Domain Graph” on page 239 in the *Configuration Guide* for information on how ClaimCenter builds the domain graph.

More Information on Archiving

You can find more information about archiving in the following topics:

- “Archive Parameters” on page 36 in the *Configuration Guide* – information on the configuration parameters used in archiving.
- “Configuring Claim Archiving” on page 573 in the *Configuration Guide* – information on configuring archiving, selecting entities for archiving, and archiving and the object (domain) graph.
- “Archiving Integration” on page 575 in the *Integration Guide* – describes the archiving integration flow, storage and retrieval integration, and the plugin interfaces.
- “Archive Rule Set Category” on page 40 in the *Rules Guide* – information on base configuration archive rules and their use in detecting archive events and managing the claims archive and retrieval process.
- “Logging Successfully Archived Claims” on page 27 in the *System Administration Guide*.
- “Purging Unwanted Claims” on page 50 in the *System Administration Guide*.

- “Archive Info” on page 169 in the *System Administration Guide*.
- “Upgrading Archived Entities” on page 256 in the *Upgrade Guide*.

Validation

Validation is a general application behavior that helps you avoid making mistakes and saving invalid business data. ClaimCenter validates data in the following ways:

- **Field-level validation** – Validation behavior tied to one or more specific fields of a datatype, which can be implemented at:
 - **Data model level** – Includes data types and field validators.
 - **User interface level by using validation expressions** – Includes validation behavior tied to one or more specific fields, which can be implemented at the user interface level in Gosu code.
- **Validation Rules** – Through the use of rules, you can configure ClaimCenter to verify the maturity of a claim or exposure. You can also use rules to execute validation behavior at a global level when the error might not relate to one specific field. For example, a carrier allows up to five vehicles to be covered on a single personal auto policy. The underwriter enters six automobiles. The business data is invalid, but there is not any one field that is causing the error.

This topic describes the types of validation and how ClaimCenter uses them.

This topic includes:

- “Field-level Validation” on page 135
- “Validation Rules” on page 136

Field-level Validation

Field-level validation works at both the data model level and the user interface level.

ClaimCenter performs validation on data types and field validators at the data model level. Each time you enter data on a field with data model validation anywhere in ClaimCenter, the system checks to see if the entered data is in the correct format. Additionally, you can add validation expressions to user interface fields for immediate validation.

Validation on Data Types

ClaimCenter validates several kinds of data types to ensure that the values are legitimate for the field's underlying datatype. For example, you must enter a date field in a particular way. If you do not, ClaimCenter shows an error message identifying the problem so that you can correct it. Another example is a policy or claim number. Each must be in a particular format, also called a *pattern*. Because this type of validation is in the base application, there is no need for any configuration.

Validation on Field Validators

A field validator is a pattern tied to a field or datatype in the data model. If an entered value does not match the pattern, ClaimCenter prevents the data from being saved and shows an error message so you can make corrections. Field validators are used for simple data validation. You can use them to override validation for a specific field of a datatype or to add validation to datatypes that do not have it.

For example, a social security number must be in a certain format. If you enter the number without two hyphens, ClaimCenter will not save the number because it does not match the pattern of *xxx-xx-xxxx*. This *field validation* occurs each time the field is used.

Components of a Field Validator

Field validators consist of the following:

- **name** – Name of validator, such as `SocialSecurityNumber`.
- **value** – Pattern that must be matched, such as three digits, a hyphen, two digits, a hyphen, and four digits.
- **description** – Message to show when the pattern is not matched. For example, if you enter a social security number with a letter, ClaimCenter shows a message indicating the correct format to be used.
- **input-mask** – Optional mask that helps you enter the correct pattern. For example, the social security number field already has the hyphens in the correct place, and you need to enter only the numbers.

You create field-level validators in Guidewire Studio by creating an error message display key, creating the field validator, and associating the field validator with the entity field. See “Field Validation” on page 251 in the *Configuration Guide* for details.

Validation Expressions

A validation expression is an expression in Gosu code that is tied to a widget that uses field-level validation. When the expression returns `null`, validation has succeeded, and the application saves the data. When the expression returns a `string`, it is an error message saying how the validation failed. The error message describes what to do to enter the correct data. For example, a validation might ensure that a date-of-birth field must occur in the past.

You create these expressions by using Gosu code embedded in PCF files. For example, if you want only one date-of-birth field to be validated, use a validation expression in the applicable PCF file. However, if you want the validation to apply to multiple date-of-birth fields throughout the system, write a rule for it instead. For more information, see “Validation Rules” on page 136.

Validation Rules

ClaimCenter can enforce validation of data through rules. Rules can validate whether:

- A claim or exposure has matured to a certain level.
- A transaction can occur.

The system enforces validation through rules by performing validation checks on certain entities as the last step before committing them to the database. These entities are described in “Validatable Entities” on page 137. For

example, a claim is required to eventually have payments made on it. Rules can ensure that the claim contains all required data to process it at the level that allows payments to be made. Each time you click **Update** for a claim, ClaimCenter runs configurable validation rules in a certain order before data can be saved to the database. These validation rules check the data and advance the maturity of the entity to the maximum level it qualifies for.

IMPORTANT Claim objects are not allowed to move backwards in maturity because maturity levels often correspond to information being sent to external systems.

ClaimCenter automatically performs validation checks on entities as the very last step before committing them to the database and making them available for further processing. For example, you might write validation rules that occur before:

- Saving a claim, ensuring that it contains sufficient information about its related policy, and that the loss type is appropriate for the policy type.
- Closing a claim, ensuring that no open activities remain for it.
- Reopening an exposure, ensuring that its claim is already open.
- Scheduling a payment or increasing a reserve, ensuring that coverage limits are not exceeded.

This topic includes:

- “Validatable Entities” on page 137
- “Validation Levels” on page 138
- “Preupdate and Validation Rules” on page 138
- “Validation Errors and Warnings” on page 139
- “Running Validation Rules Manually in the User Interface” on page 139

Validatable Entities

An entity must be validatable to have pre-update and validation rules associated with it. ClaimCenter validates only the following entities in the following order:

1. Policies
2. Claims
3. Exposures
4. Matters
5. TransactionSets (and ReserveSets, CheckSets, and other subclasses)
6. Groups, Users, and Activities (in no particular order)
7. Any other custom validatable entity

Claims, or any validatable entity with a field that triggers validation, can have related subobjects. Whenever the claim itself is created or modified, claim validation rules run. Additionally, whenever a validatable subobject of the claim is created or changed, such as the creation of a document or a change to a matter, claim validation rules run. A change to a validatable subobject triggers claim validation because validation logic at the claim level can be related to information at the subobject level.

Custom Validatable Entities

You can create custom entities that are validatable and have Preupdate and Validation rules run on them. To do so, you must:

- Create the entity and implement the validatable delegate.
- Create PCF components, if necessary.

- Create rule sets and rules. The rule set name must be named `YourEntityNameValidationRules`. If you use the `reject` method, you must pass in an `errorLevel`. An error level is required because custom validatable entities do not mature. Guidewire recommends a level such as New Loss Completion, which has code `newloss`, because it is usually required. The method is used for both warnings and errors.

Validation Levels

Validation levels are defined in Guidewire Studio in the `ValidationLevel.ttx` typelist. The Load And Save, New Loss Completion, and Ability To Pay levels are required by ClaimCenter and cannot be removed. You can remove Valid for ISO or Send to External System. Additionally, you can configure more levels as described in “Validation Rule Set Category” on page 74 in the *Rules Guide*.

In the base configuration the validation levels are:

Validation Level Name	Code	Description
Load and save	<code>Toadsave</code>	Claims and exposures imported from an external system must contain a minimal level of information to be saved in ClaimCenter. However, the system needs more information before an adjuster can work on them.
New loss completion	<code>newloss</code>	If you create a claim from the wizard, this level defines the minimum amount of information for it to be saved as a claim.
Ability to pay	<code>payment</code>	This level ensures that a claim has all the required data needed to make a payment on it.
Valid for ISO	<code>iso</code>	(Optional) This level verifies that all required fields are complete before sending to ISO.
Send to external system	<code>external</code>	(Optional) This level can verify if the claim has enough information before it is sent to an external system. In the base configuration, there is no functionality associated with this level.

You can write integration code that is triggered when a claim reaches a certain validation level. For example, a claim is sent to a back-end system only when the claim reaches **Send to external system** level. One reason that a claim cannot go backwards in validation level is that it might already have been sent to an external system based on the validation level achieved.

Note: Some entities have rules that are not tied to a particular level, such as Transaction Validation rules. These rules can generate warning or error messages.

Viewing Claim and Exposure Validation Levels in the User Interface

In the base application, you can see the validation level for a claim and an exposure.

- For an open claim, navigate to Summary → Status. On the **General Status** screen, look at the **Claim Validation Level** field to see the validation level of the claim.
- To see the validation level for an exposure of a claim, open the claim and then click **Exposures** in the sidebar to open the **Exposures** screen. Click the exposure number to open the detail view for the exposure. The exposure validation level is in the **Validation Level** field.

Preupdate and Validation Rules

If a validatable object or a subobject that triggers the validation of the parent is either created or modified, Preupdate rules for that object run first. Validation rules fire after Preupdate.

- **Preupdate rules** – These rules can make or change data before validation rules run. For example, a document is added to the claim and now someone needs to take action on it. Preupdate rules can create an activity so that the correct person can review the document.

- **Validation rules** – These rules always promote an object to the highest possible level. Promotion also occurs as far as possible, which could result in a promotion either to the next highest level or across multiple levels. As the result of a change, the system allows the change if an object:

- Meets all the conditions at the next higher level.
- Does not violate any conditions at the current or lower levels.

Validation rules can also verify that rule conditions are met. If rule conditions are not met, the system can show warning or error messages.

If the object fails validation, any work that was done by the Preupdate rules is also rolled back.

Validation Errors and Warnings

Validation rules support two types of failure, warnings and errors. You can implement one type of failure or both types. Both types of validation messages are shown in the **Validation Results** worksheet, which opens if there are messages. In most cases, you can click a particular message to go to the data that it references.

Validation errors – These errors prevent you from continuing until you fix the errors. Error messages display during an update only in the following two cases:

- You first save a claim or exposure, and it does not pass all validations at the Load and Save level.
- You edit a claim or exposure in such a way that would have forced the object to revert in maturity.

Note: ClaimCenter displays warning and errors only for validation levels that the object has achieved.

Validation warnings – Rules that return a warning message do not perform any other action. For example, after you attempt to save a claim, a rule can detect that an optional field is blank and show a message asking that the field be filled in. If you update a second time after you have received warnings, the system allows you to save. You see warning messages only for validations at levels that are at or below the level that the object is achieving with the current save.

Handling Validation Errors and Warnings

Validation errors and warnings display in **Validation Results** worksheets. Clicking an error or warning in one of these screens takes you to the object in question, enabling you to make corrections. You must correct all errors to proceed, but you can ignore any or all warnings and go on by clicking **Update**.

Running Validation Rules Manually in the User Interface

You can validate a claim or exposure manually if you need to discover why a validation level has not been attained. ClaimCenter checks all validation rules for the specified validation level and below. You can see if there are any warnings or error messages generated by the validation rules for the claim or exposure. To manually run validation rules, open a claim and navigate to **Actions** → **Claim Actions**. You can validate one of the following at any level: the claim only, the claim and its exposures, or the policy. For example, you want to make a payment on a claim but are unable to do so. You can navigate to **Actions** → **Claim Actions** → **Validate Claim + Exposures** → **Ability to pay** to run validation rules on the claim and its exposures. Doing so can help you see what is preventing your payment.

See also

- “Claim Web Service APIs and Data Transfer Objects” on page 152 in the *Integration Guide*
- “Validation Rule Set Category” on page 74 in the *Rules Guide*

Claim Fraud

Fraudulent claims are a continuing problem for all who handle them, and identifying suspicious claims can be difficult. Too often, flagging a suspicious claim is left to a manual process that might be different for each adjuster. ClaimCenter provides a mechanism to help you determine when to further investigate a claim for possible fraud.

The centerpiece of the ClaimCenter fraud detection is its ability to analyze claims and determine a risk potential, or *Special Investigation* (SI), score for them. ClaimCenter creates this score by using both a set of business rules to analyze a claim's information for possible fraud and a set of questions that the adjuster answers. As the adjuster adds more data to the claim and answers the Special Investigation question set, this score can grow. If this score reaches a preset threshold, ClaimCenter can then assign activities to review the claim for fraud.

Using business rules and question sets to trigger claim fraud investigations enables you to:

- Reduce leakage in handling claims.
- Enforce business processes evenly across the organization.
- Assign the same standardized weight to each suspicious fact in each claim.
- Have more transparency in the process of deciding what to investigate.
- Perform a fact-based evaluation of all claims.
- Keep an audit trail of why and how claims became suspicious.

These features can be important both financially and legally.

This topic includes:

- “Fraud Detection Overview” on page 142
- “Evaluating Risk Potential” on page 144
- “Using Question Sets” on page 145
- “Evaluating the Special Investigation Score” on page 146
- “Using the Special Investigation Details Screen” on page 146

Fraud Detection Overview

Special Investigation (SI) rules and question set answers identify suspicious characteristics of a claim and assign points to each of these characteristics. The sum of these points is the Special Investigation score. Depending on your business logic, you can set up your own suspicious claim analysis as follows:

- Create Special Investigation rules to detect conditions that your business practices have shown to be fraud indicators. This set of rules analyze a claim each time information is added to it and collect and maintain a running score of all the suspicious information it receives.
- Create Special Investigation question sets that an adjuster uses to detect conditions that your business practices have shown to be fraud indicators. Answers are scored appropriately.
- Assign different point values to suspicious characteristics obtained from both rules and answers.
- Create a single Special Investigation score for each claim from the sum of all points.
- Select the score threshold at which to create an activity for further investigation.

The two Special Investigation scores from rules and question sets can be combined to reach one value that describes the likelihood of fraud. Using this integrated score, you can make informed decisions on whether to start a fraud investigation of a suspicious claim. When the score reaches a predefined value, for instances, the supervisor can determine whether to assign the claim to a fraud investigator or Special Investigation team for further review.

Special Investigation Question Sets

Question sets are created in XML using the `QuestionSet` and related entities and imported into ClaimCenter. You need administrative permissions to import and export question set files. See “Working with Question Sets” on page 270.

Special Investigation Rules

Rules that flag suspicious claim activity are useful, because they do not require the adjuster’s time to ask a set of questions. They are guaranteed to treat every claim equally.

Special Investigation rules reside in the Claim Preupdate rule set, where they run regularly. See “When to Run Special Investigation Rules” on page 143.

Some items that special investigation rules can look for are:

- After a certain time period, no claimant telephone numbers, police report, on-scene report, or witnesses exist.
- There has been an unreasonable delay in reporting the loss.
- Discrepancies exist between official reports and claimant’s statements.
- The claimant conducts business orally, so there is no record.
- The claimant has had other recent claims.
- The claim occurred just after the policy was purchased or renewed.
- The first notice of loss report (FNOL) is followed closely by attorney involvement.
- The driver is a minor and is not listed on the policy.

After creating these rules, you assign points to each one. The first time a Special Investigation rule is `true`, ClaimCenter performs the following actions:

- Adds the rule description to a Special Investigation array for display. It also adds its score and any additional information the rule gathers. For example, a rule finds an unlisted minor driver involved in an accident. ClaimCenter adds the “Driver is a minor not listed on the policy” rule description to the claim’s Special Investigation array. It also adds the driver’s name in the Additional Information part of the array.
- Increments the Special Investigation score by the value specified in the rule’s actions.

When to Run Special Investigation Rules

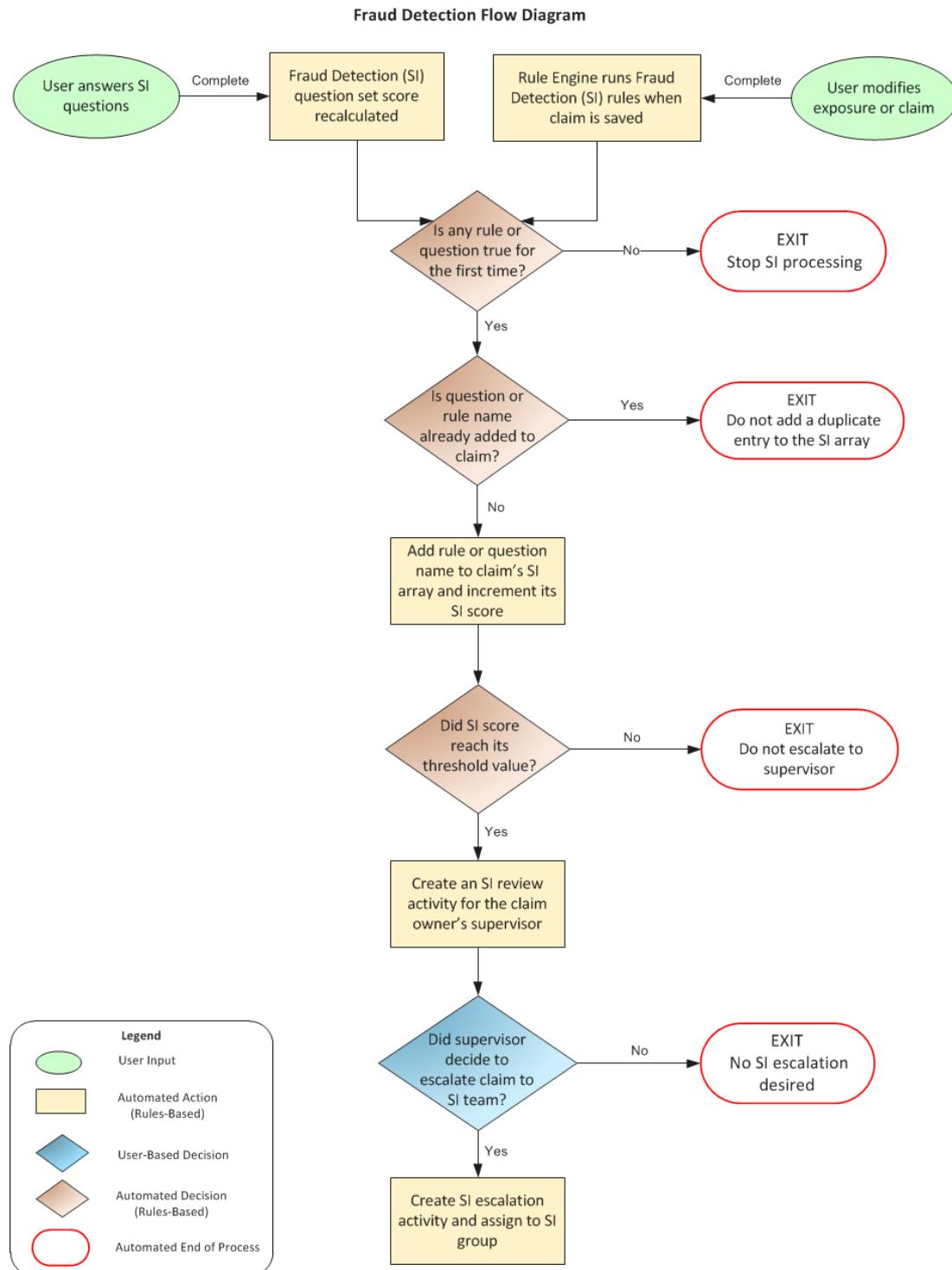
A good practice is not to run the Special Investigation rules when a claim is created, but to run them at later points in the claim's lifecycle. A claim preupdate rule, which runs daily as part of the claim exception rule set, advances the stage of a claim's lifecycle. Trigger rules, part of the claim preupdate rule set, then decide when to run, based on the stage. The `ValidationLevel` typelist contains the validation level definitions used in validating an entity to determine its lifecycle stage. This mechanism restricts rules to a specific claim lifecycle stage.

See also

- “Validation Levels” on page 138
- “Detecting Claim Fraud” on page 129 in the *Rules Guide*

Evaluating Risk Potential

The following flow diagram illustrates the process by which Special Investigation scores are created and evaluated using question sets and rules.



Using Question Sets

Question sets answered by an adjuster or other fraud investigator can help to determine whether a claim might be fraudulent. The following question sets contain sample questions that can help in that determination.

Points	Questions for Any Claim Type
none	Is claimant familiar with insurance claims terminology and procedures
no = 1	If yes, would claimant's business give claimant this knowledge?
yes = 1	Does claimant avoid using fax, email, or mail and only communicate verbally?
yes = 2	Is claimant aggressively demanding settlement?
yes = 3	Will claimant accept a partial settlement if it is immediate?
yes = 1	Is claimant experiencing financial difficulties?
choice	If yes, is claimant's credit score low, medium, high, or unknown?
yes = 2	Are there discrepancies between claimant's statements and official accident reports?
yes = 1	Are there discrepancies between claimant's statements and those of witnesses?
yes = 1	Are the claimant's lifestyle and income level inconsistent?
yes = 2	Has claimant provided an excess of documentation and supporting material?
yes = 1	Does claimant have other or prior injuries?
no = 2	If yes, are they consistent with other damage or injuries in the incident?

Points	Questions for Auto Claims
none	Was the vehicle purchased in another state or province?
none	Was the vehicle stolen?
yes = 5	If yes to either of the above, does the vehicle have a salvage title?
yes = 1	If yes, does a salvage or auto repair shop have an interest in the claim?
yes = 1	If stolen, had the vehicle not been seen for some time?
choice	If yes, how long - a week, a month, or two months, or more?
yes = 2	Do the involved vehicles have a disproportionate amount of damage?
yes = 1	Do accounts of the accident by drivers, passengers, or witnesses appear rehearsed?
yes = 2	Are accounts of the accident by drivers, passengers, and witnesses inconsistent?
yes = 1	Do neighbors, friends, and relatives have knowledge of the vehicle?
yes = 1	Do appraisal photographs show only close-up damage views, but not enough to identify the vehicle?
yes = 1	Was the vehicle repaired before the claim was reported?

Points	Questions for Workers Compensation Claims
yes = 2	Is it possible that the injury is not job-related?
none	Is claimant missing work due to the injury?
yes = 1	If missing work, is claimant resisting going back to work?
yes = 2	If missing work, does claimant have a new job?

Notes

- You can create conditional questions for cases where a question is dependent on the response to another question. The tab shows the conditional question only when the dependent question's answer is positive.

- Questions can display a choice list with several answers for the user to select from, each associated with a different number of points. An example would be a question such as “What is the claimant’s credit score?” with possible answers including Below 500 (3 points), 501-600 (2 points), and so on.

By assigning points to each question or answer choice, ClaimCenter can calculate their sum, which, along with the points from the Special Investigation rules, comprises the Special Investigation score. It is this score that can trigger new activities, such as evaluation by a carrier’s Special Investigation Unit. Using the full set of questions ensures that all claims are examined in a uniform and fair way.

Each time Special Investigation questions are answered, ClaimCenter performs these actions:

- Adds the question description to the Special Investigation array for display, along with its score.
- Recalculates the Special Investigation score using any change in the question set’s total points.

Answering Special Investigation Question Sets

To access the SI question set

1. Open a claim and navigate to **Loss Details → Special Investigation Details**.
2. Click **Edit** to respond to questions.
3. Click **Update**.

After you enter or change any answer, ClaimCenter recalculates the claim’s Special Investigation score.

Evaluating the Special Investigation Score

The Special Investigation score is the sum of the Special Investigation rules score and the Special Investigation question set score. After the score reaches a defined threshold, a rule in the claim preupdate rule set creates an activity for the claim handler’s supervisor to review this particular claim. A user with administrator privileges can set this threshold by navigating to **Administration → Utilities → Script Parameters** and setting the **SpecialInvestigation_CreateActivityForSupervisorThreshold** script parameter. The default value is 5.

In response to being assigned the activity, a claim supervisor reviews the contents of the **Loss Details → Special Investigation Details** screen and the details of the claim.

After review, the supervisor can choose to escalate the claim to another user, as follows:

1. Click **Edit**.
2. In the **Supervisor Review** section, set **Refer claim to SIU team** to **Yes**. Enter comments, if needed.

After the supervisor clicks **Update** to save the changes, ClaimCenter assigns the activity to a member of the Special Investigation group by round-robin assignment. ClaimCenter also automatically adds that person to the claim in the role of Special Investigation (SIU) investigator. If an investigator is already associated with this claim, ClaimCenter sends the activity to that individual.

Using the Special Investigation Details Screen

While viewing a claim, use the **Loss Details → Special Investigation Details** screen to view and track details of suspicious claims. Click **Edit** to make changes to this screen. This screen contains:

- **Section One - Possible fraud indicators detected** – A list view that shows the Special Investigation rules this claim violates and the points for each violation. There can also be additional information pertaining to the rule.
- **Section One Score** – Total of all fraud indicator points.
- **Section Two - SIU Questionnaire** – Depending on the claim, the questionnaire can have more than one question set.

- **Auto SIU** – The first Special Investigation question set for an auto claim.
- **WC SIU** – The first Special Investigation question set for a workers' compensation claim.
- **General SIU** – The general Special Investigation question set is always present, including answers and corresponding points if the questions have been answered.
- **Section Two Score** – Total of all question set points.
- **Total Score (Supervisor notified at 5 or above)** – Total points from rules and question sets.
- **Supervisor Review** – Section that supervisor fills out after reviewing SIU and claim information.
 - **Refer claim to SIU team** – By default, this value is No. If the supervisor or other reviewer changes it to Yes, the following two fields become visible. You cannot change it back to No directly, but if you click **Cancel**, the value reverts to No.
 - **Date referred to SIU team** – ClaimCenter fills in this date when the reviewer clicks **Update**.
 - **Supervisor Comment** – Any additional comments by the supervisor who escalated the claim to the SIU team.

The ClaimCenter Rules Guide provides general information about writing rules. Use Studio to write rules and add them to the proper rule sets. See “Working with Question Sets” on page 270 for information on creating and editing question sets.

Updating the Rules and Answers

Saving the claim again runs the Special Investigation rule set. With the correct permissions, you can see and edit any or all the SI questions.

Click **Edit** to change SI responses, and click **Update** to save the answers.

Referring the Claim for a Special Investigation Review

To access the **Special Investigation Details** screen, open a claim and navigate to **Loss Details** → **Special Investigation Details** → **Edit**.

If you have the `editSensSIUdetails` permission and click **Edit**, the Yes/No radio buttons are enabled next to the **Refer this claim to the SIU team** field. If you click Yes, the optional **Supervisor Comments** field appears, where you can enter any notes you have about this referral.

Special Investigation Permissions and Restrictions

Special Investigation information is considered privileged. Only the claim owner and managers with the `editSensSIUdetails` permission can:

- View answers to the SI questions.
- Edit the answers.
- Access **Date referred to SIU team** and **Total Score**.
- Control what a specific user can view and change with permission settings. No one can edit the descriptions of the rules that have fired or the **Additional Information** entered by any rule. The only editable fields of this screen are answers to questions, **Refer claim to SIU team**, and **Supervisor Comment**.

Assessments

Assessment is the process of evaluating the value of lost or damaged property and then providing and monitoring the services required to indemnify the insured and cover related expenses. Especially in the United States market, this process is often managed by other systems, such as Mitchell International and CCC Information Services. When managed by other systems, detailed damage assessments cannot reside in an insurer's claim system except as attached documents. Outside the United States, assessment is more central to a claims system. ClaimCenter provides a framework to manage the assessment information. This framework enables you to configure assessment based on your business requirements.

IMPORTANT The assessment feature is not integrated with Services. It uses terminology in some cases that sounds like Services terminology, but the functionality is entirely separate.

This topic includes:

- “Assessment Overview” on page 149
- “Working with Assessments” on page 150
- “Data Model for Assessments” on page 153

Assessment Overview

Assessments are important for many lines of business (LOBs), including auto, property, general liability, and workers' compensation. Auto claims typically have the most highly developed assessment systems, covering initial damage estimates and the cost of replacement parts and labor. Medical claims, especially those involving rehabilitation, can also be estimated by assessment procedures. One difficulty in doing assessments of medical claims is determining how long it takes to perform rehabilitation services. Estimation of property losses can also be complex, due to depreciation, uniqueness, and determining what constitutes equal replacement value.

ClaimCenter incorporates the assessments feature into both auto and property claims. This solution includes:

- Maintaining lists of sources, which are called evaluators or assessors. See “Source” on page 151.
- Itemizing and then categorizing property for assessment. See “Property Incident Assessment Line Item Sections” on page 151.

- Managing documents and notes associated with the assessment process. See “Documents and Notes Used in Assessments” on page 153.
- Sending work orders to multiple sources to perform evaluations.
- Collecting and evaluating the estimates and quotes generated by the work orders.
- Agreeing to the loss value, typically a negotiation between the claimant and adjuster based on the assessments obtained.
- Providing the necessary services to indemnify the insured for the loss, either repair or replacement. See “Source” on page 151.
- Evaluating the quality of the indemnification. See “Property Incident Assessment Line Item Sections” on page 151.
- Maintaining a status display of the assessment work orders and repair orders. See “Property Incident Assessment Line Item Sections” on page 151.

For vehicle losses, providing timely assessment services is a key component of controlling leakage. Ideally, the every first notice of loss (FNOL) conversation concerning an auto loss includes notifying the insured of:

- Where and when to have the damaged vehicle assessed.
- The name of the appraiser.

The base configuration provides one assessment process for each vehicle, building, or group of property items. You can access the assessment feature in the **New Claim** wizard, as well as in the claim at a later time. The assessments feature is an extension to Incidents, and therefore to Exposures as well.

Working with Assessments

Accessing Assessments

Each vehicle and property involved in a loss has an **Assessment** screen that stores and evaluates assessment information.

To open the Assessments screen

1. Navigate to a claim and click **Loss Details**.
2. Select a vehicle under the **Vehicles** section or a property under the **Properties** section.
3. Click the **Assessment** tab.

Assessment Tab

The **Assessment** tab has the following sections:

General

This section is a general description of the vehicle or property and contains the following fields:

- **Involving** – The property or vehicle. This information comes from the incident of the exposure.
- **Description** – A text field describing the assessment.
- **Status**: The status of the assessment process. It is **Open** until the insured party or claimant is satisfied, and then it is **Closed** (from the **AssessmentStatus** typelist).
- **Target Close Date** – The estimated completion date of the entire assessment process.
- **Comment** – A text field that can be used for any purpose.
- **Internal User** – The adjuster or other user assigned to this part of the claim.

For vehicle incidents:

- **Total - Approved** – The auto-generated total of all Estimate amounts of all **Approved** items in the Line Items table.
- **Total - In Review** – The auto-generated total of all Estimate amounts of all **In Review** items in the Line Items table.

For property incidents, there are Detail Damage radio buttons:

- **To Building?** – Choosing Yes shows additional fields for **Building Components**, described later, and **Building Estimate**:
 - **Total - Approved** – The auto-generated total of all Estimate amounts of all **Approved** items in the **Building Components** table.
 - **Total - In Review** – The auto-generated total of all Estimate amounts of all **In Review** items in the **Building Components** table.
- **To Contents?** – Choosing Yes shows additional fields for **Content Items**, described later, and **Content Value**:
 - **Total - Approved** – The auto-generated total of all Estimate amounts of all **Approved** items in the **Content Items** table.
 - **Total - In Review** – The auto-generated total of all Estimate amounts of all **In Review** items in the **Content Items** table.

Source

The **Source** list shows all contacts—persons or vendors—who provide or will provide assessment services, including estimating, quoting, repairing and restoration, and replacement. You can enter sources manually, or, if ClaimCenter is integrated with ContactManager, you can use ContactManager to maintain lists of searchable sources. The list contains these columns:

- **Name** – The name of the assessor, required unless the entry comes from ContactManager.
- **Source Type** – The category of assessor, such as internal appraiser or approved vendor.
- **External Assessor** – Whether or not the source is an employee of the carrier.
- **Description** – A text field that can be used for any purpose.
- **Create Time** – ClaimCenter creates this time stamp when this source is added.
- **Event Lines** – Events related to this source, each of which has the following fields:
 - **Date** – The date on which the event occurred.
 - **Event** – Events selected from a drop-down list. Events include **Assignment Accepted**, **Assignment Canceled**, **Estimate Accepted**, **Repair Complete**, and so on.
 - **Notes** – A text field that can be used for any purpose.

Property Incident Assessment Line Item Sections

If the incident is a property incident and **To Building?** in the **General** section is Yes, you see the **Building Components** section. If **To Contents?** is Yes, you see the **Content Items** section. Both sections can be visible at once.

Both sections have buttons you can use to add, remove, approve, or deny one or more line items in the list. Additionally, you can set the source for one or more line items or choose a source and click **Associate With** to associate one or more line items with a source.

Note: The *LineItemCategory* and *LineItemSchedule* typelists used in the following line item sections are based on IRS-Publication 584B: Business Casualty, Disaster, and Theft Loss Workbook. All these typelists are extendable.

Building Components

- **Category** – A building component that was damaged, selected from a drop-down list. Components include **Air Conditioning**, **Building**, **Heating System**, **Roof**, and so on. These values are from the **PropertyLineItemCategory** typelist.

- **Description** – A free-form field typically used to describe the item. Visible and selectable in the **Building Components** list as **Description**.
- **Action** – Whether the amount for this item has been **Approved** or **Denied** or is undergoing **Reviewing**. These values are from the **AssessmentAction** typelist.
- **Estimate** – Estimated cost to perform the work.
- **Create Time** – ClaimCenter creates this time stamp when this item is added.
- **Comment** – A free-form field typically used to add comments about the item.
- **Source** – The contact that produced the information, such as **Estimate**, shown in this line of the table.

Content Items

When you create or edit a content item, there are two sections, **Summary** and **Financials**.

The **Summary** section has the following fields:

- **Schedule** – A high level category for items covered in the policy. The drop-down list includes the following schedules: **Equipment**, **Homeowners**, **Information Systems**, **Office Furniture and Fixtures**, **Office Supplies**, **Other**, and **Travel**. These values are from the **ContentLineItemSchedule** typelist.
- **Category** – A building component that was damaged, selected from a drop-down list. Components depend on the **Schedule** selected. For example, for the **Equipment** schedule, you can choose categories such as **Calculator**, **Clocks**, **Copiers**, **Microwave**, and so on. These values are from the **ContentLineItemCategory** typelist.
- **Number of Items** – How many of this type of content item were damaged, lost, and so on.
- **Brand** – The brand name of the content item, such as **Armani** or **Sony**.
- **Description** – A free-form field typically used to describe the item. Visible and selectable in the **Content Items** list as **Description**.
- **Date Acquired** – Date the item was bought or otherwise acquired.
- **Action** – The action taken on the amount for this item: **Approve**, **Deny**, needs a **Review**, or is **To be Depreciated**. These values are from the **AssessmentContentAction** typelist.
- **Related Source** – A contact for this information.
- **Create Time** – ClaimCenter creates this time stamp when this item is added.
- **Comment** – A text field that can be used for any purpose.

The **Financials** section has the following fields:

- **Purchase Cost** – Original cost of the item when it was bought.
- **Depreciation** – Amount that the value of the item has decreased over time.
- **Salvage** – Value of the item if retrieved from the property.
- **Item Value** – A calculated value based on the entries for purchase cost, depreciation, and salvage.

Vehicle Incident Assessment Line Items

This list of line items shows damaged or lost property for a vehicle. Above the list are buttons you can use to add, remove, approve, or deny one or more line items in the list. Additionally, you can set the source for one or more line items or choose a source and click **Associate With** to associate one or more line items with a source.

Note: The *LineItemCategory* and *LineItemSchedule* typelists used in the following line item sections are based on IRS-Publication 584B: Business Casualty, Disaster, and Theft Loss Workbook. All these typelists are extendable.

The vehicle incident **Line Items** list shows the following information for each line item:

- **Category** – A vehicle component that was damaged, selected from a drop-down list. Components include **Body**, **Brakes**, **Suspension**, **Wheels**, and so on. These values are from the **VehicleLineItemCategory** typelist.

- **Description** – A free-form field typically used to describe the item. Visible and selectable in the **Line Items** list as **Description**.
- **Action** – Whether the amount for this item has been **Approved**, **Denied**, or is undergoing **Reviewing**. These values are from the **AssessmentAction** typelist.
- **Estimate** – Estimated cost to perform the work.
- **Create Time** – ClaimCenter creates this time stamp when this item is added.
- **Comment** – A text field that can be used for any purpose.
- **Source** – The contact that produced other information, from the **Source** list in the Vehicle Incident screen. If you have not added a source in that screen, this one will just list <none>.

Documents and Notes Used in Assessments

Documents related to assessments, such as body shop quotes for repair of dents, are handled by the normal process of attaching documents to claims. The same is true for notes.

Permissions

You do not need special or additional permissions to view or edit the Assessment card for a claim. Access to the claim itself is sufficient to view and edit assessments.

Data Model for Assessments

There is one assessment process per vehicle or fixed property. Therefore, assessments are properties of to the **Incident** entity. Entities related to assessments include:

Assessment entity	Contents and Use
AssessmentSource	Multiple parties can inspect and assess the same vehicle or property. The Incident array key SourceLine is an array of AssessmentSource entities, which capture this information.
AssessmentLine	Many events can take place related to an assessment. For example, assignments can be scheduled and canceled. The AssessmentSource array key StatusLine is an array of AssessmentLine entities.
AssessmentItem	Both vehicles and property have this itemized list of damages and costs to indemnify. The Incident array key ItemLine is an array of AssessmentItem entities.
AssessmentContentItem	Property, in particular, has both the structural component captured in the AssessmentItem array and itemized content. This entity represents a single content item. The difference between the two is the depreciation on the items. The Incident array key ContentItemLine is an array of AssessmentContentItem entities.

The assessment feature uses a number of typelists. All are extendable. The **LineItemCategory** and **LineItemSchedule** typelists are based on IRS-Publication 584B: Business Casualty, Disaster, and Theft Loss Workbook. All these typelists are extendable.

Assessment typelist	Contents and Use
AssessmentAction	Action taken for each estimate: Reviewing, Approved, or Denied. For auto and fixed property losses, but not for contents that can depreciate.
AssessmentContentAction	Action taken for each estimate: Review, Approve, To be Depreciated, or Deny. For contents losses.
AssessmentEvent	Events capture the time line of the assessment process. Some typical events include Assignment Accepted, Estimate Complete, Estimate Accepted, Repair Date Set, and Repair Complete.

Assessment typelist	Contents and Use
AssessmentSource	The source of the assessment—the Insured’s Vendor, an Approved Vendor, an Internal Appraiser, a Third Party’s Vendor, or a Desk Review. A <i>desk review</i> is an appraiser’s combination of assessments from different sources.
AssessmentStatus	Open until the insured or claimant is satisfied, and then Closed.
AssessmentType	Property, Auto, or Contents, which can be from either a damaged auto or building.
ContentLineItemCategory	Items found in properties, such as appliances, electronics, televisions, printers, servers, and monitors. They are categorized by typecodes of the ContentLineItemSchedule typelist.
ContentLineItemSchedule	Categories of the items found in the ContentLineItemCategory typelist, such as Equipment, Homeowners, Information Systems, and Office Furniture and Fixtures.
PropertyLineItemCategory	A building or its major parts, such as its Roof, Air Conditioning, Heating System, Plumbing System, or Lighting System.
VehicleLineItemCategory	Major systems of a vehicle, such as Body, Brakes, Engine, Suspension, and so on.

Catastrophes and Disasters

The term *catastrophe* in the property insurance industry denotes a natural or man-made disaster that is unusually severe. The industry designates an event a catastrophe when claims are expected to reach a certain dollar threshold and more than a certain number of policyholders and insurance companies are affected. Carriers monitor the extent and type of these losses, dates of occurrence, and geographic areas affected by the catastrophe-related claims to forecast loss estimates and loss reserves. Carriers often group claims by the catastrophes that caused them. This helps the carrier to:

- Estimate the severity of the catastrophe itself and its potential liability due to the catastrophe.
- Estimate the reserves it must set aside to cover future claims from the catastrophe.
- Manage its resources, such as mobile adjusters, in responding to the catastrophe.
- Create reports about the catastrophe and its financial consequences for the carrier.

This topic includes:

- “Catastrophe Overview” on page 155
- “Working with Catastrophes” on page 156
- “Catastrophe Bulk Association” on page 158
- “Associating a Claim with a Catastrophe” on page 158
- “Catastrophe Dashboard” on page 160

Catastrophe Overview

From a reinsurance perspective, it is in a carrier’s best interest to associate every claim with an applicable catastrophe. Carriers closely track their total exposure for catastrophes because they often have reinsurance agreements that cover their exposure over a given amount. In this way, carriers can take on the large risk associated with catastrophes.

In ClaimCenter, you can associate every claim that results from a catastrophe with that catastrophe, as described at “Working with Catastrophes” on page 156. If you do not associate these claims with their catastrophes, you risk leakage because you might not be able to recover money for these claims from the reinsurer. You can also use rules like the Claim Preupdate rule **Related to Catastrophe** to identify claims that match a catastrophe’s profile but

have not yet been linked to that catastrophe. ClaimCenter can ensure that all the catastrophe-associated claims are caught and marked appropriately.

ClaimCenter defines a catastrophe by the following characteristics:

- A *date range* – A start and end date
- A geographic *region*
- One or more *perils* – A combination of a Loss Type, such as property, and Loss Cause, such as wind

For example, a carrier declares Hurricane Katrina to be a catastrophe. This catastrophe involves claims in the states of Florida, Alabama, Mississippi, and Louisiana for property damage due to flood, wind, or rainstorm. The catastrophe occurred during the period from July 2005 to December 2005.

ClaimCenter assists carriers handling catastrophes in the following ways:

- Defining and maintaining a list of catastrophes. See “Catastrophe List” on page 156.
- Associating at most one catastrophe with a claim. See “Associating a Claim with a Catastrophe” on page 158.
- Providing a way to search for all claims associated with a catastrophe and see their distribution on a heat map. You can access this heat map and catastrophe claims search capability by navigating to:
 - Administration tab → Business Settings → Catastrophes
 - Search tab → Claims → Catastrophe Search

Note: You must have certain permissions and perform some setup before you can see the **Catastrophe Search** screen. See “Preparing to Access the Catastrophe Search Screen” on page 162.

See also “Catastrophe Dashboard” on page 160.

Working with Catastrophes

You can manage catastrophes in several ways:

- Creating and maintaining a list of catastrophes.
- Associating a catastrophe with a claim.
- Finding and associating claims created prior to the catastrophe’s being entered into the system.

This section includes:

- “Catastrophe List” on page 156
- “Working with Catastrophes” on page 157
- “Catastrophe History” on page 160
- “Using Catastrophes Defined by ISO” on page 158

Catastrophe List

You can access the list of catastrophes by clicking **Administration** → **Business Settings** → **Catastrophes**.

The list of catastrophes shows fields that ClaimCenter maintains for each catastrophe. The following list includes fields that you see on the **Catastrophe Details** page when you click a catastrophe in the list:

- **Status** – A catastrophe can have a status of Active or Inactive, controlled by the **Activate** and **Deactivate** buttons.
- **Name** – Any value is acceptable. The name is a value that can be used in a search.
- **CAT No** – You must assign each catastrophe a unique number. This number can be used for sort order as seen in the Catastrophe drop down menu in the **Loss Details** screen. It is also a number that might have come from legacy or other mainframe systems or a governing body, such as the United States state of Washington.
- **Begin Date** and **End Date** – The date range of the catastrophe.

- **Type** – Either Internal or ISO. *ISO* means that the data was generated from a governing body, such as ISO in the United States. *Internal* means that the data was generated by other means, such as manually by the carrier. The values come from the **CatastropheType** typelist. See “Using Catastrophes Defined by ISO” on page 158.
- **PCS Serial Number** – Optionally, there can be an ISO Property Claim Service (PCS) serial number. This field is shown only on the **Catastrophe Details** screen.
- **Comments** – A free-form text field typically used to describe the catastrophe.
- **Last Edited** and **Last User** – The user that edited the catastrophe and the date of the last edit. These fields are visible only on the list of catastrophes.
- **Areas Covered** – The geographical areas in which the catastrophe occurred, such as the U.S. state Florida.
- **Zone Type** – The type of geographical region in which the catastrophe occurred. You see **Zone Type** only on the **Catastrophe Details** screen when you edit a catastrophe.
- **Coverage Perils** – Each coverage peril is defined by both a Loss Cause from the **LossCause** typelist and a Loss Type from the **LossType** line of business typelist. Coverage perils are visible only on the **Catastrophe Details** screen.
- **History of Matched Claims** – Shows all the claims that were matched to this catastrophe.

Working with Catastrophes

This topic describes how to add, edit, deactivate, and active catastrophes.

To add a new catastrophe

1. Navigate to **Administration tab** → **Business Settings** → **Catastrophes**.
2. Click **Add Catastrophe**.
3. Enter your data on the **Details** card.
4. Click the **Policy Locations** tab to enter data about policy locations to be included on the map.
5. Click **Update** to save your work.

To edit an existing catastrophe

1. Navigate to **Administration tab** → **Business Settings** → **Catastrophes**.
2. Click the name of a catastrophe to open the **Catastrophe Details** screen.
3. Click **Edit** and make your changes on the **Details** card.
You can click **Add** to add Perils to the catastrophe.
You can click the **Policy Locations** card to update information on policy locations.
4. Click **Update** when you are done with your changes.

To deactivate a catastrophe

You cannot delete a catastrophe from the system, but you can deactivate it. Even after the time period for a catastrophe has passed, many claims can continue to be associated with the catastrophe. The search features and report generators must be able to find claims by their associated catastrophes.

1. Navigate to **Administration tab** → **Business Settings** → **Catastrophes**.
2. Select the check box for an item on the list. Click **Deactivate**.
The catastrophe status becomes **Inactive**.

Note: You cannot associate a claim with a catastrophe that has been marked inactive.

To activate a catastrophe

1. Navigate to **Administration tab** → **Business Settings** → **Catastrophes**.
2. Select the check box for the inactive catastrophe.
3. Select **Activate**.

This catastrophe status becomes **Active**.

Using Catastrophes Defined by ISO

In the United States, ISO produces a list of catastrophes that you can use to define your own list. The ISO list defines for each catastrophe the same information that the ClaimCenter list contains. Also, ISO defines for each catastrophe the loss severity, which is estimated total liabilities, and a catastrophe number, which can help correlate your catastrophe data with other information. You can also use ISO severity data to help you estimate your own liabilities and reserve levels.

Note: ISO provides this information in a CSV file.

Catastrophe Bulk Association

The topic “Catastrophe Overview” on page 155 describes how to create a catastrophe profile in the ClaimCenter **Catastrophes** screen before attaching claims to a catastrophe. You navigate to **Administration tab** → **Business Settings** → **Catastrophes** to open the **Catastrophes** screen. Adjusters can create claims that are caused by the catastrophe prior to the catastrophe’s being entered into the system. For example, a catastrophe might not have been entered yet because the government has yet to deem the event a catastrophe and give it a CAT code.

If such a claim is already in ClaimCenter, you must link the claim to the catastrophe after creating the catastrophe profile. You can search for claims that match the catastrophe profile but have not yet been linked. Not all claims returned as a match are necessarily a result of the catastrophe, so you must decide whether to link the claim to the catastrophe. For each matching claim, ClaimCenter creates a **Review Claim for Catastrophe** activity and assigns it to the claim owner, who determines whether the claim is a result of the catastrophe. If so, the adjuster sets the cat field on the claim and completes the activity. If not, the adjuster just completes the activity.

To learn how to find claims and associate them with a catastrophe, see “Working with Catastrophe Bulk Association” on page 159.

Associating a Claim with a Catastrophe

On a claim, a catastrophe is a claim characteristic. A claim can be associated with at most one catastrophe. After making this association, you can write rules to perform a number of useful functions:

- Assignment rules that assign claims to catastrophe management groups
- Rules that write reports to:
 - Track reserves and payments for claims associated with the same catastrophe
 - Determine the costs of a catastrophe

See also

- “Catastrophe-Related Rules” on page 66 in the *Rules Guide*

To associate a claim with a catastrophe

1. Navigate to a claim and select the **Loss Details** menu item on the left pane. You can also do this from the New Claim wizard.

2. Click Edit.**3. Select a catastrophe name from the Catastrophe drop-down menu and click Update.**

ClaimCenter runs checks to determine if:

- The claim's loss date is within the catastrophe's date range.
- The claim's location matches the zone type for which the catastrophe is valid.
- The claim's cause of loss and loss type matches one of the catastrophe's defined perils.

In the base configuration, the Claim Update and Claim Validation rules check that all these conditions are met. ClaimCenter rules prevent you from associating a catastrophe with a claim that has a Loss Date or Loss Address that does not match the catastrophe's time period or region. If a rule finds such a claim, ClaimCenter issues an error message. While ClaimCenter allows an association with a catastrophe if the claim's Loss Cause or Loss Type does not match the catastrophe's Peril, ClaimCenter also issues a warning message. The following table describes mismatches that cause errors and warnings:

Non-matching data	Association allowed
date, place, and peril	no, reject
peril	yes (warning)
place	no, reject
place and peril	no, reject
date and peril	no, reject
place and date	no, reject
date	no, reject

ClaimCenter support for associating a claim with a catastrophe

After you have entered the Loss Location, Loss Date, Loss Type and Loss Cause (peril), ClaimCenter can determine whether the claim could be caused by a catastrophe. ClaimCenter does not automatically make this association. Instead, ClaimCenter alerts you by creating a Review Claim for Catastrophe activity for you to decide if you want to make the association.

Matching data	Association allowed	ClaimCenter response
date, place, and peril	yes	Create one activity to alert you of a potential match to the catastrophe.
date and place, not peril	yes	Create one activity to alert you of a potential match to the catastrophe.

If a new claim matches a catastrophe category but is not so defined, ClaimCenter creates an activity.

Working with Catastrophe Bulk Association

To search for claims that do not have a catastrophe associated with them and then associate them if they meet the catastrophe criteria, perform the steps that follow. The system does not automatically associate a claim with the catastrophe, but rather creates an activity and assigns it to the claim owner for each matching claim.

To associate a group of claims with a catastrophe

1. Navigate to Administration tab → Business Settings → Catastrophes.
2. Click the catastrophe name to open the Catastrophe Details screen.
3. Click **Find Unmatched Claims**. The application searches all active catastrophes.

ClaimCenter uses a batch process to perform a search to find all claims with the following criteria:

- Claim loss date is within the catastrophe's effective dates.
 - Claim loss location matches one of the catastrophe's affected zones.
 - Claim loss cause is one of the catastrophe's coverage perils.
 - Claim does not already have an activity on it for potential catastrophe match.
4. The batch process gets scheduled that night and then the system displays the message, **The number of matched claims will be available the next business day at 8 am.**
5. The system marks each claim that the criteria applies to. If the number of found claims related to a catastrophe exceeds the system configurable limit for the number of found claims, `MaxCatastropheClaimFinderSearchResults`, only that limited number of claims are processed. The rest of the claims are processed the next day.
6. The `CatastropheClaimFinder` batch process runs according to the time set in the `scheduler-config.xml` file. A section of the **Catastrophe Details** screen, **History of Matched Claims**, shows any claims that match the catastrophe after the batch process has completed. A Review for Catastrophe activity is created for each claim that has a potential match to that catastrophe.
- Note:** The count includes all claims that have a Review for Catastrophe activity open.
7. To respond to a Review for Catastrophe activity, you must find the claim and navigate to its **Loss Details** screen. You can search in one of two ways:
- Navigate to **Desktop** tab → **Activities** and change the filter on the **Activities** screen to **All open**. The activity subject to choose is **Review for Catastrophe**.
 - Click **Search** → **Activities**, and then specify one of the required search criteria. Then, next to **Subject**, click the drop down menu and click **Review for Catastrophe** and click **Search**.

Catastrophe History

When a catastrophe is initially associated with a claim or the association with a claim has changed, the **History** tab logs the event in claims associated with that catastrophe. This event is a custom event, and this behavior can be removed. See “Claim History” on page 119.

Catastrophe Dashboard

The **Catastrophe Search** screen, accessed from **Search** tab → **Claims** → **Catastrophe Search**, shows catastrophe claim and policy location search results on the Catastrophe Claim Dashboard.

This topic includes:

- “Catastrophe Dashboard Overview” on page 160
- “Preparing to Access the Catastrophe Search Screen” on page 162
- “Accessing the Catastrophe Search Screen and Heat Map” on page 163
- “Working with the Catastrophe Heat Map” on page 163
- “Searching in the Heat Map” on page 164

Catastrophe Dashboard Overview

The default view of the Catastrophe Claim Dashboard shows the geographic distribution of catastrophe claims and policy locations on a heat map. This map provides a quick visual impression of the location of hot spots—areas of concentration for claims or policies—and the impact the catastrophe has had on the carrier.

ClaimCenter generates the heat map from a set of claims or policy locations overlaid on a geographical map. A square marker represents each claim or policy location. As ClaimCenter shows claim or policy location counts, it displays a single blue marker for each location that does not overlap any other markers.

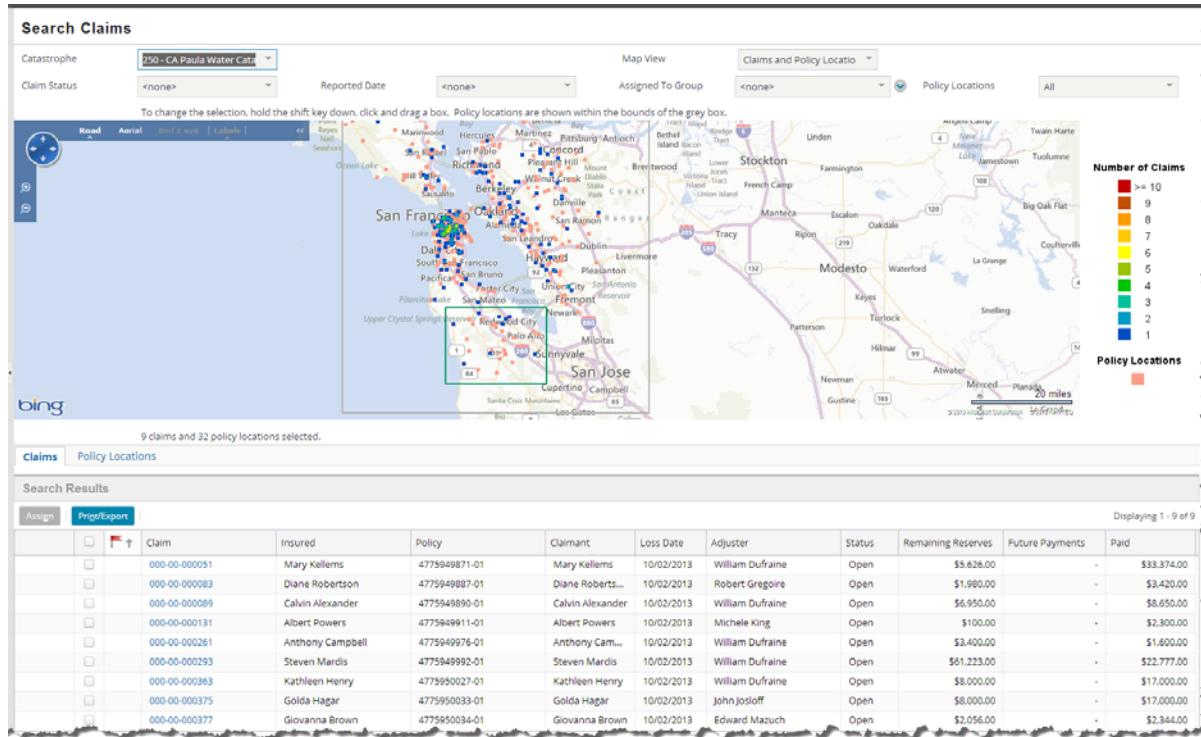
If multiple markers overlap, the map shows a single marker with a color that represents the number of overlapping markers. ClaimCenter shows ten or more overlapping markers in red. The map's color legend on the right shows the intermediate values that correspond to the other colors.

For map views that show financial amounts, ClaimCenter determines the color for each marker by the sum of the values of the overlapping markers.

If you hold the shift key down and drag the mouse, you can select an area. The green rectangle created on the map encloses the selected area. Just below the map, a message gives a summary of the data points in the selected area. For example:

9 claims and 32 policy locations selected

The following figure shows a sample catastrophe heat map:



You can show subsets of catastrophe claims and policy locations on the heat map view by using the **Catastrophe Search** filters and heat map navigation and selection controls. After you have selected a set of claims for further analysis you can:

- Drill down into individual claims and policy locations.
- See below the map a tabular report of the claims and policy locations you want to further analyze.
- Produce a printed or exported version of the tabular report to aid you in your offline catastrophe workflow.
- Assign claims to an adjuster or other individual user, or assign them to a group.
- Perform other actions that require specialized configuration.

Map Views

The Catastrophe Dashboard provides five map views:

- **Claims** – The number and distribution of claims.

- **Claim Total Incurred** – Color coding represents the amount for the claim. The legend to the right of the map shows colors and corresponding amounts. If an area is selected, you also see total incurred listed below the map.
- **Claims and Policy Locations** – The number and distribution of claims and the distribution of policy locations.
- **Policy Locations** – The number and distribution of policy locations.
- **Total Insured Value** – Color coding represents the total insured value for the policy location. The legend to the right of the map shows colors and corresponding amounts.

Policy location views use data downloaded periodically from the policy system through the Catastrophe Policy Location Download batch process. The batch process must be enabled for this data to be available. The batch process downloads policy location data for a catastrophe within the Catastrophe Area of Interest for the effective date defined in the **Catastrophe Detail** screen. The Catastrophe Area of Interest is the bounding box shown on the **Catastrophe Dashboard** in light gray.

Map views that include policy locations—**Claims and Policy Locations**, **Policy Locations**, and **Total Insured Value**—are visible only if the batch process has been enabled. They show data points only if the batch process has downloaded data for the catastrophe. For more information on enabling this batch process, see “Enabling Catastrophe Search and Heat Maps” on page 18 in the *System Administration Guide*.

Tooltips

Clicking a claim or policy location marker on the map displays a tooltip summarizing the key information for the claim or policy location. For example, the **Catastrophe Search** search screen displays a tooltip for a policy location. If the policy system supports this action, clicking the policy number in the tooltip opens the policy in a new browser window.

Configuring the Heat Map

You can configure the Catastrophe Search heat map. For example, you can:

- Change the map colors.
- Add additional filters.
- Add new data sets or map views.
- Create other screens with heat maps that are independent of the Catastrophe Search screen.

For more information, see “Configuring the Catastrophe Dashboard” on page 537 in the *Configuration Guide*.

Preparing to Access the Catastrophe Search Screen

Before you access the Catastrophe Search screen, you must:

- Have the Catastrophe Admin role added to your user account, or have View Catastrophes permission.
- Perform the steps to enable the heat map described in “Enabling Catastrophe Search and Heat Maps” on page 18 in the *System Administration Guide*.

This procedure calls for using the Bing Maps plugin and the Bing Maps AJAX Control v. 6.3. Additionally, if you have PolicyCenter installed, this procedure calls for enabling the Catastrophe Policy Location Download batch process.

- You can learn more about the AJAX control at <http://msdn.microsoft.com/en-us/library/bb429619.aspx>.
- To use the Bing Maps plugin, your company must have its own account and application key with Bing Maps. For more information, go to <http://www.bingmapsportal.com>, where you can set up a Bing Maps account and obtain an application key. After you create a key, the application name is arbitrary and no application URL is required.
- For more information on the batch process, see “Catastrophe Policy Location Download” on page 132 in the *System Administration Guide*.

Accessing the Catastrophe Search Screen and Heat Map

Only users with the View Catastrophes permission can view the **Catastrophe Search** screen and heat map.

You can access the Catastrophe Search and heat map in two different ways:

- Navigate to **Search tab** → **Claims** → **Catastrophe Search**.
- Navigate to **Administration tab** → **Business Settings** → **Catastrophes**.

To access the catastrophe heat map from the search screen

1. Log in to ClaimCenter as a user with the Catastrophe Admin role or one that has the View Catastrophes permission on your user account.
2. Navigate to **Search tab** → **Claims** → **Catastrophe Search**.
3. Use the **Catastrophe** drop-down list to select the name of a catastrophe.

The catastrophe heat map appears.

To access the catastrophe heat map from the Catastrophe Details screen

1. Log in to ClaimCenter as a user with the View Catastrophes permission.
2. Navigate to **Administration tab** → **Business Settings** → **Catastrophes**.
3. In the **Catastrophes** screen, click the name of a catastrophe. The **Catastrophe Details** screen appears.
4. In the **Catastrophe Details** screen, click **Show Map**. ClaimCenter redirects you to the **Catastrophe Search** screen with the catastrophe already selected.

Working with the Catastrophe Heat Map

After you access the **Catastrophe Search** heat map, you can use the map controls to show the area of interest.

You use the controls to do the following:

- **Change the center point of the map** – Click and drag the mouse.
- **Center and zoom** – Double-click the new center point.
- **Zoom in / Zoom out** – Move the scroll control on the mouse up and down or click the plus and minus buttons under the directional buttons on the left.
- **Select an area** – Shift-click one corner of a rectangle, drag to the opposite corner, and release. A green rectangle encloses the selected area.

Filtering the Data on the Map

You can do limited filtering of data in a map on the **Catastrophe Search** screen. You can select the **Map View** and set **Policy Locations** to all policies, policies with claims, or policies without claims.

Additionally, you can set filters that apply by default to the maps shown for a catastrophe.

To limit the types of claims and policy locations shown on the map:

1. Navigate to **Administration tab** → **Business Settings** → **Catastrophes**.
2. In the **Catastrophes** screen, click the name of a catastrophe. The **Catastrophe Details** screen appears.
3. Click **Edit**.
4. In the **Catastrophe Details** screen, click the **Policy Locations** card.
5. Change the settings on the screen, such as **Policy Effective Date** for policy retrieval or **Map View** to set the default map view.

- For claims, set one or all of the **Claim Status**, **Reported Date**, and **Assigned to Group** drop-downs.
- For policy locations, set **Policy Locations**.

The map updates immediately.

It is possible to add additional filters through configuration.

Searching in the Heat Map

You can create a list of all catastrophe claims in the selected region of the **Catastrophe Search** heat map.

1. Select a region of the map that contains the claims that interest you. Shift-click the mouse at one corner of the area you want to select and drag diagonally to create a bounding search rectangle with a green border.
2. The selection message located below the map shows how many claims and policy locations you have selected. Lists of the claims and policy locations found in the search rectangle also appear under the map. The search does not return more than 300 claims, for performance reasons. You can configure this limit in Guidewire Studio by editing the `config.xml` file.
3. You can click a claim number to navigate to its claim summary. If your policy system supports it, you can click a policy number to navigate to the policy in a new browser window.
4. To return to the map, navigate to **Search tab** → **Claims** → **Catastrophe Search**. The map opens with the claim and policy list in the same view as before you navigated away.

Service Provider Performance Reviews

An important part of claim handling is using and recommending service providers that help resolve losses, such as a body shop, assessor, attorney, or physical therapy clinic. ClaimCenter enables you to evaluate your carrier's service providers by gathering review information on them. Having this information helps in selecting the best providers, controlling your claim costs, increasing customer satisfaction, and increasing claim processing efficiency.

In particular, you can:

- Conduct post-service reviews on any type of vendor.
- Score each review as part of the claim associated with the vendor's work.
- Score each vendor by combining its individual review scores.

Once you have collected reviews on your vendors, you can:

- Define lists of preferred vendors based on their past performance, as quantified by their reviews.
- Search for nearby vendors with high review scores.
- Assign nearby and high-rated vendors to provide services.
- Remove poorly performing vendors and steer business to high performers.
- Negotiate contracts with vendors for future services based on objective past performance standards.

Because this feature is available only if ClaimCenter is integrated with ContactManager, the full description is in the Guidewire Contact Management Guide. See "ClaimCenter Service Provider Performance Reviews" on page 215 in the *Contact Management Guide*.

part IV

ClaimCenter Lines of Business

Homeowners Line of Business

The Homeowners line of business enables you to collect the data needed to track, manage, and, if necessary, pay on the claim. Claimants typically file Homeowners claims when a loss occurred at the claimant's property that affected either the property itself or the contents of the property. Claimants can also file claims if someone was injured on the property.

ClaimCenter handles these claims and provides the following benefits:

- **Summary information located in one place** – Enables you to quickly understand the current status of the claim and whether you need to take action.
- **View the policy** – Not only in ClaimCenter, but also in a policy administration system (PAS).
- **Streamlined New Claims wizard** – Simplifies the FNOL claims intake process and enables you to quickly capture claims.
- **Services can be arranged early in the claim intake process** – The adjudication process is accelerated. Any further damage is mitigated at the outset, which ultimately reduces cost.
- **Automatic Incident creation** – Assists in the claim intake process.
- **Scheduled items are automatically pulled into the claim**.
- **Manage contents** – Enables you to manage damaged items on a claim, including scheduled items.

This topic includes:

- “Homeowners Screens” on page 169
- “Homeowners Coverage Types” on page 172

Homeowners Screens

The homeowners line of business provides screens that capture information specifically needed to process that type of claim. ClaimCenter organizes that data in meaningful sections. This topic describes the screens and the fields that pertain to this line of business.

This topic includes:

- “Summary Screens” on page 170

- “Loss Details Screens” on page 170
- “Policy Screens” on page 172

Summary Screens

The **Summary**, **Claim Status**, and **Claim Health Metrics** screens contain the most relevant information for you to determine the status of a claim.

See also

- “Claim Summary Screens” on page 31
- “Claim Status Screen” on page 397
- “Claim Health Metrics” on page 392

Loss Details Screens

The **Loss Details** screens contain information about the loss as it specifically relates to homeowners. These screens are organized into **Loss Details** → **General**, **Associations**, and **Special Investigation Details**.

The **Loss Details** screen contains the following sections:

- **Details** – This section contains information about what occurred, the loss date, loss location, cause, fault rating, if there was a catastrophe, or if weather was a factor.
- **Damage Type** – If fire or water was selected in the **New Claim** wizard and the questions were answered, this section shows the selections made there, **Fire** or **Water** or both. You can also edit the **Loss Details** screen and select **Fire** or **Water** or both under **Damage Type**. If neither damage type is selected, you do not see this section.
- **Loss Items** – This section can show any or all of the following incidents. If you click **Edit** and then click **Add** under **Loss Items**, you can see the entire drop-down list and make changes in a screen for each incident type.
 - **Dwelling** – There can be only one loss related to a dwelling. This section contains sections that describe the damage, services, related exposures, and repairs, if any.
 - **Injury** – Captures information about people who might have injuries.
 - **Living Expenses** – The living expenses incident is associated with the **Loss of Use** coverage type. This section captures information about temporary dwelling costs and duration and meal costs. Additionally, there might be related exposures and services that had to be performed, both of which can also be captured in the **Living Expenses** screen.
 - **Other Structure** – This incident captures information about structures other than the main dwelling, such as a secondary building like a shed or artist’s studio. This section is also where you enter data if a shared fence was damaged. Additionally, there might be related exposures and services that had to be performed, both of which can also be captured in the **Other Structure** screen.

The **Other Structure** screen also provides an **Assessment** card that captures information about damage to the structure. The information includes a description, estimated loss amount, if already repaired, and if any fences were damaged. Additionally, there might be related exposures and services that had to be performed, both of which can also be captured in this card.

- **Personal Property** – The personal property incident is associated with the personal property coverage type. Use this section to capture the list of damaged content items, including scheduled items. Additionally, you can add any services needed related to that property damage. See “**Line Items**” on page 171.
- **Property Liability** – Use this screen to capture any damage to third party property. Additionally, you can specify any services needed that are related to that property damage and information about repairs.

The **Property Liability** screen also provides an **Assessment** card that captures information about the assessment of damages. Among other things, the information can include who the assessor was, when the assessment will be done, details on the damage, and estimates of the costs. See “**Assessments**” on page 149.

If you select the item to edit or click **Add** to create a new scheduled item, you can see how many scheduled items are listed on the policy. You can specify in detail how the value of replacing the item is to be determined.

- **Line Items** – This section shows specific line items that are mentioned in the policy. See “Line Items” on page 171.
- **Witnesses** – In edit mode, you can list witnesses that might be important to the claim.
- **Officials** – If any official, such as a police officer or coroner, was involved and wrote a report, you can enter that information in this section.
- **Metropolitan Reports** – If you received any reports, you can list them in this section and link to the document.
- **Notification and Contact** – Use this section to document how the claim was reported, who reported it, who is the main contact, and so forth.

Notes

- In the base configuration, the ISO card is not enforced. If you want to use that feature for ISO or any other statutory reporting organization, you must set up ISO rules in Studio.
- If you try to create exposures for all the earthquake and flood coverage subtypes and exposure types, ClaimCenter warns you that **No two exposures can have the same Coverage/Claimant combination**. The solution is to open Guidewire Studio and set the configuration parameter `EnableClaimantCoverageUniquenessConstraint` to `false` in the `config.xml` file.

Line Items

A claimant’s policy can contain specific items that are mentioned in the policy. Examples could include a heirloom grandfather clock or a wedding ring. If these items are damaged or stolen, the way an adjuster determines those amounts depends on the claimant’s policy.

There are two ways to determine the amount of money that the insurer pays to indemnify the claimant for a particular line item. This is the replacement value (RCV) or actual cash value (ACV). Depending on the type of coverage the insured has, reimbursement is either by RCV or ACV.

- **Replacement Cost Value (RCV)** – The maximum amount the carrier pays the claimant for damage to covered property without a deduction for depreciation. The RCV payment uses the current cost to replace the property with new, identical, or comparable property. For example, five years ago the insured paid \$100, plus sales tax, for a table. It is no longer available, but a comparable item currently costs \$125. With RCV coverage, the maximum amount the carrier pays the insured for the item is \$125, plus sales tax.
- **Actual Cash Value (ACV)** – The amount the carrier pays the claimant for damage to covered property with a deduction for depreciation. The formula is:

When the RCV value is null, then the ACV is equal to the original cost minus depreciation: $ACV = \text{Original cost} - \text{Depreciation}$.

Otherwise, the ACV is equal to the RCV minus depreciation: $ACV = RCV - \text{Depreciation}$.

For example, five years ago the insured paid \$100, plus sales tax, for a table. Since ACV is the current replacement cost less depreciation, you must consider wear and tear, if any. If the table had a reasonable life expectancy of 10 years, and the insured used it for five years, the table might have depreciated 50% of its value. The item, or a comparable equivalent if the item is no longer available, currently costs \$125. With ACV coverage, the maximum amount the carrier pays the insured for the table is \$62.50, plus sales tax: current replacement cost, \$125, plus sales tax, less 50% depreciation.

Homeowners policies normally have limits for each of the line item categories in the policy language. If the policy has a limit for a particular content category being itemized on the personal property incident, then you enter that limit into the **Limit Amount** field. Since there is no transactional validation in the base configuration, you must configure rules to restrict this programmatically.

Associations Screen

Use this screen to associate any other claims with this claim. For example, if there was a large accident at work and there were several claimants, you might associate all the claims together.

Special Investigation Details

This screen contains a question set that, depending on the answers, can trigger an investigation to rule out fraud. To learn about this feature see “Claim Fraud” on page 141.

Policy Screens

The **Policy** screens contain information related to the policy. ClaimCenter organizes these screens into **General**, **Locations**, **Endorsements**, and **Aggregate Limits** sections

- **General** – Enables you to edit the policy, refresh it, select another policy, and view the policy in a policy system.

Action	Description
Edit	ClaimCenter warns you that if you edit a policy, then it is marked as unverified. Edits made to the policy are saved only in ClaimCenter.
Refresh	This selection replaces policy information with a fresh policy snapshot.
Select another policy	Selecting a new policy removes any references on the claim such as vehicles, properties, and coverages.
View the policy in a policy system	If ClaimCenter is integrated with a policy administration system or with Guidewire PolicyCenter, a new browser window opens into that application. See “Enabling Integration between ClaimCenter and PolicyCenter” on page 97 in the <i>Installation Guide</i> .

The **General** screen contains information related to the policy, such as policy number, type, dates, status, agent, underwriter, data on the insured, and other related information. If you edit this information, you cause the policy to be no longer verified it with the policy system.

See “Working with Policies in Claims” on page 91 to learn more.

- **Locations** – Contains address details of the locations and details on the type of coverage. For example, a policy can have earthquake coverage with a \$5,000 USD deductible and an incident limit of \$800,000 USD. If you add or edit locations, you cause the policy to be no longer verified it with the policy system.
- **Endorsements** – Lists any endorsements that might be on the policy. For example, the homeowners policy has a limit of \$4000 USD for jewelry, but the insured decided to have a separate endorsement for a very expensive heirloom necklace.
- **Aggregate Limits** – An *aggregate limit* is the maximum financial amount that an insurer is required to pay on a policy or coverage during a given policy period. For more information, see “Aggregate Limits” on page 103.

Homeowners Coverage Types

To understand the relationships between coverages, subtypes, exposures, and incidents, it might be useful to see how lines of business are set up in Guidewire Studio.

1. Open ClaimCenter studio by navigating in a command window to the `ClaimCenter/bin` directory and entering `gwcc studio`.
2. Navigate in the Project window to `configuration → config → Extensions → Typelist`, and then double-click `PolicyType.ttx`.

3. In the Typelist editor, expand **PolicyType** → **Homeowners** → **Children** to see the list of coverage types in the table that follows.

- Expand a coverage type and then expand **Children** to see its coverage subtypes.
- Expand a coverage subtype and then expand **Children** to see its exposure type.
- Expand an exposure type and then expand **Other Categories** to see the type of incident.

The following table lists the homeowners coverage types, subtypes, exposures, and incidents.

Coverage Type Name	Coverage Subtype	Exposure Type	Incident
Dwelling Theft	Dwelling Theft	Content	PropertyContentsIncident
Earthquake Coverage	Earthquake - Other Structures	Other Structure	OtherStructureIncident
Earthquake Coverage	Earthquake - Personal Property	Content	PropertyContentsIncident
Earthquake Coverage	Earthquake - Property Damage	Dwelling	DwellingIncident
Fire Dwelling	Dwelling Fire - Dwelling	Dwelling	DwellingIncident
Fire Dwelling Loss of Use	Dwelling Fire - Loss of Use	Living Expenses	LivingExpensesIncident
Fire Dwelling Medical Payments	Dwelling Med Pay	Med Pay	InjuryIncident
Fire Dwelling Ordinance Or Law	Dwelling - Ordinance or Law	Property	FixedPropertyIncident
Fire Dwelling Other Structures	Dwelling - Other Structures	Other Structure	OtherStructureIncident
Fire Dwelling Personal Liability	Personal Liability - BI	Bodily Injury	InjuryIncident
Fire Dwelling Personal Liability	Personal Liability - Gen. Damages	General	Incident
Fire Dwelling Personal Liability	Personal Liability - PD	Property	FixedPropertyIncident
Fire Dwelling Personal Property	Dwelling - Personal Property	Content	PropertyContentsIncident
HO Personal/Advertising Injury	HO Personal/Advertising Injury	General	Incident
Homeowners Dwelling	HO Dwelling	Dwelling	DwellingIncident
Homeowners Loss Of Use	HO Loss of Use	Living Expenses	LivingExpensesIncident
Homeowners Medical Payments	HO - Med Pay	Med Pay	InjuryIncident
Homeowners Ordinance Or Law	HO - Ordinance or Law	Property	FixedPropertyIncident
Homeowners Other Structures	HO Other Structures	Other Structure	OtherStructureIncident
Homeowners Personal Liability	HO Liability - BI	Bodily Injury	InjuryIncident
Homeowners Personal Liability	HO Liability - Gen. Damages	General	Incident
Homeowners Personal Liability	HO Liability PD	Property	FixedPropertyIncident
Homeowners Personal Property	HO Personal Property	Content	PropertyContentsIncident
Inflation Guard	HO Inflation Guard	General	Incident
Limited Fungi, Wet or Dry Rot or Bacteria Florida	HO Fungi - FL cov	Property	FixedPropertyIncident
Limited Fungi, Wet or Dry Rot or Bacteria	HO Fungi etal	Property	FixedPropertyIncident
Other Insured Locations Occupied By Named Insured	HO Other Insured Residences	Other Structure	OtherStructureIncident
Other Structures Off The Residence Premises	HO Off Premises Structures	Other Structure	OtherStructureIncident
Other Structures On The Residence Premises	HO Other Structures on Premises	Other Structure	OtherStructureIncident
Personal Property At Other Residences	HO Personal Prop at Other Residences	Content	PropertyContentsIncident
Scheduled Personal Property	HO Scheduled Personal Property	Content	PropertyContentsIncident

Coverage Type Name	Coverage Subtype	Exposure Type	Incident
Section I Deductibles	HO Property Deductibles	General	Incident
Section II - Limited Coverage For Computer Related And Other Electronical Problem	HO Ltd. Computer Liability	General	Incident
Section II Limited Fungi, Wet Or Dry Rot Or Bacteria	HO Ltd. Fungi Liability	General	Incident
Special Limits Personal Property	HO Special Limits - Personal Property	Content	PropertyContentsIncident
Specific Structures Away From The Residence Premises	HO Specific Structures Off Premises	Other Structure	OtherStructureIncident

Personal Travel Line of Business

Travelers can purchase insurance to cover the risks associated while traveling. These policies are short term, usually for the duration of the trip. The policy typically covers issues such as lost or stolen luggage, medical payments while on the trip, or issues resulting from delayed, canceled, or interrupted flights. There are several types of travel insurance available such as:

- **Personal** – Purchased for the duration of a specific trip and based on your itinerary.
- **Group** – Purchased by a travel agency for groups of people on the same trip.
- **Business** – Typically purchased by your company as a multi-region, annual policy.

The ClaimCenter default configuration contains the Personal Travel line of business, which includes a single person or families.

This topic includes:

- “Personal Travel Insurance Overview” on page 175
- “Working with the Personal Travel Line of Business” on page 177
- “Personal Travel Screens” on page 177
- “Personal Travel Coverage Types” on page 180

Personal Travel Insurance Overview

This topic describes why you might purchase a travel policy, the policy type of personal travel. It also includes items that are not covered under this policy.

Use Cases

Following are some reasons to purchase a personal travel policy.

Personal Property/Baggage/Contents

A traveler might need this coverage for any of the following scenarios:

- The insured traveler loses a bag with personal possessions in a foreign country and must purchase essentials to last through the trip. The insured mails a claim form to the carrier with the appropriate documentation. The carrier issues a check after assessing the line items for items that were replaced. Items include clothes, toiletries, small electronics, and so forth that are claimed as a loss, without a replacement.
- The insured traveler files a claim for the loss of high value electronic items such as cameras, video cameras, and laptop computers. If there is no proof of purchase or ownership, ClaimCenter flags the claim and creates activities to check for fraud.
- The insured traveler loses travel documents such as a passport. Personal property coverage covers costs incurred for additional travel to obtain new travel documents.

Cancellation or Interruption

Examples of cancellation can be the need to cancel a flight, hotel, and rental car due to a death in the family, with proof. The carrier pays out cancellation fees for all bookings as well as agent fees, if applicable, up to the maximum covered.

Delay

This coverage applies to costs arising from a delayed or canceled departure. If a claim has not yet been filed, the insured must file a claim against the travel provider, as well as proof of delay. Usually, the insured must be delayed for at least six hours for the claim to be valid. The insured receives a payment for every 24 hour delay thereafter up to the coverage limit. Costs can also be for hotel, car rental, and meal expenses.

Health/Medical

This coverage applies to health-related costs for a disabling injury, sickness, or disease. Costs paid can include medical bills, ambulance costs, accommodation costs, and so forth. However, the insured cannot have any associated pre-existing conditions in the set time period.

Rental Car

The insured has an accident in the rental car. The auto policy covers a portion of all damages incurred. The rental car coverage pays for auto damages in excess of the coverage provided by the purchased auto rental insurance. The insured is liable for any further excesses. The liability coverage pays for damage to a third party's property or death.

Travelers typically need to provide proof when submitting a claim such as:

- Travel vouchers, boarding cards, passport copies, and entry/exit visas
- Police report filed within a reasonable time frame
- Doctor's notification of illness
- Other supporting documentation such as military reporting date or jury reporting date
- Proof of baggage loss

Non-covered Items

The travel policy determines what is covered. Typically, policies do not cover:

- Delay due to detention by customs, government officials, or other authorities
- Missed flight due to mechanical failure of a personal car
- Existing medical conditions
- Theft, loss, or damage if proper care was not taken, such as failing to lock the car or hotel room or leaving possessions unattended

Working with the Personal Travel Line of Business

This topic describes how to work with a personal travel claim by using the New Claim wizard.

To create a new travel claim

1. Click the drop-down button on the **Claim** tab, and then click **New Claim**.

The New Claim wizard opens. In Step 1, you must either find a policy to associate with the claim or create an unverified policy.

- a. If you are creating an unverified policy, indicate if it is regular **Travel**, **Quick Claim Baggage**, or **Quick Trip Cancel**. Your choice determines which wizard you complete. Use **Travel** for this example.
 - b. If you find a policy, enter a loss date. At this point, you can use either the New Claim wizard, the Quick Claim Baggage wizard, or the Quick Trip Cancel wizard. This example uses the New Claim wizard.
2. Step 2 of the wizard gathers information. Optionally, you can edit the contact information.
 3. Use Step 3 of the wizard to enter loss details. Select a loss cause where you can create the following type incidents: trip, baggage damage, injury, vehicle, and property damage. Click the buttons **Add Trip**, **Add Baggage Damage**, **Add Injury**, **Add Vehicle**, and **Add Property Damage** in turn to create each kind of incident.
 4. Use Step 4 of the wizard to assign the claim and exposures and save your claim.

Personal Travel Screens

The travel line of business provides screens that specifically capture information that is needed to process that type of claim. ClaimCenter organizes data in meaningful groups. While you might see some of these screens in the New Claim wizard, it is possible that an adjuster might have limited information when the claim is first entered. The adjuster can return to the claim to add more information or to work on the claim. This section provides descriptions of screens and fields that specifically pertain to this line of business.

The following sections contains these topics:

- “Summary Pages” on page 177
- “Loss Details Screens” on page 178

Summary Pages

The **Summary**, **Claim Status**, and **Claim Health Metrics** screens contain the most relevant information for you to determine the status of a claim. You can determine the following:

- How long the claim has been open.
- What occurred, such as that the claimant lost her passport.
- If any monies have been paid.
- If there are any high risks to this claim.
- What exposures are on the claim and their status.
- Where the incident occurred.
- Who was involved.
- If there are any planned activities.

To learn specifically about Claim Performance Monitoring see “Claim Performance Monitoring” on page 391.

From the **Summary** screen, you can click an exposure under the **Exposures** section. Clicking an exposure displays the **Exposures Details** page, where you can edit, assign, create a reserve for, or close the exposure.

See also

- “Claim Summary Screens” on page 31
- “Claim Status Screen” on page 397
- “Claim Health Metrics” on page 392

Loss Details Screens

The Loss Details screens contain information about the loss as it specifically relates to travel, and are organized into: Loss Details, Associations, and Special Investigation Details. If you click **Edit** on the Loss Details screen, an edit page opens.

The screenshot shows the Guidewire ClaimCenter interface for managing a travel claim. The main window is titled "Loss Details". On the left, a sidebar menu includes "Actions", "Summary", "Workplan", and "Loss Details" (which is currently selected). Other menu items include "General", "Associations", "Special Investigation Data", "Exposures", "Parties Involved", "Policy", "Financials", "Notes", "Documents", "Plan of Action", "Services", "Litigation", "History", and "Calendar". The main content area displays the "Loss Details" screen with fields for "Description" (set to "Lost Passport"), "Loss Cause" (a dropdown menu showing options like "Abandonment", "Assault or battery", "Burglary", etc.), and "Loss Location" (fields for "Location", "Country", and "Address 1"). To the right, there are several expandable sections: "Trip" (with "Affected Trip" and "Reason for cancellation/curt"), "Baggage & Contents" (listing "Baggage" and "Trav..."), "Injuries" (listing "Name" and "Severity"), and "Vehicles". The top of the screen shows the claim number (765-10-132541) and other status information (Ins: Frances Beale, DoL: 08/22/2013, St: Open, Adj: Edgar Austin (Western Travel Group)).

The editable Loss Details screen contains the following sections:

- Loss Details** – Contains information about the incident. Of note is the drop-down list for **Loss Cause**, which enables you to set the cause of the loss. For example, the cause of the loss was that the passport document was lost. This list is configurable.
- Loss Location** – Contains geographical details concerning where the loss occurred.
- Notification and Contact** – Captures information regarding how the loss was reported, who reported it, and who is the main contact.
- Witnesses** – Witness information, including if the witness gave a statement and where they were when they witnessed the incident.
- Contributing Factors** – Captures additional information if applicable. For example, the default choices for **Category** are driver or environmental conditions. You can enter data indicating that the driver was driving too fast or that the highway had no barrier.
- Loss Items** – The incidents are listed as follows:

- **Trip** – Captures details of the trip incident, which is a subtype of **Incident**. Adding a trip opens the **Trip Incident** screen. Use this section to capture details of the trip, reason for the cancellation or delay, and any transportation and accommodation details such as associated fees. For example:

The screenshot shows the 'Trip Incident' screen in Guidewire ClaimCenter. At the top, there are tabs for 'Desktop' and 'Claim (765-10-132541)'. Below the tabs, it displays policy information: Pol: 33-514135, Ins: Frances Beale, DoL: 08/22/2013, St: Open, Adj: Edgar Austin (Western Travel Group). The main content area is titled 'Trip Incident' and includes sections for 'Trip Details', 'Reason for cancellation/curtailment/delay', 'Approved Financial Impact', 'Services to Perform', and 'Transportation Details'.

Type	Relates To	Services	Vendor

Transportation Details		Accommodation Details		
Original Transportation				
Add Transport	Remove Transport	Approved	Reviewing	Denied
<input type="checkbox"/>	Type	Transportation Description	Status	Approval Status
<input type="checkbox"/>	Airline	United	Canceled	Approved
				\$4,585.00

- **Baggage & Contents** – Captures details of the **Baggage** exposure type, which has a baggage incident type. You must select a baggage type, such as backpack, tote, suitcase, or travel documents. There are also baggage and contents line items that can be listed. To see how to calculate the value of a line item, the details of how the claimant is to be reimbursed, see “**Line Items**” on page 179.
- **Injuries** – Editing this section displays the **Injury Incident** screen. Enter any injury details.
- **Vehicles** – Capture information on vehicles if they were involved.
- **Properties** – The new property incident if there was property damage.
- **Officials** – If any official, such as a police officer or coroner, was involved and wrote a report, you can enter it that information in this section.

Note: In the base configuration, the ISO card is not supported. If you want to use that feature for ISO, or any other stationary reporting organization, you must set up ISO rules in Studio.

Line Items

A claimant’s policy can contain specific items that are mentioned in the policy. Examples could include cameras, computers, electronics, and so forth. If these items are damaged or stolen, the way an adjuster determines those amounts depends on the claimant’s policy.

There are two ways to determine the amount of money the insurer pays to indemnify the claimant for a particular line item: replacement value (RCV) and actual cash value (ACV). Depending on the type of coverage, the insured is either reimbursed by RCV or ACV.

- **Replacement Cost Value (RCV)** – The maximum amount the carrier pays the claimant for damage to covered property, without a deduction for depreciation. The RCV payment is based on the current cost to replace the property with new, identical, or comparable property. For example, five years ago the claimant paid \$100,

plus sales tax, for a camera. That model of camera is no longer available, but a comparable item currently costs \$125. With RCV coverage, the maximum amount the carrier pays the claimant for the item is \$125, plus sales tax.

- **Actual Cash Value (ACV)** – The amount the carrier pays the claimant for damage to covered property, minus a deduction for depreciation. The formula is as follows:

When the RCV value is null, then the ACV is equal to the original cost minus depreciation. ($ACV = Original\ cost - Depreciation$)

Otherwise, the ACV is equal to the RCV minus depreciation. ($ACV = RCV - Depreciation$)

For example, five years ago you paid \$100, plus sales tax, for a camera. Since ACV is the current replacement cost less depreciation, you must consider *wear and tear*, if any. If the camera had a reasonable life expectancy of 10 years, and you used it for five years, the camera could have depleted 50% of its value. The item, or a comparable equivalent if the item is no longer available, currently costs \$125. With ACV coverage, the maximum amount the carrier will pay you for the camera is \$62.50, plus sales tax (current replacement cost, \$125, plus sales tax, less 50% depreciation).

Travel policies normally have limits for each of the line item categories in the policy language. If the policy has a limit for a particular content category being itemized on the incident, then you enter that limit into the **Limit Amount** field. Since there is no transactional validation in the base configuration, you must configure rules to restrict this value programmatically.

Associations Screen

Use this screen to associate any other claims with this one. For example, if there was a large accident at work and several claimants, you could associate all the claims with one another.

Special Investigation Details

This section contains a question set that depending on the answers, can trigger an investigation to rule out fraud. To learn about this feature see “Claim Fraud” on page 141.

Personal Travel Coverage Types

Personal travel has the following coverage types:

- **Baggage** – General coverage for items such as suitcases, the contents inside suitcases, personal property such as electronics, cell phones, cameras, wallets, and documents such as passports
- **Health** – Medical payments
- **Hired Auto** – Generally excesses for hired or rented autos
- **Liability** – Third-party liability
- **Trip** – If your journey was canceled or delayed

To understand the relationships between coverages, subtypes, exposures, and incidents, it might be useful to see how lines of business are set up in Guidewire Studio.

1. Open ClaimCenter studio by navigating in a command window to the `ClaimCenter/bin` directory and entering `gwcc studio`.
2. Navigate in the Project window to `configuration → config → Extensions → Typelist`, and then double-click `PolicyType.ttx`.
3. In the Typelist editor, expand `PolicyType → Personal Travel → Children` to see the list of coverage types in the table that follows.
 - Expand a coverage type and then expand `Children` to see its coverage subtypes.
 - Expand a coverage subtype and then expand `Children` to see its exposure type.

- Expand an exposure type and then expand Other Categories to see the type of incident.

The following table lists the personal travel coverage types, subtypes, exposures, and incidents.

Coverage Type Name	Coverage Subtype	Exposure Type	Incident
Baggage	Baggage - Loss, Damage, or Delay	Baggage	BaggageIncident
Health	Travel - Medical Expenses	Med Pay	InjuryIncident
Hired Auto	Hired Auto Damages	Vehicle	VehicleIncident
Liability	Liability - Auto Damages	Vehicle	VehicleIncident
Liability	Liability - Bodily Injury Damage	Bodily Injury	InjuryIncident
Liability	Liability - General Damage	General	Incident
Liability	Liability - Property Damage	Property	FixedPropertyIncident
Trip	Trip - Cancellation or Delay	Trip Cancellation or Delay	TriplIncident

Workers' Compensation Line of Business

Guidewire designed the ClaimCenter workers' compensation line of business to collect the data needed to track, manage, and, if necessary, pay on the claim. Usually, employers file these types of claims when employees are injured at their place of employment. They might seek medical treatment and possibly reimbursement of pay for missed work. The most serious claims involve injuries that are permanent, and awards might be paid to the injured worker. Employers file these claims with their insurance carrier, and ClaimCenter assists in handling of these claims. The system provides the following features:

- **Summary information located in one place** – You can see the current status of the claim and determine if you need to take action.
- **Medical details** – Grouped in sections for convenience. Includes views of summary information, details, and medical case management.
 - **Medical Diagnosis** – Tracks diagnosis to injury by using international standards.
 - **Medical Notes** – Automatically marked for security reasons, so that only those with certain permissions can view them.
- **Time Loss** – Includes views of summary information, and benefits information. The benefit information includes type of disability, waiting period, and other jurisdictional factors that you can modify.
- **Search** – Find workers' compensation claims by injured worker.
- **Automatic creation of an injury incident and two exposures** – The exposures, **Medical Details** and **Time Loss**, are menu links in the sidebar. The injury incident is visible on the **Loss Details → General** screen in the **Injury** section.

This topic includes:

- “Workers’ Compensation Overview” on page 184
- “Workers’ Compensation Screens” on page 184
- “Compensability Decision” on page 190
- “Finding Injured Workers” on page 191
- “Jurisdictional Benefit Calculation Management” on page 191

- “Workers’ Compensation Administration” on page 192
- “Workers’ Compensation Coverage Types” on page 193

Workers’ Compensation Overview

The workers’ compensation **New Claim** wizard can automatically create an injury incident and the Medical Details and Time Loss exposures. Creating the incident and exposures depends on how much data you enter in the wizard. After claim creation, you then can create the Employer Liability exposure. All exposures are accessed from the sidebar menu of the user interface.

Medical Details Exposure

Create a Medical Details exposure in the **Loss Details** step of the wizard based on setting any of the following:

- Yes to **Incident Only?** and Yes to Medical treatment
- No to **Incident Only?** and Yes to Medical treatment
- No to **Incident Only?** and No to Medical treatment

Loss Time Exposure

If you choose Yes to **Lost time from work?** in the **Lost Time** section, ClaimCenter creates the Time Loss exposure.

On completion of the wizard, both exposures are created and you can access them directly from the left pane.

Employer Liability Exposure

After claim creation, if there is employer liability, you can add that exposure by navigating to the **Loss Details → General** screen. In the **Classification** section, choose Yes for **Employer Liability**. This setting creates the exposure, and it becomes accessible similarly to the other exposures in the sidebar menu.

Workers’ Compensation Screens

The workers’ compensation line of business provides screens that capture information that is specifically needed to process that type of claim. Many times, an adjuster needs to see the information to process the claim efficiently. ClaimCenter organizes the data in meaningful groups. While you might see some of these screens in the **New Claim** wizard, it is possible that an adjuster might have limited information when the claim is first entered. The adjuster would then need to return to the claim either to add more information or to work on it. This topic provides sample screens and descriptions of fields that specifically pertain to this line of business.

This topic includes:

- “Summary Screens” on page 185
- “Loss Details Screens” on page 186
- “Medical Details Screens” on page 187
- “Time Loss Screens” on page 189
- “Finding Injured Workers” on page 191

Summary Screens

The **Summary**, **Status**, and **Claim Health Metrics** screens, available by clicking **Summary** in the sidebar, contain the most relevant information for you to determine the status of a claim. See “Claim Performance Monitoring” on page 391.

The screenshot shows the Guidewire ClaimCenter interface with the following details:

- Header:** Guidewire ClaimCenter*, Desktop, Claim (312-36-368870), Search, Address Book, Vacation, Go to (Alt+).
- Top Bar:** Pol: 34-123436, Ins: Wright Construction, Clmt: Willy Dunn, DoL: 09/06/2013, St: Open, Adj: Gerald Ickes (Comp - TeamA).
- Left Sidebar (Actions):** Summary, **Overview** (selected), Status, Health Metrics, Workplan, Loss Details, Medical Details, Time Loss, Parties Involved, Policy, Financials, Notes, Documents, Plan of Action, Services, Litigation, Calendar.
- Main Content:**
 - Summary:** Basics: Open (46 days Target: 90), Worker fell from 2nd story scaffolding. Financials: Gross Incurred \$17,000.00, Paid \$4,500.00. High-Risk Indicators: Currently flagged.
 - Loss Details:** Loss Date: 09/06/2013 12:00 AM, Notice Date: 09/06/2013, Loss Location: 846 Yount Ln., Hollywood, CA 91357, United States, Description: Worker fell from 2nd story scaffolding, Work Status: Unknown.
 - Services:** A table showing services with columns: Type, Status, Service #, Next Action, Action Owner, Relates To ↑, Services, Vendor, Quote, Ass.
 - Exposures:** A table showing exposures with columns: # ↑, Type, Coverage, Claimant, Adjuster, Remaining Reserves, Future Payments, Paid, Recoveries. Two entries are listed:
 - 1 Medical Det... Statutory Workers' ... Gerald Ickes \$10,500.00 - \$1,500.00 -
 - 2 Time Loss Statutory Workers' ... Gerald Ickes \$2,000.00 - \$3,000.00 -
 - Parties Involved:** A table showing parties involved with columns: Name ↑, Roles, Phone. Two entries are listed:
 - Jennifer Albee Agent 818-446-1206
 - DoctorFrom Arcadia Ma Chuck Pavae Doctor 626-473-8576
 - Latest Notes:** A section containing a note: "Phone call with claimant. Spoke with the injured worker. He says that he still experiences pain w..."

Loss Details Screens

The Loss Details screens contain information about the loss as it specifically relates to workers' compensation. These screens are **Loss Details**, **Associations**, and **Special Investigation Details**.

The screenshot displays the Guidewire ClaimCenter interface for managing workers' compensation claims. The main window is titled "Loss Details" and contains several sections:

- Loss Details:** Description: "Worker fell from 2nd story scaffolding".
- Injured Worker:** Name: "Willy Dunn", Contact Prohibited?: "No", Phone: "619-275-2346", Address: "435 Duarte Ave, Arcadia, CA 91006, United States".
- Employment Data:** Average Weekly Wage: "\$750.00", Select Class Code by: " ".
- Classification:** Medical attention required? (checkbox)
- Key Dates:** Date of Injury / Illness: "09/06/2013" (Loss Date), Time of Injury / Illness: "12:00 AM", Date Shift Started: "10/09/2013", Time Shift Started: "8:56 AM", Date Employer Notified, Form Sent to Employee.
- Notification and Contact:** First Notice Suit?, How Reported, Reported By: "Nancy Furman", Relationship to Insured: "Employee", Main Contact: "Nancy Furman", Relationship to Insured: "Employee".
- Compensability Factors:** Injury During Employment? (checkbox)

The editable Loss Details screen provides the following sections:

- **Loss Details** – Information about the injury and where it occurred.
- **Injured Worker** – Standard information about the claimant.
- **Employment Data** – Includes information such as average weekly wage, date of hire state of hire, employment status, and so forth.
- **Injury** – Describes the injury. The severity of the injury can trigger a high risk indicator. For example, if the claimant died, a fatality risk indicator would be shown on the **Info bar** and **Summary** screen.
- **Classification** – Various ways you can classify a claim. If you select **Employer Liability**, either in this screen or through the wizard, ClaimCenter creates that exposure, and the **Employer Liability** menu link becomes available in the sidebar.
- **Key Dates** – Date of injury, notification to employer, time of injury, and so forth.
- **Notification and Content** – Captures information regarding how the injury was reported, who reported it, and who is the main contact.
- **Compensability Factors** – Helps you to determine if the claim is compensable by answering a set of questions.
- **Compensability Decision** – Captures compensability details related to jurisdiction, such as the compensability due date, whether the claim is to be accepted or not, and the reason for it. Even if you refuse the claim, you must still close it.
- **Body Part Details** – You can specify the area of the body that was injured and if a decision was made whether to accept or deny compensability.

- **Job Details** – Think of this section as *Employment History*. Use this section to list a claimant's possible current other jobs or past jobs. This information helps the adjuster see if an injury is tied to another place of employment.
- **Other Benefits** – If the claimant is receiving any other benefits, such as from the government or other parties, you can list them along with the amount and duration.
- **Officials** – If any official, such as a police officer or coroner, was involved and wrote a report, you can enter it that information in this section.
- **Metropolitan Reports** – If you received any reports, you can list them in this section and link to the document. See “Metropolitan Reports” on page 533.

Note: In the base configuration, even though you can see the ISO card, you must first integrate ISO to be able to use this card. See “Insurance Services Office (ISO) Integration” on page 447 in the *Integration Guide*.

Associations Screen

Use this screen to associate any other claims with this one. For example, if there was a large accident at work and there were several claimants, you could associate all the claims together.

Special Investigation Details Screen

This screen provides a question set that, depending on the answers, can trigger an investigation to rule out fraud. To learn about this feature see “Claim Fraud” on page 141.

Medical Details Screens

The Medical Details screen is organized into **Summary**, **Details**, **Medical Case Mgmt**, and **ISO** cards, and there are several actions that you can perform:

- You can edit certain fields, such as **Alternate Contact** or **Nurse Case Manager**.
- You can assign the exposure to someone else, either by using either automated assignment or by directly finding another adjuster.
- If you click **Close Exposure** to close the medical details exposure, select an outcome from the drop-down menu. Default choices include completed, duplicate, fraud, mistake, payments complete, and unnecessary.
- If you create a reserve, the items added or changed on the screen are submitted as a group. Any line item that has not been changed is not saved. Any line item with Pending Approval reserves that has its New Available reserves set to equal its Currently Available reserves will have those Pending Approval reserves deleted. Comments are saved only when another field on the line has changed.

The **Summary** card contains the following sections:

- **Exposure** – Contains basic information related to the exposure and includes who the adjuster is, the creation date, the validation level, and any alternate contacts.
- **Financials** – Lists the remaining reserves, future payments, total paid, total recoveries, and net total incurred.
- **Coding** – Records basic information collected when the claim was first entered into the system.
- **Body Parts** – Lists the areas affected, determined either through the **New Claim** wizard or at a later date in the **Loss Details** screen.
- **Medical Diagnosis** – Shows any codes that an adjuster has entered. You enter or update codes from the **Medical Case Mgmt** tab.
- **Activities** – Lists any activities associated with this exposure.
- **Medical Notes** – Lists any medical notes made concerning the exposure. Choose **Actions → Note** to create a medical note for the claim.

The **Details** card contains the following sections:

- **Medical Provider Network** – Confirms if the physician and the injured worker are in the medical provider network.

- **Maximum Medical Improvement** – The date on which the claimant has reached the *MMI limit*, defined by one of the following events:
 - The claimant's condition cannot be improved any further.
 - The claimant has reached a treatment plateau.
 - The claimant has fully recovered from the injury.
 - The claimant's medical condition has stabilized, and no major medical or emotional change is expected.

When a claimant who is receiving workers' compensation benefits reaches maximum medical improvement, their condition is assessed and a degree of permanent or partial impairment is determined. This degree impacts the claimant's benefit amount.

Maximum medical improvement means that treatment options have been exhausted. Temporary disability payments are terminated and a settlement is worked out regarding the condition of the worker at this point.

- **Initial Provider Contact** – This section is where the initial provider records the claimant complaints as reported by the claimant and assesses the condition based on the provider's medical background.
- **First Report of Injury** – This section captures critical information, including who the attending doctor was, what the diagnosis was, and if further treatment was needed.
- **Settlement** – Indicates if there was a settlement date and method.

The **Medical Case Mgmt** card provides the following sections:

- **Medical Personnel** – Information on the medical people involved.
- **Medical Treatment Approvals** – Lists what medical treatments have been approved for the claimant.
- **Medical Actions and Information** – Lists the medical actions that were reported, such as the condition of the claimant, who the provider was, source of information, treatment status, and when the contact was made.
- **Medical Diagnosis** – You can add, edit, remove, make one diagnosis primary, and reconfirm the diagnosis. The medical diagnosis uses ICD codes that are accepted worldwide. Using these codes ensures that the diagnosis matches the treatment.

Note: Workers' compensation is one of several lines of business that uses ICD codes as seen through the **Medical Diagnosis** section. See "Managing ICD Codes" on page 499 to learn more about these codes.

Medical Diagnosis						
	ICD Code	Description	Provider Name	Compensability	Started On ↑	Ended On
	V81.9XXA	Occupant of rail trn/veh i...	DoctorFrom Ar...			
	V81.2XXA	Occ of rail trn/veh inj in c...	DoctorFrom Ar...			

Note: **Medical Diagnosis** is located in different areas of the user interface depending on the line of business. For example, you would edit a **Medical Diagnosis** in a workers' compensation claim by navigating to **Medical Details** screen and clicking **Edit**. You would then click the **Medical Case Mgmt** card and make your edits on the **Medical Diagnosis** section. In a personal auto claim, you would navigate to **Loss Details** screen and click the name of a person in the **Injuries** section. Then, on the **Injury Incident** screen, you would click **Edit** and make your edits on the **Medical Diagnosis** section.

Typically, an adjuster receives a form with one or more ICD codes. You can enter these codes on the **Medical Case Management** screen and can also view them on the **Summary** tab of the **Medical Details** screen. If there is more than one code, then you must make one primary. Making a code primary is necessary for sovereign organizations, such as for ISO in the United States.

You can also enter dates and comments and indicate whether there is compensability on the exposure. This check box serves as a reminder for you that the incident is compensable. You can also select a diagnosis and

reconfirm it. Reconfirming has two purposes. It serves as a reminder that you looked at the medical diagnosis and are certain that it still applies, and it adds an entry to the history table.

Note: The link to the ICD number can open a new browser window providing a complete description of the diagnosis.

- **IME Medical Actions** – Lists any independent medical evaluations by experts.
- **Drugs Prescribed** – Lists the drugs prescribed for the injured party, who prescribed them and when, and shows the expiration date.

Time Loss Screens

The Time Loss screen is organized into **Summary** and **Benefits** cards, and there are several actions that you can perform that are the same as in the previous topic.

Summary Tab

The **Summary** tab provides the following sections in the base application:

- **Exposure** – Identifies the type of exposure and if there is a statistical line.
- **Return to Work** – Enter data if the injured employee can return to work with full or modified duties.
- **Compensation** – The average weekly wage defined in the **Employment Data** section on the **Loss Details** screen. You can also enter a percentage for the **Impairment Rating**.
- **Dependents** – List dependents in this section.
- **Lost Time/Work Status** – Enter the claimant's length of lost time, or whether they can even work.
- **Wage Statement** – If you receive the claimant's pay stub, enter that information in this section.
- **Coding** – Records basic information collected when the claim was first entered into the system.
- **Financials** – Some financial information is repeated in this section for convenience and is not editable.

Benefits Tab

Use the **Benefits** tab to add or remove defined benefit periods. The **Benefits** tab provides the following sections in the base application:

- **Claim Parameters** – Lists the amounts of what the claimant made before the injury and what the claimant's wage is post injury. You can also identify the jurisdiction, such as the state of Nevada in the United States, or a province.
- The following four sections of the **Benefits** tab derive their data from jurisdictional parameters entered through **Administration** → **Business Settings** → **WC Parameters**. You can manually override these amounts. For definitions of the following sections, see “Jurisdictional Benefit Calculation Management” on page 191.
 - **Temporary Total Disability (TTD)**
 - **Temporary Partial Disability (TPD)**
 - **Permanent Total Disability (PTD)**
 - **Permanent Partial Disability (PPD)**

Note: You must set up these parameters in the **Administration** → **Business Settings** → **WC Parameters** so that they display in the **Benefits** tab.

- **Waiting Period** – Gets its data from the Jurisdictional Benefit Calculation Management section and is editable. See “Jurisdictional Benefit Calculation Management” on page 191.
- **Other Jurisdictional Factors** – This section is not editable and gets its data from **WC Parameters**, which contains additional information that a carrier can capture.
- **Settlements** – Indicates any settlements on the claim.

Employer Liability Screen

Employer Liability is another exposure, created either in the **New Claim** wizard or by clicking **Yes** in the **Employer Liability** field on the **Loss Details** screen. The **Employer Liability** screen provides the following sections:

- **Exposure** – Identifies the type of exposure.
- **Damage** – Lists any damage and the loss estimates that came from it.
- **Settlement** – Contains a date and the type of settlement that was conducted.
- **Coding** – Enables you to indicate the jurisdictional state. Contains other information entered in the **New Claim** wizard.
- **Financials** – Summarizes the exposure's key financials in one location.

Compensability Decision

The *compensability decision* involves determining if a workers' compensation claim is valid, and hence payable. There are several factors to consider when determining compensability. For example, an adjuster can ask a series of questions, such as, "Was safety equipment used?" or "Was the person using illegal substances?". The adjuster also needs to determine if the incident was accidental in nature or in the course of employment, or if there was jurisdiction. Jurisdiction addresses time, place, and employment relationship.

How Jurisdiction Affects the Compensability Decision

Carriers must adhere to the jurisdictional deadline to accept or deny the claim. This deadline, which changes by jurisdiction, is based on either of the following:

- A number of pre-determined days after the loss date
- The date that the employer was notified

Use ClaimCenter to manage the jurisdictional deadline and the related process. For example, an employer contacts the insurance carrier to create a new claim. The adjuster enters the **Loss Date** and the **Date Employer Notified**. The carrier now has a number of days to accept, deny, or delay the claim. The number of days is based on what each state mandates. These dates are kept in the Denial Period Reference Table and are edited through **Administration** → **Business Settings** → **WC Parameters**. See "Managing WC Parameters" on page 492 for details.

Working with Jurisdictional Compensability

ClaimCenter generates an activity for determining whether to accept or deny compensability, **Determine compensability**. This activity is based on the activity pattern **claim_acceptance**. You can see this activity in your **Desktop** → **Activities** list. You can work with the activity in the **Compensability Decision** section of the **Loss Details** screen. The due date displays, and if you click **Update: Determine Compensability**, ClaimCenter shows the activity that you must complete.

After you select either **Accepted** or **Denied** for compensability, the **Create Document** button is enabled so that you can create the appropriate document.

After the **Determine compensability** activity is **Complete**, you can edit the due date, compensability, and reasons for decisions on the **Loss Detail** screen.

How the Activity Due Date is Calculated

If a valid record exists in the reference table, the reference data is utilized to indicate which formula to use, as follows:

- **Formula 1** – Y days after the Notice Date
- **Formula 2** – X days after the Loss Date
- **Formula 3** – Greater of X days after the Loss Date or Y days after the Notice Date

If a valid record does not exist in the reference table, ClaimCenter uses the default value from the activity pattern. In the base configuration, the imported data for Activity Patterns is set to five business days after the claim notice date. The escalation date is three days prior to the due date. The claim's **Compensability Due Date** is also set to the activity's due date. The **Claim** entity field for this value is **DateCompDcsnDue**.

Finding Injured Workers

Because a company can have more than one injured worker, ClaimCenter can be configured to enable you to sort by injured worker. You can view the list of injured workers in the following locations:

- The adjuster's **Desktop** → **Claims** link.
- The **Claim Search** screen in the list of search results.

For all users, in those two areas there is a column with the heading **Claimant**. This column is not sortable. For many claim types, such as the personal auto line of business, there can be many claimants that are associated with one or more exposures. For adjusters whose default claim loss type, as defined by the administrator, is workers' compensation, this column header is actually **Injured Worker**, and that column is sortable.

Changing a User's Sort Criteria

You might want to change a user's sort criteria, for example, to search for injured workers instead of claimants. A workers' compensation adjuster might find this search useful because the claimant will be the carrier, and the carrier can have multiple injured workers.

To change a role's sort criteria:

1. With administrator permissions, navigate to **Administration** tab → **Users & Security** → **Users**.
2. Find the user and click the user's link.
3. Click the **Profile** card and click **Edit**.
4. Under **Policy Type**, click **Workers' Compensation**.
5. Under **Loss Type**, click **Workers' Comp**.
6. Click **Update**.

If you log in as a user who does not have these default settings, you see the column with the header **Claimant**. For other loss types, there can be multiple claimants, and therefore sorting on this column becomes meaningless.

To test, log in as that user and navigate to **Search** tab → **Claims**. Search for claims and see that there is an **Injured Worker** column in the search results.

Jurisdictional Benefit Calculation Management

One of the key activities that a workers' compensation adjuster performs is calculating the payments for lost time due to disabilities, the *Time Loss exposure*. You can see this information on the **Time Loss** → **Benefits** tab. Benefits calculations for the following categories vary by jurisdiction in accordance with regulatory formulas.

The primary categories are Temporary Disability (TD) and Permanent Disability (PD).

Temporary Disability (TD)

If an employee is injured, but the expectation is that the employee will make a recovery or return to work, there are two possibilities for temporary disability:

- **TPD - Temporary Partial Disability** – An example is an employee who is injured in a relatively minor way, such as falling and spraining a wrist. The injured worker can work, but in a reduced capacity.
- **TTD - Temporary Total Disability** – An employee who is injured on the job and cannot return to work is entitled to receive TTD benefits during the convalescence. An example is a worker who is injured at work and requires surgery. The worker cannot perform work duties for some period of time.

Permanent Disability (PD)

If an injured worker is still totally or partially disabled after reaching the maximum medical improvement (MMI), then permanent disability benefits are determined.

- **PPD - Permanent Partial Disability** – An example is an employee whose finger is cut off or who loses an eye. The loss is permanent, but at some point the employee can still work. PPD can vary depending on the body part that is injured.
- **PTD - Permanent Total Disability** – PTD benefits are payable to employees who are never able to return to gainful employment. An employee who is determined to be permanently and totally disabled because of an on-the-job injury is entitled to PTD benefits.

A workers' compensation benefit manager or administrator can calculate and enter disability amounts in the **Administration** → **Business Settings** → **WC Parameters** screens. The calculations, which are contained in Gosu code, use these numbers. For example, you can calculate the *comp rate*, the weekly benefit for the injured worker based upon the worker's *baseRate* and the applicable jurisdictional parameters. You can also configure the maximum number of weeks to pay the benefit. However, an adjuster can manually override those amounts from the **Time Loss** → **Benefits** card in a claim.

Jurisdictional Waiting Period

A key component to managing benefit payments is understanding the jurisdictional waiting period. Each state can mandate a set number of days before paying benefits. The **Waiting Period** section on the **Benefits** card shows the following:

- Waiting Period Applied
- Waiting Period Days
- Retroactive Period

See also

- “Managing WC Parameters” on page 492 to learn about calculations, how to administer benefits, and to learn about the workers’ compensation reference tables that are accessed from the user interface

Workers’ Compensation Administration

There are several areas in the user interface where you can change workers’ compensation settings if you have administrator permissions:

- **Managing WC Parameters** – Enter the benefit parameters, PPD minimum and maximum values, PPD weeks, and denial period information. See “Managing WC Parameters” on page 492.
- **Managing ICD Codes** – Administer the codes that are used in for medical diagnosis. See “Managing ICD Codes” on page 499.

For a list of related permissions, see “Workers’ Compensation Permissions” on page 498.

Workers' Compensation Coverage Types

To understand the relationships between coverages, subtypes, exposures, and incidents, it might be useful to see them in Guidewire Studio.

1. Open ClaimCenter studio by navigating in a command window to the `ClaimCenter/bin` directory and entering `gwcc studio`.
2. Navigate in the Project window to `configuration → config → Extensions → Typelist`, and then double-click `PolicyType.ttx`.
3. In the Typelist editor, expand `PolicyType → Workers' Compensation → Children` to see the list of coverage types in the table that follows.
 - Expand a coverage type and then expand `Children` to see its coverage subtypes.
 - Expand a coverage subtype and then expand `Children` to see its exposure type.
 - Expand an exposure type and then expand `Other Categories` to see the type of incident.

The following table lists the workers' compensation coverage types, subtypes, exposures, and incidents.

Coverage Type Name	Coverage Subtype	Exposure Type	Incident
Federal Employer's Liability	Federal Employer's Liability	Employer Liability	Incident
Other States Insurance	Other States Insurance - Med Only	Medical Details	Injury/Incident
Other States Insurance	Other States Insurance - Other than Med	Time Loss	Injury/Incident
Statutory Workers' Comp	WC Coverage - Other than Med	Time Loss	Injury/Incident
Statutory Workers' Comp	WC Coverage -Med Only	Medical Details	Injury/Incident
Workers' Comp Employer's Liability	Workers' Comp Employer's Liability	Employer Liability	Incident
Workers' Comp State-Specific Deductible	State Specific Deductible - Med Only	Medical Details	Injury/Incident
Workers' Comp State-Specific Deductible	State Specific Deductible - Other than Med	Time Loss	Injury/Incident

part V

Additional Features of ClaimCenter

Work Assignment

All work in ClaimCenter has an *owner*, someone who is responsible for making sure the work is done properly. After work is *assigned* to someone, that ClaimCenter user becomes its owner. All work is assigned to both a user and group. See “Assignable Work” on page 198 for a definition of work.

Work is often assigned when it is first created, but can be assigned or reassigned later to a different owner. ClaimCenter can make assignments automatically, based on rules that model your business practices. ClaimCenter also provides the ability to assign work manually, enabling managers and supervisors to choose who they assign work to.

This topic includes:

- “How Assignment Models the Way a Carrier Distributes Work” on page 197
- “Assignable Work” on page 198
- “How Work is Assigned” on page 199
- “Assignment Methods” on page 202
- “Queues” on page 204

How Assignment Models the Way a Carrier Distributes Work

ClaimCenter mimics the way assignment is manually determined in an organization. Manual assignment often proceeds as follows:

1. An executive learns of a task and determines that it belongs to one of the executive’s departments.
2. The department manager decides that a certain team will work on the assignment.
3. The team supervisor either chooses one of the employees or assigns the work to a queue from which employees take the work items.
4. Assignment is complete. The employee assigned the work is now its owner and is responsible for its completion.

In this example, individuals—users—are ultimately assigned work, and the groups into which users are organized play a critical role in the assignment process. ClaimCenter provides a variety of ways of organizing users into groups to facilitate work assignment.

Each of those decisions is made independently, and the logic of each is simple to describe. Each assigner needs to know only how to direct the work to the right group or person within the assigner's authority.

ClaimCenter takes a similar approach. For every main work item, assignment rules model the step-by-step process of assigning a person responsible for performing the work. The assignment logic passes down through the group hierarchy to find the correct group, and then the appropriate group member.

Assignment takes into account the area that a group covers, the special capabilities of a group, the amount of work already owned by the group, and other considerations. During automatic assignment, business rules make assignments by considering these factors. There are automatic methods that assign based on location, proximity, special talents, workload, and other factors. Use these flexible methods to model an assignment process to match your carrier's manual assignment process.

Assignable Work

Work is assigned to both a group and a user or queue. Work falls into the following main areas, each corresponding to a main ClaimCenter entity:

- **Activity** – Often assigned to the owner of the related claim or exposure. ClaimCenter can also look for particular types of activities and assign them to specialists such as local inspectors, clerical workers, or medical reviewers. Activities can also be assigned to a queue; users can then pick activities off the queue and assign them to themselves or others. See “Working with Activities” on page 217.
- **Claim** – Can be assigned based on its attributes, such as its segmentation type, number and type of exposures, and geographic location.
- **Exposure** – Can be assigned to the claim owner, or can be assigned to someone else based on exposure attributes.
- **Matter** – Often assigned to the claim owner or to a user with a special role or a custom user attribute, like a legal expert.
- **ServiceRequest** – Can be assigned to the claim owner or can be assigned to someone else based on service request attributes.

You cannot make any other entities in the base configuration of ClaimCenter assignable. However, you can make extension entities that you create assignable. See “Assigning Other Entities” on page 202.

Viewing Your Assignments

You can view all claims for which you are assigned work. To do so, use the **All open owned** or **New owned (this week)** filters in the **Desktop** → **Claims** screen or the **Desktop** → **Exposures** screen. The **Desktop** → **Activities** screen shows all activities.

Note: You cannot view all matters to which you have been assigned.

To view all matters related to a specific claim:

- Open a **Claim** and click **Parties Involved** in the menu on the left. Then, click **Users**. Your matters, if any, appear in the **User Details** tab.
- Open a **Claim** and click **Litigation** in the menu on the left. All matters assigned to anyone show in the **Matters** screen.

How Work is Assigned

Global and default rule sets define how assignments are made. See “Global and Default Rule Sets” on page 199. You can assign work to an owner—the person responsible for completing it—as follows:

- By explicit or manual assignment.
- By automatic assignment, which can mean:
 - The assignment engine runs the global and default rule sets.
 - The rule set is called from Gosu in a PCF file. See “Assignment Without Using the Assignment Engine” on page 201.
 - You write your own version of automated assignment. See “Dynamic Assignment” on page 201.

Global and Default Rule Sets

For historical reasons, ClaimCenter contains both a global and default rule set for each assignable entity. The assignment engine runs the global rule set before the default rule set. The main purpose of a global rule set is to consider all groups and make an assignment to the proper one. The global rule set runs either as soon as the work is created or when a user requests automated assignment.

Multiple Default Rule Sets

Although each entity has a single global rule set, different subentities can have their own default rule sets.

For example, after the global rule set has selected a group, the group’s default rule set runs to finish assignment. It targets first the group or one of its subgroups, and then a user. The default rule set can also assign the item to a queue or create an activity to assign it into the group supervisor’s **Pending Assignment** queue.

Assignment Engine

The assignment engine is the normal way ClaimCenter executes the global and default rule sets, where the global rule set is executed first. It handles all assignment methods. You can call it at any time. It is commonly run just after a new assignable object is created. The overall logic of the assignment engine is:

Global assignment rules run first. There are several outcomes possible:

- A rule assigns both a group and a user. In this case, assignment is finished and the assignment engine exits.
- One of the rules assigns a group, but no user. The assignment process continues with the Default rule set.
- No group or user is assigned. The entity is assigned to a default user and group, and the assignment engine exits.

Default assignment rules run only when the assignment engine has assigned a group, but not a user, as follows:

- A default rule assigns a user. In this case, assignment is finished and the assignment engine exits.
- No rule assigns a user, but a rule assigns a different group. The assignment engine runs the default rules again.
- No rule assigns a user, but the group assignment does not change. In this case, the assignment has failed, and the assignment engine exits.

Note: This logic can cause the default rule set to execute more than once. Write rules carefully to avoid this situation. Also, the engine-run rules are not guaranteed to succeed. See “Default Owner” on page 199 and “Assignment Rule Set Category” on page 44 in the *Rules Guide* for more information.

Default Owner

The application’s assignment engine can fail to make an assignment. However, if the customized assignment rules do not cover all cases, and the engine cannot find any group and user for assignment, it makes the assign-

ment to a user. This user is from the sample data and is called Default (first name) Owner (last name). Never delete this user, and never assign anything to this user. Instead, write a rule to reassign all items assigned to this Default Owner, and to correct the assignment rules that cause the assignment engine to fail. See “Assignment Rule Set Category” on page 44 in the *Rules Guide* for a description of how to write assignment rules that do not fail.

Manual Assignment

After you assign work explicitly, specify the user. You can assign work:

- **To a user** – Select the owner’s name. The group can already have been chosen by the global rule set for that type of work. There is a list of group members and a search option to help consider subgroups. If the final group has not already been chosen, then, in specifying the user, you also specify the group to which that user belongs.
- **To a group** – You choose the group, and then run the group’s default assignment rule set. This rule set either assigns the work to a user or the supervisor’s **Pending Assignment** for later assignment to the final owner.
- **To a queue** – You can assign activities directly to a activity queue.
- **From a queue** – You can pick activities for yourself, or with the correct permissions, you can assign work from a queue to others.

To assign work manually, you can select a specific owner or use a search tool to select the assignee from the list that ClaimCenter provides.

Search and Manual Assignment

After searching through a list of group members during an assignment activity, you can search for potential assignees. This search returns workload statistics—how many open activities each potential assignee already has—which is the same information that shows on a supervisor’s calendar. Clicking the calendar icon that accompanies the search results returns the user’s personal calendar.

An important feature of manual assignment is the use of calendar information, which you can see before making an assignment. In the standard search return values, workload information—the same data shown on a supervisor’s calendar—is included. This feature enables you to make assignments based on workload.

You can also view a user’s calendar before making an assignment. Each assignment search returns, by default, a calendar row. Clicking the calendar icon on this row opens the particular user’s calendar:

Automated Assignment

ClaimCenter uses business rules in the work’s global and/or group’s default assignment rule sets to determine how to assign an item automatically. These rules typically consider certain attributes of the item being assigned, the workload of each owner being considered, any special skills that are required, and more.

For example, a claim can be assigned to the members of a local group by using round-robin selection. Each adjuster has a balanced workload, or the claim can be assigned to a member of a specialty group that has experience with the particular type of loss.

Auto-assignment runs when the work is created, or when, while performing manual assignment, you choose the auto-assignment option.

Auto-assignment typically results in the following outcome, depending on the rules in the default rule set:

- The item is assigned directly to an individual owner.

Round-Robin Assignment

Round robin assignment methods assign work to a user in the group specified in the method.

Other round-robin assignment methods can use a set of criteria to construct the set of potential assignees, which can span groups. The criteria, not group membership, are important. Load factors cannot be used.

Removing a User from Automated Assignment

It is often desirable to temporarily remove a user from receiving assignments by round-robin. ClaimCenter provides mechanisms for this:

- Set the user's load factor to 0 by using an **Administration** or **Team** screen.
- Set the user's Vacation status to **On Vacation (Inactive)** so the user does not receive automated assignments. Use an **Administration** or **Team** screen.
- Choose **Inactive** in the user's User Profile. However, doing so also disables access to ClaimCenter, and the user receives no assignments at all by any means, not just round-robin.

Note: **Inactive** status is also used to remove former employees from ClaimCenter.

Reassignment

After reassigning a claim or an exposure, ClaimCenter tries to reassign all related work to the new owner automatically. This feature is called *cascading assignment* because the new assignment for the top-level item cascades down to other related items. You do not have to write rule sets to do get this behavior because ClaimCenter rule sets perform cascading assignment by default. ClaimCenter uses the following logic to automatically cascade assignments:

- If a claim is reassigned, ClaimCenter reassigns activities and exposures that were assigned to the previous claim owner, as follows:
 - Reassigns the previous claim owner's activities that are connected to that claim, and not to any specific exposure, to the new claim owner.
 - Reassigns the previous claim owner's non-closed exposures that are connected to that claim to the new claim owner.
- If an exposure is reassigned, ClaimCenter reassigns all its related activities to the new exposure owner, unless the activity was already assigned outside his group.

If the reassigned claim or exposure is kept for manual assignment, assignment cascading proceeds in two steps. All related work remains unassigned until the final claim or exposure owner is selected. Related work is then assigned to the new claim or exposure owner.

Assignment Without Using the Assignment Engine

You can make assignments without using the assignment engine to run the global and default rule sets. You do so by writing your own Gosu in PCF pages to call assignment rules and methods directly. For example, you can add an **Assignment** button to any saveable PCF page and complete the assignment when saving that page.

Note: Some assignment methods cannot be used in rules that execute independently of the assignment engine.

Dynamic Assignment

Use the Dynamic Assignment interface and its methods to create your own assignments. These can reflect your own logic, such as selecting users across groups, and creating your own measures of work load. Dynamic assignment is not an assignment method, but a generic hook for you to implement your own assignment logic, for both users and groups. It is intended to supplant round-robin assignment when it is not sufficient for proper automatic assignment. Dynamic assignment can allow automated assignment under more complex conditions:

- Round robin assignment to users in different groups because you do not want to have your group structure mirror your assignment logic.

- Automatic assignment that also considers a user's current workload.
- Automatic assignment that takes into account assignments made outside of round robin assignment.

ClaimCenter provides an interface that enables you to define and implement your own strategy for assignment. In general, you define these steps, and provide methods to help implement them:

1. Find the set of users who might get the assignment in question.
2. Get and acquire the locks that control workload and related information for these users.
3. Select a user based on this set of information.
4. Update this information, release the locks, and return the selected user.
5. Dynamic assignment is not complete after these steps. This is because during FNOL intake or creating a new claim in a wizard, assignment occurs and your workload information for future assignments updates before the claim is saved. If the claim cannot be saved, the database still shows the increase in your workload. So this mechanism allows for the failure with the steps that follow.
6. If the commit fails, roll back all changes made to the user's information, if possible.
7. Otherwise, save the user name and reassign that user to the item when it is saved.

The default version of ClaimCenter does not implement dynamic assignment because it is potentially time-consuming. All methods of this type are a trade-off between speed and accuracy, and this implementation requires more database queries and locks. However, Guidewire does provide a package, key methods, and sample code.

If you want to implement a version of dynamic assignment, see “ClaimCenter Assignment” on page 94 in the *Rules Guide*.

Assigning Other Entities

You can make extension entities assignable. For example, you can define a subrogation entity when you have decided that a payment you have made might be recoverable. Assign that entity to a member of the subrogation group, along with an activity.

Assignment Methods

There are two basic kinds of assignment methods:

- Methods that choose an appropriate group to which you can assign work. These methods can also redefine the current group.
- Methods that assign work to subgroups and then to users within the current or a selected group.

In addition, there are methods useful for:

- Auto-assignment and manual assignment.
- Assignment of groups and users by proximity to a location—an address.
- Assignment based on both location and user attributes, such as assigning a user either by attribute and location or by location using proximity search, or assigning a group by location.
- Random assignment to users in a group—*round-robin* assignment.
- Assignment to a user or group based on your calculation of total workload—*dynamic* assignment.
- Assignment based on an attribute of a user, such as workload factor or user attribute.
- Immediate assignment using *autoassign*.

See “Assignment Rule Set Category” on page 44 in the *Rules Guide* for detailed descriptions of these methods.

Using Group Types and Load Factors in Assignment

Assignment rules can consider a group's *group type* attribute. For example, when assigning a minor claim, a rule can insist that it be given only to a group of the type *local office*, since no special expertise is needed. The *GroupType* typelist contains these types.

A group's load factor attribute can be used for assignment, similarly to a user's load factor (see "Load Factors" on page 441).

Using Regions in Assignment

You can give a group the attribute of a region to help in determining how best to assign work. Each group can belong to multiple regions. See "Understanding Regions" on page 444 for more details.

For example, a group can be defined as belonging to a region consisting of all ZIP codes between 90000 and 90999. In addition, the group can belong to another region consisting of Los Angeles and San Bernadino counties. Administrators define these regions when creating or editing groups. This information can also be imported.

The `assignGroupByLocation` method uses regions as part of making assignments to a group. This feature is restricted to counties, states, and ZIP codes in the United States, and the method looks for a matching region.

Using Security Zones Indirectly in Assignment

You can configure a list of security zones, and an administrator can then associate each group with one of these zones.

Since assignment gives ownership to both a user and the user's group, the group's security zone is associated with the assigned claim. Access Profiles can grant preferred permissions to view or edit claims to users related to the claim by being in the same security zone. "Creating or Editing an Access Profile" on page 454 describes claim Access Control, and how to grant permissions to users in the same security zone.

Assigning to Roles

A *role* is a collection of permissions. Users possess one or more roles. Their permissions enable users to view or edit different ClaimCenter objects. It is useful to assign work to a user who has the permission to perform it. For example, assigning a claim to an adjuster guarantees that the user has the necessary permissions to complete the work. Administrators can create roles, add permissions to them, and grant them to users.

User Assignment by Proximity

User proximity to a certain geographical location can be used as one of the criteria for assignment. Proximity is an important factor in assigning often-performed, simple tasks.

Some examples:

- You want to assign claims to adjusters who live or work near the loss site.
- If the activity pattern is a vehicle inspection and the vehicle location is known, perform a proximity search and choose an activity owner by round-robin from the closest users.
- If the accident location is within five miles of the center of a Spanish-speaking community, find the closest Spanish speaking adjusters, and chose a claim owner by using round-robin.
- You can search for all preferred vendors, such as auto repair shops within five miles of the claim loss location who specialize in European cars. After retrieving a list of contacts that fit the criteria, you can use an assignment rule to add one of those contacts to a claim.
- The user in the current group who is closest to a location you specify.
- The closest user in the group and all its subgroups, and, if several users are approximately the same distance away, choose one by round-robin.

- The user who best satisfies a pre-defined search criterion, such as *within 10 miles, or no further than 50 kilometers* from a chosen location. This technique can also perform a round-robin selection of users within a similar distance of the chosen location.

User Assignment by Activity Pattern

Although you assign most activities to the claim or exposure owner or both, some activities are best performed by a specialist, such as a field inspector or specialty medical group. A useful way of choosing is to look at the activity's *activity pattern*. Activity patterns contain an identifying `Code` value that Gosu can associate with a particular user. For example, a claim activity assignment rule assigns a **Get Witness Statement** to the claim user, but a matter activity assignment rule assigns the similar activity to a legal expert. Each activity is created with a different pattern.

User Assignment to the Current Group

Global assignment rules typically drill down the group hierarchy until they find the correct group. During this process, each rule can move another step down a hierarchy. ClaimCenter keeps the group chosen by the last rule and passes it to the next rule. `CurrentGroup` is the way such assignment rules communicate.

After the global assignment rule set finishes, the current group is available to the rules in the current group's default rule set, unless global assignment rules finish assignment. ClaimCenter can again redefine the current group as it looks for subgroups and finally finds a user.

After a rule finds the correct group and starts looking for a user in that group, the notion of the current group is no longer important. Most assignment rules in a global assignment rule set move one level down the hierarchy, and the next rule moves down another level. The current group is the selection of the first rule, which becomes the starting point for the next one. All rules require a current group as an argument.

Queues

ClaimCenter can create, maintain, and show queues of activities for each group. Assignment to one of a group's queues is an alternative to assignment to one of a group's members. Activities in a queue wait for a group member to take ownership of them. After any group member claims an activity in a queue, assignment of an activity to a user is complete.

The `assignActivityToQueue` method assigns the current activity to the current group. It also generates the necessary queue if the queue does not already exist.

Only activities can be assigned to a queue. Claims, exposures, and matters cannot be assigned to a queue.

Using a Queue to Assign Claims

Although only activities can be assigned to queues, queues can be used to indirectly assign claims, exposures, or matters. The following example illustrates how to use a queue to assign first notice of loss (FNOL) claims. After you import an FNOL, ClaimCenter triggers the rule sets listed in the table below. These rule sets generate review activities and put them on a queue. A group member then takes an activity from the queue and completes it by manually assigning the FNOL to a final user and group. The following table summarizes these tasks:

Task performed by rule	Rule set	Action
Assign FNOL claim to an intake group	Global Claim Assignment	Choose the current group that will make the final claim assignment.
Assign claim to the group supervisor	Default Group Claim Assignment	Assign the claim to a temporary owner until it can be properly assigned.

Task performed by rule	Rule set	Action
Create FNOL review activity	Claim Workplan	Use a pre-defined activity pattern to make a new activity.
Assign FNOL review activity to same group	Global Activity Assignment	Now both the claim and the activity have the same current group.
Assign FNOL review activity to queue	Default Group Activity Assignment	A current group's user takes the activity from the queue and manually assigns the claim to another group and user.

Using the Pending Assignment Queue

Until supervisors become comfortable with automatic assignment, rules can put most work into their pending assignment queues. The **Pending Assignment** queue is part of the Desktop, but visible only to administrators and supervisors.



chapter 21

Weighted Workload

ClaimCenter provides the ability to assign work based on the efficiency of an adjuster and the complexity of the workload, also known as *weighted workload*. Weighted workload assignment gives customers a robust and configurable way to balance work.

Note: Weighted workload is one of the methods that can be used with Automated Assignment in ClaimCenter. See “Automated Assignment” on page 200.

This topic includes:

- “Weighted Workload Overview” on page 207
- “Weighted Workload Classifications” on page 209
- “Calculating Weights” on page 210
- “Weighted Workload Assignment” on page 212
- “Viewing Weights” on page 212
- “Weighted Workload Classifications” on page 209
- “Calculating Weights” on page 210
- “Weighted Workload Assignment” on page 212
- “Viewing Weights” on page 212

See also

- “Work Assignment” on page 197
- “Assignment Parameters” on page 38 in the *Configuration Guide*
- “Configuring Weighted Workload Assignment” on page 517 in the *Configuration Guide*

Weighted Workload Overview

In ClaimCenter, all assignable objects, such as claims and exposures, are assigned to users, who become their owners.

Automated assignment can be done using one of the following methods:

- Round robin – Users in a group are assigned work based on knowledge of past assignments and other defined criteria. The load and difficulty of assignments is not a factor.
- Weighted workload – Users in a group are assigned work based on a calculated weight that represents the complexity of their current assignments.

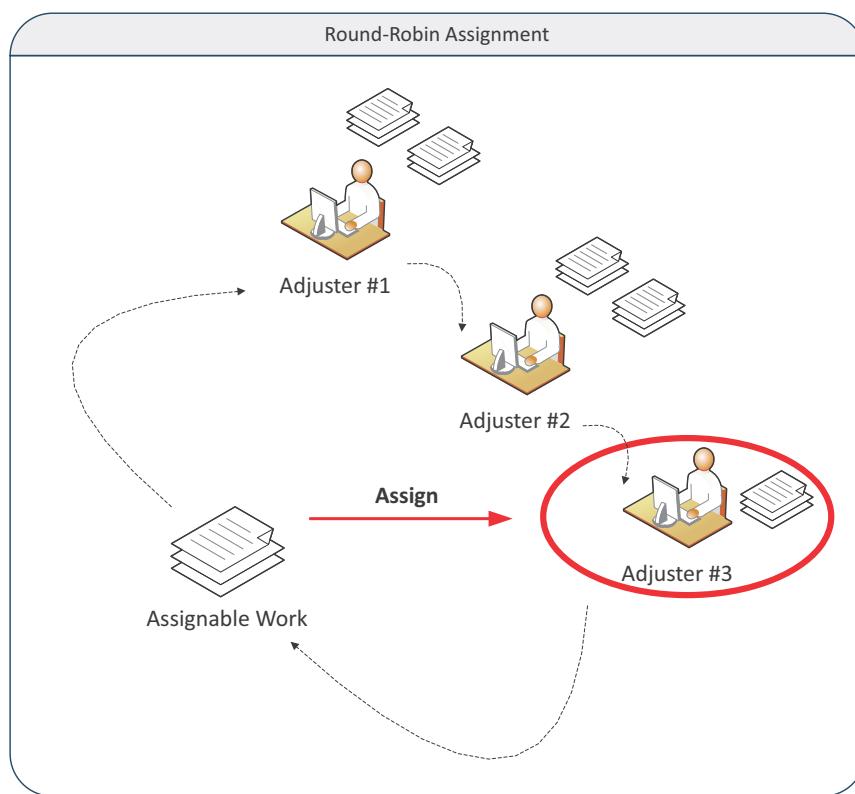
This topic describes the process of assigning work using weighted workload balancing. Weighted workload can be used for any assignable object. See “Assignable Work” on page 198.

Note: In the base configuration, weighted workload is not enabled. When enabled, it is configured for claims and exposures. Additional configuration is required to enable weighted workload assignment for other types of assignable entities such as matters and activities.

Round Robin vs. Weighted Workload Assignment

In previous versions of ClaimCenter, automated assignment used only the round-robin method. Work was assigned in a cyclical fashion, and users in a given group ended up with the same number of assignments. The idea is to evenly distribute objects across the group. The drawback of round robin assignment is that it does not take into account how efficient a worker is or how complex or time-consuming a specific assignment could be.

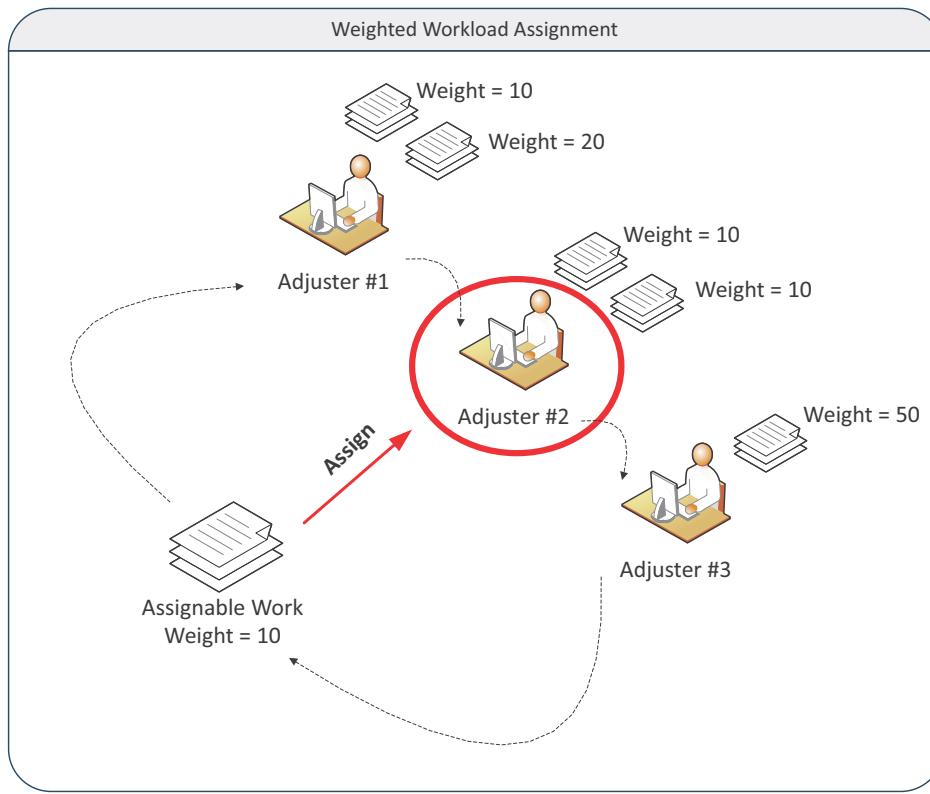
Consider the round-robin example in the figure below.



In the illustrated example, round-robin assignment results in Adjuster #3 being assigned the next assignment. An adjuster might be more efficient, and an assignment can be, potentially, more or less time-consuming than another, but these factors are not relevant.

In the case of weighted workload assignment, each assignable object is given a specific integer value, which is its weight. As work gets assigned to users, their workload, a cumulative number comprised of the individual objects they own, is calculated. The workload determines the owner of the next assignment.

Consider the weighted workload example below.



In this case, weighted-workload assignment results in the adjuster with the lightest load, Adjuster #2, being assigned the work. The weight of each user's workload is calculated from the weight of the assignable objects owned by the user. Calculations can be customized to take into account other factors, such as a user's load factor.

The total number of objects assigned to each adjuster does not figure in the assignment.

Weighted Workload Classifications

Each claim, exposure, or other assignable object needs to have an associated weight value, a non-negative integer, for weighted workload balancing. ClaimCenter uses predefined workload *classifications*, based on the complexity of the job, whose values are then matched to the assignable objects.

For example, if you have a new personal auto claim, and the **Personal Auto Claim** classification has a weighted value of 8, the claim is given a weight 8. If an assignable object does not match any existing classification, it is assigned the default global workload weight, which is defined in `config.xml`.

Classifications are managed in the **Administration → Business Settings → Weighted Workload → Weighted Workload Classifications** screen. You require the appropriate permissions to view and manage classifications. See “Weighted Workload Permissions” on page 518 in the *Configuration Guide*.

Note: Weighted workload balancing must be enabled in configuration for these screens to be available.

Adding Classifications

In the base configuration, you can create weighted workload classifications for two types of assignable objects, claims and exposures.

Use the following steps to create a new claim workload classification:

1. In Administration → Business Settings → Weighted Workload → Weighted Workload Classifications, select Add Classification → Add Claim Classification or Add Exposure Classification.
2. The General section provides basic information on the classification, including the Name, Description, and whether or not the classification is Active.
Additionally, enter the following:
 - Rank – A non-negative integer that represents the priority given to the assignable. The Rank is used only when a claim matches more than one classification, and the lower the Rank, the higher the priority assigned to the claim.
 - Weight – A non-negative integer.
3. Enter Criteria for potential matches. Criteria can be restrictive, requiring an exact match on specified fields, or non-restrictive, where at least one value must match.
Enter the following restrictive criteria:
 - Claim Loss Type – This is a required field.
 - Claim Line of Business
 - Claim Policy TypeEnter the following non-restrictive criteria:
 - Exposures – Select All, or select Restrict to any of the following, click Add, and enter a Coverage Type, Coverage Subtype, and Loss Party.
 - Claim/Exposure Segments – Select All, or select Restrict to any of the following, click Add, and enter a Segment.
 - Claim Loss Causes/Exposure Incident Severities – Select All or Restrict to any of the following. If you select the latter, select Add and enter a Loss Cause or Incident Severity.
 - Service Tiers/Exposure Jurisdictions – Select All or Restrict to any of the following. If you select the latter, select Add and enter a Service Tier or Jurisdiction.
4. Click Update. ClaimCenter displays a message indicating that to apply this newly created classification to existing open claims and exposures, you need to run the Weighted Workload batch process. Click OK.

Editing Existing Classifications

You can edit an existing workload classification using the steps below.

1. In Administration → Business Settings → Weighted Workload → Weighted Workload Classifications, select a classification name from the list.
2. Select Edit.
3. Make the necessary changes and click Update.

It is recommended that changes to workload classifications be made early in the planning stages of implementation. Once assignable objects such as claims and exposure are created, any subsequent changes will need to be manually adjusted by executing the User Workload Update batch process. See “User Workload Update” on page 143 in the *System Administration Guide*.

Calculating Weights

ClaimCenter uses weighted workload balancing to first match a classification to an assignable object and gives the assignable object the weight of the associated classification. It then proceeds to assign the object to the most suitable user in a group, using weighted workload calculations.

This topic describes the different types of weights used by ClaimCenter to calculate the workload of a user.

Classification Weight

The weight of a predefined workload classification.

Total Weight

The total weight of an assignable object, calculated as shown below:

$\text{Total Weight} = (\text{Workload Classification Weight or Default Global Workload Weight}) + \text{Supplemental Weight}$

Note: The Default Global Workload Weight is used if a claim or exposure does not match any existing workload classification.

Supplemental Weight

An additional integer value specified by the supervisor for an individual claim or exposure that further refines the level of effort required. Supervisors can define the supplemental weight for a claim, for example, in the **Summary → Status** screen under the **Workload** section. The corresponding **SupplementalWorkloadWeight** field on the **Claim** entity can also be used in rules.

Supplemental weight values can be positive or negative. A positive value increases the level of difficulty of the assignable object, and a negative value reduces it.

Default Weight

The default weight is defined in configuration and is only used when an assignable object does not match any existing classification.

Adjusted Weight

The adjusted weight is used for users within a group before assignment. This type of weight calculation takes into account the load factor of the group.

The adjusted weight of a user within a group is calculated as follows:

$\text{Adjusted Weight} = (\text{Total Weight} * 100) / \text{Load Factor}$

In the base configuration, the adjusted weight is used in the default assignment strategy.

Group Weight

A user's *Group weight* is the sum of the weights of all of the user's assigned claims and exposures in a given group. The group weight is the default weight value used by the weighted workload engine to determine assignment

Absolute Weight

A user's *absolute weight* is the total weight of the user's assigned claims and exposures across all of ClaimCenter. The absolute weight is unaffected by group associations.

In the case of users in multiple groups, the absolute weight is the sum of all of a user's group weights.

Weighted Workload Assignment

When a new claim, exposure, or other assignable object is created, weighted workload balancing uses a two-step process to complete the assignment.

1. Calculate the Total Weight of the assignable object using existing classifications and supplemental weights, if any. See “Total Weight” on page 211.

Note: When an assignable object matches more than one classification, the weight of the classification with the lowest Rank value takes precedence and is assigned to the object.

2. Assign the object to the most suitable group and user. This step is described in more detail in the next section.

Assigning Objects to Users

Once its Total Weight is calculated, an assignable object is routed to the most eligible user in the appropriate group. An eligible user is one who has the requisite permissions to own the object, is active, and has an At Work Vacation Status.

The user with the lowest weighted workload within the group is selected for assignment. Each user’s Adjusted Weight is used for this process.

Weighted workload assignment within a group adds an additional level of precision by using dynamic *assignment strategies* to process assignment decisions. In the base configuration, the default assignment strategy is `GroupUserWorkloadAssignmentStrategy`.

Assignment strategies as well as their calculations are configurable. See “Weighted Workload Assignment Strategies” on page 523 in the *Configuration Guide*.

Resolving a Tie

If the weighted workload values of two or more users are equal, the following additional conditions apply in the order of preference below:

1. Select the user whose total workload was updated least recently. If unavailable, select the most recently updated user.
2. Select the user based on the sort order of the User Name, which is always unique.

Note: A user with a group load factor of zero is blocked from assignment.

Viewing Weights

Supervisors can view the weights associated with claims or exposures in the Desktop → Claims or Desktop → Exposures.

You can also view the weights associated with an individual claim or exposure using the steps below.

1. Open a claim.
2. Select **Summary** → **Status** to view the claim’s associated weights in the **Workload** section. Select the **Exposures** menu link and click on an individual exposure to see the associated weights in the **Workload** section.

Claim Segmentation

Claims are segmented into logical groups to enable multiple users to handle different parts of a claim.

This topic includes:

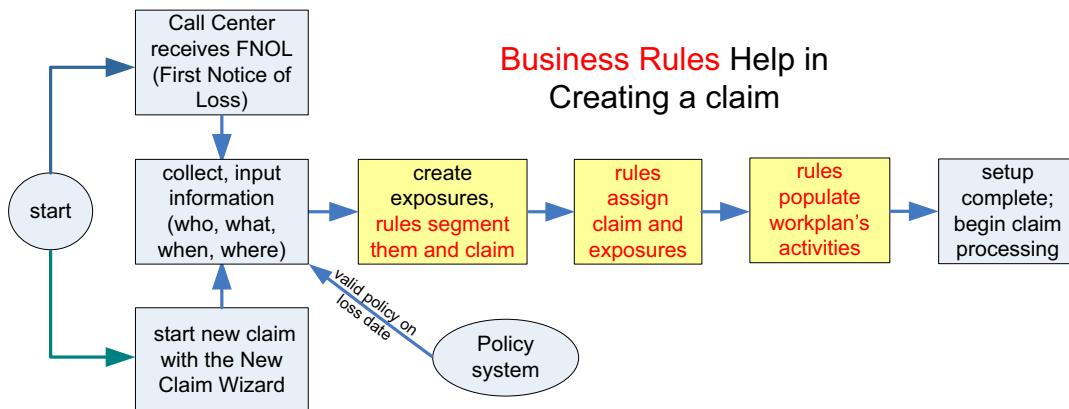
- “Automated Claim Setup” on page 213
- “Segmentation Rules” on page 214
- “Comparing Strategy to Segmentation” on page 215
- “Uses of Segmentation” on page 216

Automated Claim Setup

After the initial claim information is entered into ClaimCenter, the following automated processes set up the claim to go to its new owner, ready to be worked on:

- “Claim Segmentation” on page 214
- “Assignment of Work” on page 214
- “Workplan Generation” on page 214

For claims generated in ClaimCenter, these setup rules run on exiting the New Claim wizard. If the claim does not pass final validation at the New Loss level, all setup rule actions are reversed. For imported claims, these setup rules again run prior to your saving the claim. The claim must then pass validation at the New Loss level.



Claim Segmentation

Segmentation enables you to categorize incoming claims and their exposures into both segments and strategies based on business criteria, such as:

- Segments that describe the type and severity of losses, such as multi-car, single car, injuries, and glass only
- Segments that describe the loss location, such as close to field office
- Strategies based on policyholder type, such as normal, preferred, sensitive, or questionable

These category pairings, called segmentation, help assignment rules make good choices when deciding how to handle the loss. For example, if the segment was *theft* and the strategy was *preferred*, then assign the claim to the closest office for fast-track processing.

Assignment of Work

Assignment determines the baseline strategy to be applied to the claim and defines the preliminary handling. ClaimCenter makes assignments based on claim attributes and adjuster profiles, including adjuster skills, current workload, and any other available information. Besides assigning new claims to adjusters, the ClaimCenter rules make assignments both for individual exposures within the claims and for activities associated with the claims. See “Work Assignment” on page 197.

Workplan Generation

The claim’s workplan is its list of all activities. In creating a new claim, ClaimCenter uses business rules to create an initial set of activities for processing each new claim. The workplan’s list of activities show finished and unfinished tasks, including any activities that are overdue or escalated. The claim owner or supervisor can add or reassign these activities. ClaimCenter can also add activities, such as resolving escalations.

Segmentation Rules

ClaimCenter uses segmentation rules to set the segment and strategy properties of claims and exposures. These properties categorize the claim and exposures. Other rules can then take category-specific actions on them. After you select automated assignment for a new claim or exposure, ClaimCenter runs segmentation rules prior to running assignment rules. Typically, values set for the segmentation and strategy for a claim or exposure are later used to assign the claim or exposure.

Arriving at a decision on the segment of an exposure requires examining the fields on the exposure. For example, for an injury there could be fields like severity, body part injured, nature of injury, and first-party as opposed to third-party claimant. Other possible fields on the claim can be: cause of loss, loss location, or type of insured.

It is easier to make decisions about the segmentation of the claim as a whole after each exposure has been categorized. For example, an auto claim can be categorized as complex if there are any third-party injury exposures. For this reason, the exposure segmentation rule set runs before the claim segmentation rule set.

Segmentation Rule Example

The following code is in the claim segmentation rule **CSG011 - Auto**, which segments auto losses:

Rule Conditions:

```
true
/* This example claim segmentation rule is not as efficient as the one found in CSG02100 - Property,
   but it is more easily understood. If efficiency of claim segmentation is of primary concern, you
   should consider using the model from the other rule instead.
*/
```

Rule Actions:

```
uses gw.api.util.Logger

/* Find an exposure with the most important segmentation. If not found, repeat for
   the rest of the segmentations in reverse order of importance. As soon as an
   exposure is found in any of these searches, segment the claim in the manner of
   the exposure and then leave the claim segmentation rules. If no exposure is found,
   leave this rule and drop into the default rule.
*/
var highestExposure = claim.Exposures.firstWhere(\ e -> e.Segment == "auto_high")

if (highestExposure == null) {
    highestExposure = claim.Exposures.firstWhere(\ e -> e.Segment == "auto_mid")
}
if (highestExposure == null) {
    highestExposure = claim.Exposures.firstWhere(\ e -> e.Segment == "auto_low")
}
if (highestExposure != null) {
    claim.Segment = highestExposure.Segment
    Logger.logDebug(displaykey.Rules.Segmentation.Claim(actions.ShortRuleName))
    Logger.logDebug(displaykey.Rules.Segmentation.Claim.SegmentedTo(claim.Segment))
    actions.exit()
}
```

Segmentation Values Example

ClaimSegment typelist could contain these segment values for an auto claim or exposure	ClaimStrategy typelist could also contain these strategy values for an auto claim or exposure
auto - glass, auto - low complexity, auto - mid complexity, auto - high complexity	Auto - Fast Track
single car, pedestrian, two-car, multi-car	normal
injury - low complexity, injury - mid complexity, injury - high complexity	Auto - Investigate

Comparing Strategy to Segmentation

The Strategy property, similar to the segmentation property, is a second way to categorize claims and exposures. Rules can assign strategies for both claims and exposures defined in the ClaimStrategy typelist. ClaimCenter provides only two strategies, which can then be used as super-groups of segments.

You can use the strategy property as a superset of segments. The base application has *investigate* and *fast-track* for auto claims. With this small number of choices, it might be appropriate to assign the strategy as soon as the segment has been determined:

```
If claim is of type auto, then set strategy to be "investigate"  
If claim segment is "Auto - Glass" or "Auto - Low", then set strategy to "fast-track"
```

There can be many other uses for the strategy property:

- Strategies can be an orthogonal way of classifying claims. If you segment an auto exposure by severity of vehicle damage, you can assign a strategy based on the age of the vehicle. You can make decisions based on both these properties.
- Using many segment values can result in more accurate assignment and in the creation of more specialized workplans. But a smaller number of strategies can be useful for looking at the statistics of claim outcomes.
- Another use of strategies might be to randomly assign claims with the same segmentation into two strategy groups. Then you could use different approaches to handling the claims, based on the claim's strategy value. You can then compare the effectiveness of the old and new approaches.

Uses of Segmentation

The original, and most common, purpose of segmentation is to assist assignment rules in assigning work to the best group and the most capable user. A rule that examines the segment and loss location parameters can determine whether to assign the exposure to a local or regional office. This assignment would be based on both the severity, as described in the segment, and the location. However, the segment can also determine other claim-related actions, as described in the topics that follow.

Segmentation and Reserve Levels

One common use of segmentation is to set reserve levels. For example, you can write a series of rules to set an exposure's reserves based on its segment value:

```
If the exposure is part of an auto claim,  
  If the exposure's segment is "Auto - Glass", set the reserve level to a very low level.  
  Else if the exposure's segment is "Injury - High Complexity", set a much higher reserve level.  
  Else if "Injury - Low Complexity" segment value, set another reserve value.
```

Claim Segmentation Based on Exposure Segments

You can use segmentation rules to categorize the entire claim, independent of its exposures' segment properties. However, it can be more useful to assign the most serious segment found among the claim's exposures to the entire claim. You can also set the strategy in this rule set.

Segmentation and Activities

Activities appropriate to some types of exposures are inappropriate to others. For example, a claim can have an exposure segment of Injury - High Complexity and a loss severity of High. This is useful in deciding whether to create medical review activities and assign them to a nursing case manager.

Segmentation and the Data Model

`Segment` and `Strategy` are properties—single fields—of both `Claim` and `Exposure` objects. The `ClaimSegment` and `ClaimStrategy` typelists provide the values for both claims and exposures. You can extend both typelists.

Working with Activities

ClaimCenter tracks all tasks, or units of work, involved in handling a claim. Actions such as inspecting a vehicle, reviewing medical information, negotiating with the claimant, making payments, and so on are called *activities*.

Activities are the central mechanism for tracking completion of all varieties of tasks. ClaimCenter divides the work for a claim into activities and provides a list of these activities to enable you to track them to completion. These activities track everything that must be done to settle every claim.

The claim segmentation process creates an initial set of activities for a new claim. Additional activities can be added to the claim at any time. Multiple users can be assigned activities on a single claim. Assigned activities represent units of work for the claim and enable the work units to be divided among users.

Tracking work by using activities enables claim owners to perform all necessary claim-handling tasks and identify missed tasks. Supervisors and managers can also track assigned work and identify problem claims, such as claims with many overdue or escalated activities.

See also

- “Claim Segmentation” on page 213.

This topic includes:

- “Activities Overview” on page 217
- “Viewing Activities” on page 223
- “Understanding Activity Patterns” on page 225
- “Activity Calendars” on page 228
- “Activities and the Data Model” on page 229

Activities Overview

You can generate and assign an activity either manually or automatically. Automatic generation and assignment uses business rules and activity patterns to assign work to users based on their workloads, special skills, or locations.

This topic includes:

- “Activities as Tasks” on page 218
- “Elements of an Activity” on page 218
- “Creating Activities” on page 219
- “Assigning Activities” on page 220
- “Completing or Skipping Activities” on page 221
- “Activity Escalation” on page 223
- “Activity Statistics” on page 223

Activities as Tasks

Activities are tasks necessary to process claims. Each activity is a single task that can be assigned to a person and completed, including work that cannot be completed directly in ClaimCenter. ClaimCenter tracks the assignment and completion of all activities to ensure that the claim is correctly handled.

Activities store information about what needs to be done, who does it, and a history of information about the activity after it is completed. Activities themselves do not store the results of the work. Some examples of work resulting from activities are:

- An externally stored, signed agreement document.
- A note within ClaimCenter summarizing the activity’s investigative results.
- A new reserve that was set up, or a settlement plan that was created.

Elements of an Activity

The following fields define an activity:

- **Subject** – Activity name.
- **Description** – Text describing the activity.
- **Related To** – Indicates if the task is a claim level task or is related to a person or a covered item that is part of the claim.
- **Due Date** – The date the activity is scheduled to be completed, after which the activity appears in red.
- **Escalation Date** – The date on which ClaimCenter sends alerts that the activity is overdue or generates other activities to deal with the overdue activity.
- **Priority** – Used for sorting a list of activities. Values are **urgent**, **high**, **normal**, or **low**.
- **Calendar Importance** – Used for calendar display of the activity. Values are **top**, **high**, **medium**, **low**, **not on calendar**.
- **Mandatory** – Indicates whether or not the activity can be skipped. If not mandatory, an activity is just a suggestion.
- **Externally Owned** – Indicates whether the activity is to be done by an outside group or user.
- **External Owner** – If externally owned, name of the user who owns the activity.
- **Document Template** – Name of the template used by a correspondence activity to generate a document.
- **Email Template** – Name of the template used to generate an email.
- **Assign To** – Indicates whether the task is assigned automatically or assigned to a specific user, to the claim or exposure owner, or to the company or super user.
- **Recurring** – Indicates whether or not the activity repeats. If the activity repeats, completing the activity creates a new one.

The activity template associated with the activity gives the initial, or default, values for these attributes.

Some of these fields are visible on the Desktop tab → Activities screen. Most of the fields are visible when you click an activity's Subject field to open the Activity Detail worksheet for the activity.

See also

- “Workplans and Activity Lists” on page 224.

Creating Activities

Because activities are central to the claim process, they can be created in a number of ways:

- By users in the ClaimCenter user interface. Users create activities for themselves or, with authority, for other users.
- Externally, by using API calls.
- By running batch processes, which can generate activities.
- By ClaimCenter rules, which can create activities while ClaimCenter is:
 - Generating workplans.
 - Responding to escalations or claim exceptions.
 - Handling manual assignments.
 - Obtaining approvals, investigating fraud, and processing other events.

Automated Activity Generation

During a new claim’s setup process, as described at “Automated Claim Setup” on page 213, ClaimCenter uses your organization’s business rules to create activities automatically. After you enter an auto claim, for example, ClaimCenter can create activities to contact the witnesses, get the police report, and have the vehicle inspected. Claim segmentation often determines which activities are appropriate. For example, an auto claim would produce one set of activities, while a property claim would produce several different activities.

ClaimCenter can also automatically create activities to convey information or to require someone to make a decision. For example, in the base configuration, if you try to issue a payment that exceeds your authority, ClaimCenter automatically creates an activity for your supervisor to review that transaction. If rejected, ClaimCenter creates another activity to inform you that the activity was rejected.

The workplan rule sets for claims, exposures, and matters generate activities in this way.

Batch Processes and Activities

Several batch processes can identify claims and activities for which you might want to create new activities. For example, new activities can be created for claims and activities that have reached their escalation dates or have not been looked at for a long period. Some useful batch processes include:

Batch process	What it finds	Parameter name
Activity Escalation	Activities that have reached their escalation dates	Escalation Days or Hours, set in the Activity Pattern
Claim Exception	Claims with exceptions (new, since last run)	none
Idle Claim Exception	Open claims with no activity for a defined period	IdleClaimThresholdDays in config.xml—defaults to 7 days
Idle Closed Claim Exception	Closed claims with no activity for a defined period	IdleClosedClaimThresholdDays in config.xml—defaults to 7 days

For information about scheduling batch processes, see “Batch Processes and Work Queues” on page 123 in the *System Administration Guide*.

Creating Activities

You can create activities for yourself and for other users, as follows:

1. Open a claim.
2. Navigate to **Actions** → **New Activity** and select an activity type.
Choose the general activity type and then the specific activity type, an activity pattern, from the menu actions under **New Activity**. If the specific type of activity is not present, you can create a new one by creating a new activity pattern. See “Creating and Editing Activity Patterns” on page 226.
3. On the **New Activity** screen, enter the activity details. See “Elements of an Activity” on page 218 for the meanings of individual fields.
4. For **Assign To**, indicate how or to whom the activity is to be assigned.
 - Click **Select from list** and use the drop-down list. You can choose **Use automated assignment** and have the application use rules to assign the activity, or you can choose the assignee.
 - Click **Search for user, group, or queue** to find an assignee, and then click **Assign** for the one you want.
5. Click **Update** to save the activity.

See also

- “Automated Assignment” on page 200
- “Assigning Activities” on page 220

Assigning Activities

An activity must eventually be assigned to a user after it is generated. Many activities, including those generated after new claim creation, are assigned to the owner of the new claim. If you have created an activity, you can assign it either to yourself or to someone else. You can also reassign an activity that you own.

Assigning Activities from a Queue

Automatic assignment, often used in conjunction with automated activity generation, can put automatically generated activities on a queue. From this queue, you can assign activities to yourself or others, as follows:

1. Navigate to **Desktop** tab → **Queues** and choose a queue.
2. Filter the queue’s list of activities to locate those of interest.
3. Assign the selected activities, depending on your user permissions.
 - If you are not a manager or supervisor, you have only the following choices:
 - Click **Assign Next in Queue to Me**.
 - Click the **Subject** field of an activity to open it in the **Workplan** screen so you can assign it. See “Reassigning an Activity” on page 221
 - If you are a manager or supervisor, you have the same choices listed previously. Additionally, you can select a check box for each activity you want to manage and then have the following choices:
 - Click **Assign Selected to Me**.
 - Click **Assign** and then, depending on the radio button you select, you can do the following:
If you choose **Select from list** to do the assignment, choose an item from the list and click **Assign** to perform the assignment. If you are taken to a screen showing the **Update** button, click that button to complete the reassignment.
If you chose **Find as user, group, or queue** to do the assignment, find the user, group, or queue, and then click **Assign** for the one you want.

See also

- “Automated Assignment” on page 200

Reassigning an Activity

With the correct permissions, an activity owner or the supervisor can reassign an activity to another group member. Also, activities belonging to a claim or exposure are automatically reassigned to the new owner after the claim or exposure is reassigned.

1. On the **Claim** tab under **Activities** on the left, click **Workplan**.
2. Depending on your permissions, you can do one of the following to assign an activity on the list:
 - Select an activity by clicking its check box, and then click the **Assign** button.
 - Click the subject of an activity to open its **Edit** screen below the list of activities, and then click **Assign**.
3. Choose one of the following options on the **Assign Activities** screen to assign the activity.
 - If you choose **Select from list** to do the assignment, choose an item from the list and click **Assign** to perform the assignment. If you are taken to a screen showing the **Update** button, click that button to complete the reassignment.
 - If you chose **Find as user, group, or queue** to do the assignment, find the user, group, or queue, and then click **Assign** for the one you want.

Completing or Skipping Activities

To avoid having a finished activity marked overdue and escalated, you must mark it as complete when you finish the associated task. After the activity is marked completed, ClaimCenter changes its status to **Complete**, logs this event, and creates an entry in the claim history. For information on claim history, see “Claim History” on page 119.

To mark an activity as complete

1. Locate the activity in either a **Claim** → **Workplan** activity list or in the **Desktop** tab → **Activities** list.
2. Select the check box for the activity and then click **Complete**.

Before clicking **Complete**, you can click the activity’s **Subject** link and view or edit the **Activity Detail** worksheet for the activity.

Note: Some activities can recur—create another activity when this activity completes. On the **Activity Detail** worksheet, look under **Activity Tracking** to see the setting for **Recurring**.

To skip an activity

Activities that are not **Mandatory** are skippable. To skip a non-mandatory activity:

1. Locate the activity in the **Claim** tab → **Workplan** activity list or in the **Desktop** tab → **Activities** list.
2. Select the check box for the activity, and then click **Skip**.

Skipped activities are treated similarly to completed activities. ClaimCenter changes the status to **Skipped**, logs this event, and creates an entry in the claim history.

Note: You cannot resurrect a completed or skipped activity. Create a new one instead.

Completing a Recurring Activity

You can schedule the next occurrence while completing the current recurring activity.

1. Locate the recurring activity in the **Claim** tab → **Workplan** activity list or in the **Desktop** tab → **Activities** list.
2. Click the **Subject** field of the activity to open the **Activity Detail** worksheet.

3. Enter the dates and any other information needed to complete the current activity.
4. Click **Complete and Create New**.
5. Edit the dates and any other part of the new activity and click **Update**.

Completing a Review Activity

If adjusters schedule payments that exceed their authority, ClaimCenter creates approval activities that are assigned to the adjuster's supervisor. If you fill this supervisory role in your organization, you can be assigned the activity of reviewing the payment and either approving or rejecting it. To perform this type of activity:

1. Locate the activity. For example, navigate to **Claim tab** → **Workplan** or **Desktop tab** → **Activities**.
2. Click the **Subject** field of the activity to open its **Activity Detail** worksheet.
3. Review the payment in the **Activity Detail** worksheet.
4. Enter the reason you approve or deny the payment in the **Approval Rationale** box.
5. Select either **Approve** or **Reject** to complete the activity.

ClaimCenter generates an activity for the original issuer of the payment if the payment is rejected. It also logs the decision and notes it in the claim history.

Completing a Correspondence Activity

Sending a letter or an email is a correspondence activity. Typically, when the activity is created, a document or email template is attached to be used for the correspondence task. To work on the task, you can click the **Subject** field for the activity and open its **Activity Detail** worksheet. You then click either **Create Email** or **Create Document** as appropriate and complete the correspondence. You might need to do more, like printing and mailing a document. With an email, you can simply click **Send Email**.

After you complete the correspondence, the **Activity Detail** worksheet opens again. If you have created a document that you want to link to the activity, you can click **Link Document** to find the document and link it.

When the task is complete, click **Complete** to indicate that you have sent the letter or email.

See also

- “Working with Email in Claims” on page 231
- “Working with Documents” on page 527

Working with Documents in Activities

Documents related to activities appear in the **Documents** section of the **Activity Detail** worksheet. You can view, edit, or send these documents directly from the originating activity.

- **List Claim Documents** – A **Search** option replaces the claim Documents page’s filter. Document names in the list appear as links. Selecting the document name displays a property dialog about that document.
- **Author** – You can search for a document by entering its author.
- **Hide** – You can hide, but not delete, documents. Only administrators have permission to fully delete documents by using the **Delete** subtab.
- **Link** – You can attach, or link, documents to an activity. Linking is different from a document’s being related to an exposure or matter. A document can be related only to one entity, but it can be linked to many entities, such as notes and financials.

Activity Escalation

After an activity reaches its due date, the date appears in red, and a star symbol appears in the **Desktop tab → Activities** list. If the activity later reaches its escalation date, this event triggers escalation rules that expedite handling of the activity. For example, a rule can create a new activity for the supervisor of the user who owns the escalated activity, requesting that the supervisor intervene.

The Activity Escalation Rules rule set contains the rules that determine the actions to take after an activity reaches its escalation date. The Activity Escalation batch process, which in the base configuration runs every 30 minutes, executes this rule set.

Activity Statistics

ClaimCenter keeps statistics that measure how you are handling your workload. These measurements include open, overdue, and completed activities, and open, new, and closed claims. Supervisors can also see statistics for their teams, including overdue activities and open, new, and closed claims. To see these statistics from the **Desktop** tab, select **Actions → Statistics**. The **Statistics** tab at the bottom of the screen shows statistics about your activities and claims and, if you are a supervisor, your team's activities as well. Supervisors can see details for their teams by clicking the **Team** tab and drilling down to the level of detail needed.

Statistics are recalculated on a predetermined schedule, so you do not always see the latest numbers.

See also

- “Team Management” on page 403
- “Claim Health Metrics Calculations” on page 393

Viewing Activities

Activities are central to claim handling, and ClaimCenter displays them in a number of ways:

- To see a list of all your activities for all claims, navigate to **Desktop tab → Activities**. On the **Activities** screen, in the base configuration, by default you see your activities for the current day. You can filter activities in several ways in addition to **My activities today**, such as:
 - **Due within 7 days** – Activities that are open and due in the next week.
 - **All open** – All activities that are open regardless of status or due date.
 - **Overdue only** – Activities that are overdue or will become overdue at today’s end.
 - **All open external** – All activities assigned to people without access to ClaimCenter.
 - **Closed in last 30 days** – All activities closed in the last 30 days.
- To see a list of all the activities of one claim, including those owned by others, open the claim and click **Workplan**. See “Workplans and Activity Lists” on page 224.
- To see a list of all activities belonging to your group that are open, overdue, and completed today, click the **Team** tab. You must be a manager or supervisor to see this tab. See “Team Management” on page 403.
- If navigate to **Desktop tab → Actions → Statistics**, you can see the summary of activity statistics described at “Activity Statistics” on page 223.
- To find specific activities, choose **Search tab → Activities** and enter your search criteria.
- Calendars also display lists of activities. See “Activity Calendars” on page 228 for details.

After viewing any list or calendar of activities, clicking the **Subject** field of an activity opens its **Activity Detail** worksheet.

Workplans and Activity Lists

All activities are associated with a specific claim or a bulk invoice. The *workplan* is a screen showing all activities related to one claim. The **Workplan** screen displays the following information for each activity:

- **New or Updated**  – A  icon in this column indicates that the assigned activity new, has been reassigned to you by someone else, or has been edited by someone else recently.
- **Escalated**  – A  icon in this column indicates that the activity has been escalated.
- **Due** – Indicates the activity's targeted completion date. The due date is red if the date has passed, indicating that the activity is overdue.
- **Priority** – The importance of the activity, typically Urgent, High, Normal, or Low. You work first on activities that are escalated or new, and then on urgent or high priority activities.
- **Status** – Whether the activity is open, complete, skipped, or cancelled.
- **Subject** – The title of the activity. Clicking an activity's **Subject** field opens its **Activity Detail** worksheet.
- **Exposures** – Any associated exposure.
- **External** –Whether the activity is owned by a user without access to ClaimCenter.
- **Ext Owner** – Indicates who the owner is if external.
- **Assigned By** – The user that assigned this activity, if any.
- **Assigned To** – The owner of the activity.

The **Workplan** screen provides the following buttons that help in managing the activities, some of which are visible only if you are a manager or supervisor:

- **Filter** – Show the activity list after being filtered by various criteria, such as showing just today's activities, activities due within seven days, overdue activities, or all open activities.
- **Assign** – Assign an activity to someone else, either by selecting a user or group or by using automated assignment.
- **Skip** – Skip non-mandatory activities.
- **Complete** – Change the status of the activity to completed, and mark the completion date as today.
- **Approve** – If the activity is to approve a transaction for another user, then approve it and mark it complete.
- **Reject** – If the activity is to approve a transaction for another user, then reject it.
- **Print/Export** – Save the list of activities as a PDF file or export them to a CSV file.

The Desktop and Activities

The **Desktop** tab → **Activities** list of activities shows all your activities for all claims. The information is similar to that shown in the **Workplan** screen, but has none of that screen's information about other users. The **Activities** screen has the same buttons as the **Workplan** screen.

The following fields are the same as in the **Workplan** screen, described at “Workplans and Activity Lists” on page 224:

- **New or Updated, Escalated, Due, Priority, Subject, Exposures, and External**.

In addition, the **Activities** screen provides the following fields for each activity:

- **Claim, Insured, LOB, State** – Information about the claim with which the activity is associated.

Searching for Activities

Click **Search** tab → **Activities** to find activities. You must specify one of the following search criteria:

- **Claim Number** – Claim to which the activity belongs.
- **Assigned to Group** – The group to which the activity was assigned.

- **Assigned to User** – The user who is working on the activity.
- **Created by** – The user who created the activity.
- **External Owner** – Activities owned by users who do not have access to ClaimCenter.

You can also specify optional criteria to narrow the search results, such as:

- A particular **Status**, **Description**, **Subject**, **Priority**, **Due date**, **Closed date**, or **Creation date**
- A specific time period, such as activities due in the last 30 days
- A **Completed late** date or activities that are **Pending Assignment** or are **Overdue Now**

See also

- For descriptions of some of these search criteria, see “Workplans and Activity Lists” on page 224.

Team Activities

As a supervisor, you have access to lists of activities for all the groups, or teams, that you manage. You reach these lists through the **Team** tab. See “Team Management” on page 403.

Activity Detail Worksheet

Clicking the **Subject** field of an activity opens a detailed view of its fields. The fields of the **Activity Detail** worksheet are described in “Elements of an Activity” on page 218.

See also

- “Viewing Activities” on page 223
- “Completing or Skipping Activities” on page 221

Understanding Activity Patterns

Activity patterns are templates that standardize the way ClaimCenter generates activities. Both rules and selections made in the user interface create activities based on these patterns. Each pattern describes one kind of activity that might be needed in handling a claim. For example, **Get vehicle inspected** is a common activity pattern for auto claims. It is used to generate a **Get vehicle inspected** activity when needed as part of an auto claim.

Activity patterns contain default characteristics for each activity, such as name, relative priority, and due date. After an activity is added to a claim’s **Workplan**, ClaimCenter uses the pattern as a template to set the activity’s default values, such as **Subject**, **Priority**, and **Target Days**. You can override these default values, either as you create activities or through rules.

An activity pattern and an activity created from the pattern can have the same name. The default activity name is that of the activity pattern. You can think of a pattern as an entity, and the corresponding activity as an instance of it.

You can see the list of available activity patterns by opening a claim and clicking **Actions**. Click each menu action under **New Activity** to see the activity patterns in the submenu.

Administrators can view, create, and edit patterns by navigating to **Administration tab** → **Business Settings** → **Activity Patterns**. Users and rules can create activities based on these patterns, as can external systems using API calls.

See also

- “Creating Activities” on page 219

Activity Pattern Types and Categories

Every activity pattern has both a type and a category. A category classifies activity patterns into related groups. Each typecode of the `ActivityCategory` typelist is an activity pattern category and relates each category attribute to the typelist `ActivityType`.

Each activity pattern has a defined type. You can add an activity pattern only with a `General` type, and only if you have administration permissions. General activities are patterned after the a diary—work for a claim that is assigned to a person and has a deadline. For example, getting a vehicle inspected has a general activity pattern type.

Internal Activity Pattern Types

In its default configuration, ClaimCenter defines a number of internal activity pattern types in the `ActivityType` typelist. Activity patterns with types other than `General` are usable by Gosu code and must not be removed. However, administrators can customize attributes of these internal activity patterns, such as their due dates. The internal activity pattern types are:

- **Approval** – Activities to approve or deny a financial transaction, like a payment or reserve increase.
- **Assignment Review** – Assignment activities added to a supervisor's Pending Assignment queue.
- **Approval Denied** – Activities for reviewing a denied approval request.
- **Litigation** – Activities related to a legal action, matter, or negotiation.

Any pre-existing activity patterns of type `General` are examples provided by Guidewire that you can fully customize or delete.

Creating and Editing Activity Patterns

With administrator permissions, you can edit or create new activity patterns. Navigate to **Administration** tab → **Business Settings** → **Activity Patterns** and then click **Add Activity Pattern**.

On the **New Activity Pattern** screen, you must specify:

- **Subject** – The activity's name, which is shown both in lists of activities and in lists of patterns.
- **Short Subject** – Names the activity in a calendar entry or for a subject name that too long to display in full. There is a limit of 10 characters.
- **Class** – Determines if the activity is a `Task` and has either a due date (target days) or an `Event`, which does not have target days. For example, trial dates are events—they occur on a given date, but cannot become overdue or escalated.
- **Type** – All patterns that you create or change must be of type `General`. ClaimCenter reserves all other types for the patterns it uses to generate activities. The `ActivityType` typelist defines these types. See “Activity Pattern Types and Categories” on page 226.
- **Category** – ClaimCenter uses this value to show available activity patterns in its **New Activity** drop-down list. Pick a category that is appropriate for the activity pattern. For example, in the base configuration, the `Interview` category includes the `Get a statement from witness`, `Make initial contact with claimant`, and `Make initial contact with insured` patterns.
- **Code** – Name used in Gosu code. The maximum length is 30 characters and the convention is to use a name similar to the subject that uses lowercase letters with underscores. For example, the code name for the `Make initial contact with insured` activity pattern is `contact_insured`.
- **Priority** – Enables ClaimCenter to sort activities into urgent, high, normal, or low priority in a list of activities.
- **Mandatory** – Indicates whether the activity must be completed or can be skipped.
- **Calendar Importance** – Indicates the priority for the calendar—top, high, medium, low, or not on calendar.
- **Claim loss type** – Type of claim loss—auto, liability, property, travel, or workers' compensation—for which the pattern is allowed.

- **Automated Only** – Indicates whether an activity can be created only by rules or if a user can also create an activity based on the activity pattern.

Note: You can use this field instead of removing an activity pattern, which is not recommended. To effectively remove an activity pattern, set this value to `true`. Doing so prevents users from creating new activities from this pattern, but does not break existing rules that use the pattern.

- **Available for closed claim** – Set to `true` if the activity can be added to a closed claim.
- **Externally Owned** – Indicates if an outside group or user can own the activity. This setting is used for activities not under the control of the owner, such as a car repair, which a vendor completes in a time not under owner control.
- **Document Template** – Optionally appears on the activity. Useful if the activity is sending a letter or other document.
- **Email Template** – Optionally appears on the activity. Useful if the activity is sending an email.
- **Recurring** – Indicates if the activity recurs—when one activity ends, another is created.
- **Description** – A text description that is visible when looking at the activity's details.

In addition, each activity pattern includes two calculated dates and the settings used to calculate them:

- **Target Date** – Date on which to complete the activity, after which ClaimCenter displays the activity in red. This value determines the due date.
- **Escalation Date** – Date on which ClaimCenter sends alerts that the activity is overdue or generates other activities to deal with the overdue activity.
- The following settings determine the **Target Date**:
 - **Target days** – Days between the start and target date.
 - **Target hours** – Hours between the start and target date.
 - **Target start point** – Activity creation date, loss date, or notice date.
 - **Include these days** – All days or only business days.
- The following variables determine the **Escalation Date**:
 - **Escalation days** – Days between the start and escalation date.
 - **Escalation hours** – Hours between the start and escalation date.
 - **Escalation start point** – Activity creation date, loss date, or notice date.
 - **Include these days** – All days or only business days.

See “Activities and the Data Model” on page 229 for information of how to define holidays and weekends after calculating dates.

Generating an Activity from an Activity Pattern

Activity patterns are used to generate activities in several ways:

- You can manually generate an activity in the ClaimCenter user interface. Open a claim and click **Actions**, and then click a menu action under **New Activity** to see its activity patterns. The menu actions under **New Activity** are categories, and their submenus show activity patterns. You click an activity pattern to create an activity. When you create an activity, you can override all default values set by the pattern.
- Rules can automatically create activities in response to the following events:
 - Making a workplan during claim creation.
 - Escalations, claim exceptions, or other events.
 - Assistance needed with manual assignment.
 - Actions requiring approval.
- External systems can also create activities through API calls.

Activity Assignment

An activity pattern does not control how an activity is assigned. There are, however, several ways activity patterns can assist assignment:

- Assignment rules can assign an activity based on the activity pattern by using its code value. For example, writing a request to **Get an initial medical report** is an activity that might be assigned to a medical case manager.
- While creating a new activity, you can choose auto-assignment rules or select a user manually by using a search feature on the activity creation screen.
- After searching through a list of group members during an assignment activity, you can search for potential assignees. This search returns workload statistics—how many open activities you have already—which is the same information as seen on a supervisor's calendar. Selecting the calendar icon that accompanies the search results returns your personal calendar.

Activity Calendars

In the base configuration, ClaimCenter provides a variety of calendars to help organize activities. They show activities in both monthly and weekly views. You can access these calendars from either the **Desktop** tab or the **Claim** tab, and you can filter the listed activities in a number of ways. For example, you can filter the activities to show those related to legal matters. Supervisors can also view activities of other users.

Calendar Displays

On the **Desktop** tab, click **Calendar** in the sidebar to open your calendar. If you are a manager or supervisor, you can also open a Supervisor calendar. Select a calendar to show:

- Calendars for the current week and month, or any other start date. Weekly calendars always start with the current day. The monthly calendar always starts on the previous Monday.
- Activities related to all claims and matters, those unrelated to legal matters, or those related only to matters.
- If looking at matter-related activities, either a display of all such activities or just all trial dates.
- Activities assigned any priority, or just activities of a specific priority, such as **Urgent**.

After opening a claim, you can open a calendar showing all activities, including matter activities, relating to just that one claim. From **Claim**, click **Calendar** in the sidebar to open both the current monthly and weekly calendar. You can view all the activities for this claim that are assigned to anyone, or just the activities assigned to you.

Calendar Information

If you need to obtain more details do the following.

In the monthly view:

- **Calendar items are truncated** – Hover your mouse over a truncated item to reveal the full name. If you click the name, the **Activity Detail** worksheet opens to show more information.
- **Calendar cells show up to four items** – If there are more than four items on one date, the calendar cell displays **More**. Click **More** to see that day's activities.
- **Calendar items are numbered** – The numbering correlates with the numbering in the weekly view and with extra information that appears below the calendar. This extra information is either the claim number and name of the insured if the activity is claim-related or the name of the matter if related to a matter.
- **An activity has been escalated** – An escalated activity is red.
- **A calendar becomes cluttered** – A supervisor's calendar can look at a large number of subordinates. To avoid clutter, the calendar can show only the total number of open activities of each priority owned by each supervised group. These totals reflect all the activities of each employee. In the totals are the activities the super-

visor assigned and the activities assigned to the supervisor's subordinates by virtue of their membership in other groups. This feature helps a supervisor get a better assessment of the total workload.

In the weekly view:

- **Calendar items are truncated** – Hover your mouse over a truncated item to reveal the full name. If you click the name, the Activity Detail worksheet opens to show more information.
- **An activity has been escalated** – An escalated activity is red.
- **Each claim-related activity shown has standard information** – Includes its name, claim number, and the insured name.
- **The calendar might show only trial dates** – The detail shown includes the insured, the venue, the jurisdiction, and the names of the opposing attorneys.
- **A supervisor's calendar shows limited information** – Lists the activities with highest priority.

Calendar Priority Governs What Shows in the User Interface

Activities carry a Calendar Importance tag, which is assigned after the activity is created. The default value comes from the value of the **Calendar Importance** field of the activity pattern that helped create the activity. You can assign importance levels of **Urgent**, **High**, **Normal**, or **Low**. These values come from the **Priority** typelist. The calendar shows the priority of each activity it displays.

However, if the priority is either **Low** or **Not on calendar**, the item does not display because these priority values suppress the activity's presence on the calendar.

Calendars and Manual Assignment

Using calendar information can be helpful in making a manual assignment. In the standard search for potential assignees, workload information appears. This information is the same data as that seen on a supervisor's calendar. Viewing this information helps you in making assignments based on workload.

You can also view a user's calendar before making an assignment. Each assignment search returns, by default, a calendar row. Selecting the calendar icon on this row displays the particular user's calendar.

Calendars and Holidays

The calendar displays all days of the week, but does not show weekends or holidays.

Activities and the Data Model

This topic lists the main entities and typelists that relate to activities.

Main Entities Related to Activities

Entity	Description
Activity	The main entity. It has foreign keys to Claim, Exposure, Matter, ServiceRequest, Document (array), TransactionSet, ActivityPattern, and BulkInvoice with which it is associated or previously was associated. It also has foreign keys to Group, and User. It also contains typekeys to the ActivityClass, ActivityStatus, ActivityType, ImportanceLevel, and Priority typelists, shown in the next table.
ActivityView	Displays activities efficiently as lists. Has the following subtypes for specialized views: <ul style="list-style-type: none"> • ActivityDesktopView – View in the Desktop tab. • ActivitySearchView – For search results and the claim summary screen. • ActivityTeamView – For the Team pages. • ActivityUnassignedView – For the Awaiting Assignment display. • ActivityVacationView – For the Vacation display. • ActivityWorkplanView – In the Workplan screen.
ActivityPattern	The template used to create activities. See “Creating and Editing Activity Patterns” on page 226 for more information.

TypeLists Related to Activities

TypeList	Description
ActivityCategory	Used by activity patterns to create different categories. Examples are Approval, Interview, Litigation, File Review, New Mail, Request, ISO.
ActivityClass	Used to indicate if an activity is a task, which has a due date, or an event, which does not. Used by activity pattern.
ActivityStatus	Whether an activity is open or complete, or has been canceled or skipped.
ActivitySubjectSearchType	Whether to search for an activity by its ActivityPattern or by text it contains. Used by the activity search entity ActivitySubjectSearchCriteria.
ActivityType	Activities you create must be of type General. All other types are used internally.
CalendarContext	Used to retrieve and sort activities for different calendar views.
ImportanceLevel	Set by activity patterns. Sorts calendar displays.
Priority	Choices are urgent, high, normal, or low. Priority is used by activity patterns. ClaimCenter sorts list of activities by priority, and then alphabetizes each priority group.

Email

Email is a communication tool for adjusters and other users involved with the claim resolution process. From ClaimCenter, you can write and send emails. You have the ability to:

- Define and store a variety of email templates.
- Create email messages from templates or from scratch.
- Fill in names and email addresses by using contact information or by doing it manually.
- Send emails from all claim screens.
- Send attachments with emails.
- Define activity patterns that enable the sending of emails from activities created by the pattern.
- Create activities that involve sending emails.
- Store and retrieve emails as claim documents.
- Use Gosu to automatically create a history event when you send an email.
- Use Gosu to send an email, including emails that contain attachments, from a rule.

ClaimCenter sends emails only in the context of a specific claim. ClaimCenter can store sent emails as documents attached to that claim.

Note: You must configure email in Guidewire studio before you can send email in ClaimCenter. See “Configuring ClaimCenter to Send Emails” on page 140 in the *Rules Guide*.

This topic includes:

- “Working with Email in Claims” on page 231
- “How Emails are Sent” on page 233

Working with Email in Claims

You compose and send mail from the **Email** worksheet. There are multiple ways to access this worksheet, all of which require that you have a claim open.

This topic includes:

- “Opening the Email Worksheet” on page 232
- “Email Worksheet” on page 232
- “Sending an Email from a Rule” on page 233

Opening the Email Worksheet

You can open the **Email** worksheet from any claim and from some activities:

To access the Email worksheet from a claim

While in a claim, there are two ways to open the Email worksheet:

1. Enter **Email** in the QuickJump box and press **Enter** to open the **Email** worksheet.
2. Choose **Actions** → **New** → **Email**.

To access the Email worksheet from an activity

After you open an activity created with an activity pattern that specifies an email template, the activity includes a **Create Email** button. Clicking the button opens the main **Email** worksheet. This **Email** worksheet is the same one that you reach directly from a claim, except that it lacks the **Use Template** button. Instead, it displays the subject and body of the template specified by its activity pattern. You can use the template’s text as the email body, or you can modify or delete it. You cannot, however, obtain another email template by using this screen.

See “Viewing Activities” on page 223.

To configure an activity pattern to send an email

After creating or editing an activity pattern, specify an email template name in the optional field. All activities created from this pattern contain the **Create Email** button. See “Creating and Editing Activity Patterns” on page 226.

Email Worksheet

You compose and send email in the **Email** worksheet. This worksheet has the functionality of a typical email client, enabling you to specify recipients, subject, and attachments, and to enter text in the body of the email. You can also send and store an email from this worksheet. Closing the **Email** worksheet returns you to the claim.

You can use the worksheet for:

- “Selecting an Email Template” on page 232
- “Selecting Email Recipients” on page 233
- “Adding Attachments to an Email” on page 233
- “Sending an Email” on page 233
- “Saving an Email” on page 233

Selecting an Email Template

An email template gives you a body and subject for your email. If you do not use a template, you can type the subject and body directly into the **Send Email** screen.

To use a template, click **Use Template** to open the **Find Email Templates** screen that searches for templates. You can search by **Topic** or for one or more **Keywords**, or both. You can also click **Search** without entering any values.

The email template specifies topics and keywords on which you can search. Each template has a **topic** attribute and a **keywords** attribute used by the template creator to specify one or more values. To search by topic or keyword, you must enter topics and keywords. There is no drop-down list from which to select.

Click **Search** to display the search results. Click **Select** next to a template to choose it.

You can conduct another search by clicking **Reset**. You can cancel template selection by clicking **Cancel** or **Return to Email**.

If you select a template, the **Email** screen opens with the subject and body specified by the template.

See also

- “Understanding Email Templates” on page 137 in the *Rules Guide*
- “Creating an Email Template” on page 139 in the *Rules Guide*

Selecting Email Recipients

Each email must have at least one recipient. Click **Add** to add each recipient. You can also click **Add CC Recipients** to copy recipients and **Add BCC Recipients** to copy recipients who are hidden from the other recipients. After clicking one of these buttons, you click **Add** to add each recipient of this type.

If ClaimCenter is integrated with a contact management system, such as ContactManager, instead of entering a name and email address, you can click **Search**  to search for recipients.

See also

- “ContactManager Integration” on page 519
- “Working with Contacts in ClaimCenter and ContactManager” on page 519

Adding Attachments to an Email

Clicking **Add** in the **Attachments** section of the **Email** worksheet opens the document search screen. You can select any document already associated with the claim. The document must be present either in ClaimCenter or in the document management system with which ClaimCenter is integrated. You cannot attach documents that are not already present.

After you select a document, it is added to the list in the **Attachments** section. To remove a document from the list, you can select its check box and click **Remove**.

Sending an Email

The **Send Email** button in the **Email** worksheet sends the email and closes the worksheet.

Saving an Email

If you mark the **Save as a New Document** check box in the **Email** worksheet, the email becomes a document stored in the document management system. Saving an email as a document mixes the email with other documents.

Sending an Email from a Rule

Gosu provides methods that you can use in rules that send emails and email attachments and that create history events.

See also

- “Email Utility Methods” on page 136 in the *Rules Guide*
- “Event Message Rule Set Category” on page 48 in the *Rules Guide*

How Emails are Sent

ClaimCenter sends emails asynchronously by using its messaging subsystem. You must also register an `emailMessageTransport` class to hold the email messages and do the actual sending. Email messages are

processed and sent one at a time, like any other message. See “Email Transmission” on page 137 in the *Rules Guide*.

Since emails are sent by using the normal messaging mechanism, emails that fail to reach their recipients are treated just as other messages. An administrator gets a report of these messages and must take action, so the sender is not directly notified. See “Monitoring and Managing Event Messages” on page 64 in the *System Administration Guide*.

Handling Incoming Email

Some document management systems accept incoming emails, parse them to read the claim number they contain, and store them as documents attached to that claim. Such systems accept either scanned email or emails from an email server. Linking ClaimCenter to incoming emails requires you to integrate with a document management system with such capabilities. You must configure this feature.

Incidents

ClaimCenter uses the `Incident` data entity to track important items related to a claim. In ClaimCenter, an `Incident` entity subtype captures specific information such as vehicles, property, and injuries involved in the claim. For example, the `LivingExpensesIncident` entity tracks living expenses related to a homeowners claim.

IMPORTANT The insurance industry uses the term *incident* differently from Guidewire. Most commonly in the insurance industry, an incident is an event or accident or near-miss that might or might not develop into a claim. ClaimCenter supports this alternate concept as well with the incident-only claim. If you indicate that a claim is incident-only, ClaimCenter sets the `Claim.IncidentReport` to `true`. See “Incident-Only Claims” on page 241 for more information.

ClaimCenter uses incident subtypes to ensure that you can capture a large amount of information, independent of selecting coverage and creating an exposure. For example:

1. A call center representative (CSR) does not have enough information to create an exposure on a claim or does not have permission to create an exposure. The CSR captures details about the claim in an incident report.
2. An adjuster decides at a later date to use those incidents as the basis for exposures, potentially resulting in payments against the claim.

This topic includes:

- “Incident Overview” on page 236
- “Incidents, Exposures, and Claims” on page 236
- “The Incident Entity and Its Subtypes” on page 238
- “Creating Incidents” on page 239
- “Incident-Only Claims” on page 241

Incident Overview

Typically, you gather information about incidents during the intake process. This information is useful in determining the indemnities—the claim costs—needed to pay for the claim. The nature of this information varies across lines of business. For example:

- In an auto claim, the list of incidents can include vehicles.
- In a property claim, the list of incidents can include fixed properties such as buildings.
- In a workers' compensation claim, an incident typically includes an injury.
- In an homeowners claim, incidents can include living expenses incurred during the time that the claimant is unable to live in a house that was damaged by fire.

Incidents serve these primary purposes:

- **Capturing information about the loss without having to create exposures** – This purpose is useful for a CSR who does not have sufficient expertise to create exposures. An incident is also useful if the CSR is unsure of what exposures are necessary at the time the claim is created. For example, it might not be immediately obvious which coverage covers the loss.
- **Sharing information about a lost or damaged item across multiple exposures** – This purpose is useful if a single item suffers multiple losses covered by multiple exposures, such as an auto policy with separate vehicle damage and towing coverages.

You can use ClaimCenter incidents for the following purposes:

- To gather injury, vehicle, and property damage data that is independent of exposure creation.
- To view all injuries, vehicles, or properties associated with a claim from a single screen.
- To see the relationships between a contact and vehicles or properties.
- To view injury fields in each claim contact record and to store incident injury information.

Incident Permissions

You do not need any special permissions to create or edit incidents.

- If you have the Edit Claim permission `claimedit`, you can create and edit incidents.
- If you have the View Claim permission `claimview`, you can link an incident to an exposure, but you cannot further edit the exposure.

See also

- “Incidents, Exposures, and Claims” on page 236
- “The Incident Entity and Its Subtypes” on page 238
- “Creating Incidents” on page 239
- “Incident-Only Claims” on page 241

Incidents, Exposures, and Claims

In working with incidents, claims, and exposures, it is important to understand the following:

- Incidents capture the information about what was lost, hurt, or damaged. They do not capture coverage, coding, financials, or other carrier involvement.
- Incidents and claims have a *many-to-one* relationship—a single claim can have multiple associated incidents.
- Incidents and exposures have a *one-to-many* relationship—a single incident can have multiple associated exposures.

It is possible to associate an incident with an exposure, but you do not have to do so. For example, you do not associate an incident with an exposure in the following circumstances:

- You do not know what coverage is to be applied. Or, it is possible that you do not have the authorization to choose a particular coverage.
- No claim or exposure will result from the incident. If an incident describes damage to abandoned property, there is no claimant in that case.

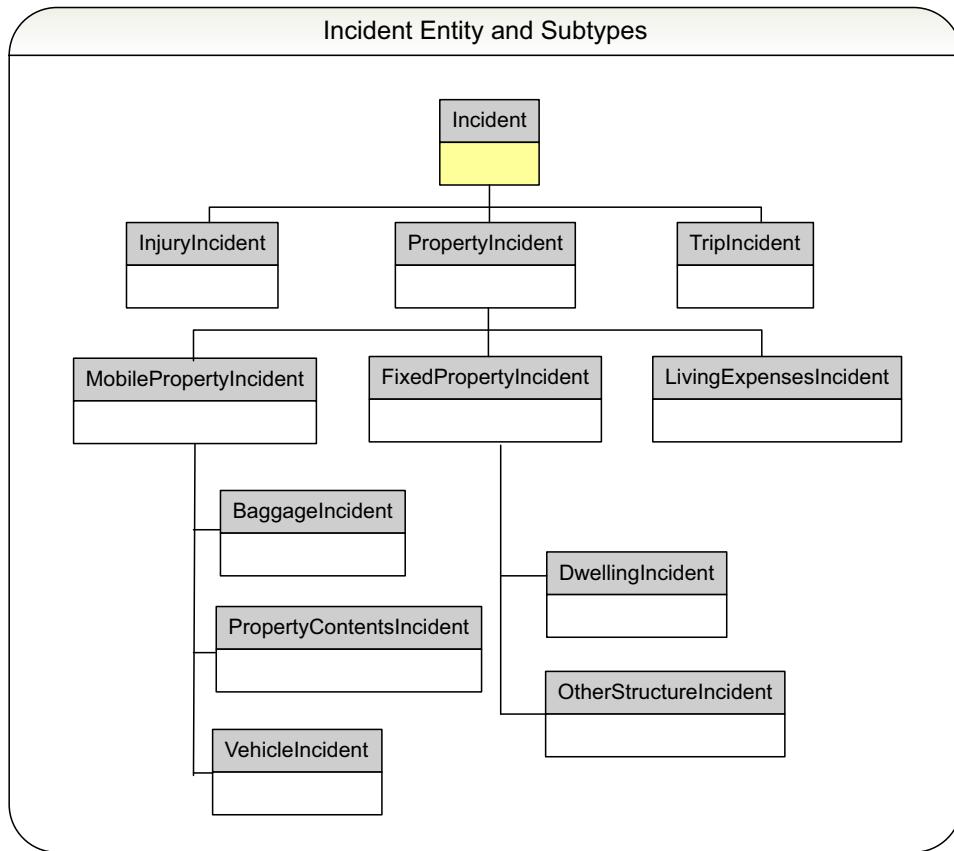
Initially, all incidents relate to a claim. At a later date, you can associate an incident with a specific exposure. You can also create an incident when you create an exposure if no incident currently exists. For example, in the Personal Auto line of business, if you create an exposure after creating the claim, you must identify an incident before you update the new exposure. At this point, you can also choose to edit the incident details before updating the exposure. ClaimCenter displays the **Vehicle Incident** screen so you can add more information.

See also

- “Incident Overview” on page 236
- “The Incident Entity and Its Subtypes” on page 238
- “Creating Incidents” on page 239
- “Incident-Only Claims” on page 241

The Incident Entity and Its Subtypes

The following diagram illustrates the relationships between the **Incident** entity and its subtypes in the ClaimCenter base configuration. For more information on the **Incident** entity and its subtypes, see the ClaimCenter Data Dictionary.



Every exposure type maps to the **Incident** entity or to one of its subtypes. Every exposure has at least one underlying incident. As you create a new exposure, ClaimCenter also creates and initializes an incident. The link between **ExposureType** and **Incident** identifies the type of incident to create and initialize. The following table lists these relationships.

ExposureType	Incident subtype	Description
Baggage	BaggageIncident	Loss, damage, or delay of baggage. Also includes the loss of travel documents, such as tickets and passports.
Bodily Injury	InjuryIncident	Generic for all lines of business, contains all injury-related data for workers' compensation (WC), auto, Personal PIP, and Medical Payments (MP).
Content	PropertyContentsIncident	Includes items such as electronics, jewelry, furniture, and similar items.
Dwelling	DwellingIncident	Covers damage to a dwelling, such as a damaged roof or rooms in a building. Also includes property damaged by an earthquake.
Employer Liability	Incident	Used mainly for employer liability, both private and federal, associated with workers' compensation. Contains just description and loss estimate.
General	Incident	Generic for use with all lines of business, contains just description and loss estimate.

ExposureType	Incident subtype	Description
Living Expenses	LivingExpensesIncident	Captures food and lodging details.
Loss of Use	PropertyIncident	Used for all kinds of property damage, including third-party and rental car loss of use.
Med Pay	InjuryIncident	Generic, for use with all lines of business.
Medical Details	InjuryIncident	Generic, used mainly for workers' compensation injury exposures.
Other Structure	OtherStructureIncident	Covers another building on a property.
Personal Property	MobilePropertyIncident	Primarily for loss of the contents of a vehicle, such as theft or vehicle loss, or for moveable property such as a cellular phone.
PIP	InjuryIncident	Generic, primarily for personal injury protection, not commercial losses.
Property	FixedPropertyIncident	Loss unrelated to a vehicle, for example, a building and its contents, inland marine, and similar items.
Theft	VehicleIncident	Auto coverages related to vehicle theft.
Time Loss	InjuryIncident	Mainly for workers' compensation, contains just description and loss estimate.
Towing and Labor	VehicleIncident	Auto coverages, especially towing and labor.
Trip Cancellation or Delay	TripIncident	If you missed your destination due to trip cancellation or delay.
Vehicle	VehicleIncident	Covers auto coverages related to vehicle damage.

See also

- “Incident Overview” on page 236
- “Incidents, Exposures, and Claims” on page 236
- “Creating Incidents” on page 239
- “Incident-Only Claims” on page 241

Creating Incidents

To create an incident:

- You can manually enter all information to create incidents in the **New Claim** wizard.
- You can manually enter the required information to create an incident as you create an exposure on a claim.
- You can indicate that one of the risk units on the policy, such as a vehicle on an auto policy, is involved in the claim. ClaimCenter then uses that risk unit as the basis for an involved incident.

Creating an Incident by Manually Entering Information

Typically, you identify an incident during the intake process through the **New Claim** wizard in the **Loss Details** screen. In many cases, ClaimCenter requires that you create an incident as you create an exposure on the claim.

To add an incident in the New Claim wizard

1. Create a new claim by using the **New Claim** wizard.
2. Access the **Loss Details** screen.
3. Select an incident type from those shown at the bottom of the screen. For example, depending on the claim type, it is possible to see one or more of the following incident types:
 - **Add Vehicle**
 - **Add Property Damage**

- Add Pedestrian
4. Click the appropriate button. ClaimCenter opens a screen in which you can enter the details about the incident. For example, if you elect to add a new vehicle incident, ClaimCenter opens the **Vehicle Details** screen. Use this screen to enter information about the vehicle type, year, make, and model, as well as information on the driver of the involved vehicle.

To add an incident to an existing claim

1. Access the claim to which you want to add an incident.
2. Navigate to the **Loss Details** screen for that claim.
3. Click **Edit**.
4. Select an incident type from those shown at the right side of the screen. For example, depending on the claim type, it is possible to see one or more of the following:
 - Vehicles
 - Properties
 - Injuries
5. Click **Add**. ClaimCenter opens a screen in which you can enter the details about the incident. For example, if you elect to add a new vehicle incident, ClaimCenter opens the **New Vehicle Incident** screen. Use this screen to enter information about the vehicle type, year, make, and model, as well as information on the driver of the involved vehicle.

To create an incident on an exposure

1. Open the claim to which you want to add an incident.
2. Click the **Actions** menu and choose one of the following from the **New Exposure** section:
 - Choose by Coverage Type
 - Choose by Coverage
3. Choose a specific coverage.
4. Enter the incident information as requested. ClaimCenter requires that you associate incident information with each exposure as you create it. It is possible to update this information at a later time.

Creating an Incident by Using Policy Information

It is possible to use policy information from a policy administration system as the basis for potential incident descriptions. In the base configuration, you have the option of selecting information that can be the basis of an incident if you are working with a verified policy. Selecting information in this way helps to minimize mistakes that might arise from entering the information manually.

For example, if you have already selected a verified policy, you can do the following in the **New Claim** wizard of a personal auto claim:

- You can select one or more vehicles to include on **Claim** as incidents from the list of vehicles in the **Basic Info** screen of the **New Claim** wizard.
- You can add information regarding other vehicles, pedestrians, or property damage in the **Loss Details** screen of the **New Claim** wizard.
- You can add driver and passenger information on the **Vehicle Details** screen.

See also

- “Incident Overview” on page 236
- “Incidents, Exposures, and Claims” on page 236

- “The Incident Entity and Its Subtypes” on page 238
- “Incident-Only Claims” on page 241

Incident-Only Claims

In the base configuration, the **Loss Details** screen of the **New Claim** wizard provides an **Incident Only** radio button. Clicking this radio button sets a Boolean **IncidentReport** property on the **Claim** entity. Set this indicator to **true** if you expect that you will never have to make payments on a claim, for any reason.

IMPORTANT The **Claim.IncidentReport** property has nothing to do with the **Incident** entity. Setting this property does not create an incident. Rather, it marks a claim to indicate that there is no intention of ever making payments against it. You create or add an incident through the **Incident** screens that you access through the **Loss Details** screen of the claim. You can also add an incident when you add an exposure to a claim.

See also

- “Incident Overview” on page 236
- “Incidents, Exposures, and Claims” on page 236
- “The Incident Entity and Its Subtypes” on page 238
- “Creating Incidents” on page 239

Legal Matters

Most claims are settled without conflict. Some, however, cannot be settled without mediation, arbitration or lawsuits.

This topic includes:

- “Legal Matters Overview” on page 243
- “Working with Matters” on page 249

Legal Matters Overview

ClaimCenter provides tools that organize information for the following methods of conflict resolution:

- A formal legal process, involving hearings and lawsuits.
- Arbitration as a formal alternative to a legal process.
- Mediation, an informal alternative.
- Simple negotiations with no legal underpinning. ClaimCenter handles negotiations differently from legal matters. See “Negotiations” on page 45.

In these cases, you determine the possible extent of your legal liability by evaluating your possible and maximum settlement costs. You can either track and manage your legal costs in the **Budget Lines** screen or use the **Evaluations** screen. For more information on these screens, see:

- “Budget Lines Screen” on page 248
- “Evaluations” on page 45

The Matters feature enables you to:

- Create matters pages that support both informal mediation and formal legal process flows.
- Show information relevant just to new matters.
- Create pages for each matter in a claim, then manage multiple issues on each matter’s single page.
- Organize information as separate matters of different types—General, Lawsuit, Arbitration, Hearing, and Mediation.

- Manage your legal costs with a **Budget Lines** screen that tracks both budgeted and actual legal expenses.
- Show all matters on a legal calendar.
- Prevent deletion of a user who has an open matter.
- Use Access Control Lists to divide matters into different security classes and define security for each one.

Matters Screen

If you have defined one or more matters for a claim, you can open the claim and click **Litigation** in the sidebar to see the **Matters** screen. This screen shows some information about each matter. In this screen, you can select one or more matters and then **Assign** them to another user, **Close Matter**, add a **New Matter**, and see **My Calendar** for matters. See “Working with Matters” on page 249.

The information shown for each matter in the list view is:

- **Name** – The name of the matter. Click the name to open the details screen for the matter.
- **Case Number** – An identifying value assigned to the case. For example, the court might assign a case number for a litigation matter.
- **Final Settlement** – The total final cost of the settlement.
- **Trial Date** – The date the trial is scheduled, or the date it occurred.
- **Assigned To** – The user, such as a claims adjuster, that is tracking the matter for the claim.

Matters Details Screen

If you have defined one or more matters for a claim, you can open the claim to see the **Matters** details screen. Click **Litigation** in the sidebar, and then click the name of a listed matter.

The **Matter** details screen shows the following information:

- The name of the matter at the top.
- Sections that describe the details of the matter, such as **Matter**, **Litigation Details**, **Primary Counsel**, **Trial Details**, and **Resolution**. These sections vary by matter type, as described at “Matter Type Sections in the Matters Detail Screen” on page 245. Click **Edit** to change the information in these sections.
- A **Calendar** button, which displays the **Legal Calendar**. See “Activity Calendars” on page 228.
- A **Status Lines** list view where you enter matter status milestones, each of which has a **Start Date** and a **Completion Date**. Milestones include Matter Filed, Discovery Completed, Trial Begun, and other litigation status types listed in the **MatterStatus** typelist.
- A **Secondary Attorney** list view where you can add and delete contacts by using a contact picker. There is an **Attorney** contact subtype for this claim contact.
- A **Planned Activities** list view that shows all activities created by certain activity patterns, such as Arbitration Date, Hearing Date, and Legal Review.
- The **Latest Notes** relating to any matter on the claim. You see each note along with its type and name.

The following example shows a matter open for edit. This edit screen shows the elements of the General matter type.

Matter Type Sections in the Matters Detail Screen

The **Matters** detail screen displays different information that depends on the matter type selected. There are several types of matters specified in the **MatterType** typelist provided in the base configuration. Each matter type tracks different kinds of information. The following table lists the types of matters that are in the base configuration. Each section that shows in the **Matters** detail screen for a matter type is indicated by a dot. You can modify the matter types to include other information needed by your business model, and you can add new types. The General type includes all the sections except mediation details.

Matter Type	Matter	Litigation Details	Primary Counsel	Trial Details	Arbitration Details	Hearing Details	Mediation Details	Additional Details	Resolution
General	•	•	•	•	•	•		•	•
Lawsuit	•	•	•	•				•	•
Arbitration	•		•		•			•	•
Hearing	•		•			•		•	•
Mediation	•						•		•

The sections are described in the following topics:

- “Matter Section” on page 246
- “Litigation Details Section” on page 246
- “Primary Counsel Section” on page 246

- “Trial Details Section” on page 247
- “Arbitration Details Section” on page 247
- “Hearing Details Section” on page 247
- “Mediation Details Section” on page 248
- “Additional Details Section” on page 248
- “Resolution Section” on page 248

Matter Section

The **Matter** section contains the basic information needed by any matter type. All fields are optional except **Name**. The fields are as follows:

- **Name** – The name of the matter.
- **Case Number** – The assigned case number, if any.
- **Owner** and **Group** – Who the matter is assigned to and which claim group that user belongs to. These fields are set by ClaimCenter when you create the matter or when you reassign it.
- **Type** – Values in the base configuration can be <none>, **General**, **Lawsuit**, **Arbitration**, **Hearing**, or **Mediation**. Default is **General**.
- **Plaintiff and Defendant** – You can choose from a list, search for contacts, or enter new contacts manually. Use the picker  to search for or create a contact. Searching returns results only if a contact management system, like ContactManager, is integrated with ClaimCenter. See “ContactManager Integration” on page 519.
- **Related to Subrogation?** – Subrogation often involves legal action. This field helps classify the matter. See “Subrogation” on page 275.
- **Close Date** – ClaimCenter enters this date for you when you close the matter, and it removes the date if you reopen the matter.
- **Reason Reopened** – After you reopen a closed matter, this field shows a description of why you did so.

Litigation Details Section

The **Litigation Details** section contains information used by **General** and **Lawsuit** matter types:

- **Court Type** – In the base configuration, **Federal**, **State**, and **County** are the choices in the drop-down list, which come from the **MatterCourtType** typelist.
- **Court District** – In the base configuration, you can choose any state of the United States from the drop-down list. The choices come from the **MatterCourtDistrict** typelist.
- **Legal Speciality** – In the base configuration, values of the drop-down list can be **Personal injury**, **Motor vehicle liability**, **General liability**, and **Workers' compensation**, all from the **LegalSpeciality** typelist.
- **Primary Cause** – Primary cause of the legal suit, such as **Unreasonable Demand** or **Low settlement offer**. The choices in the drop-down list come from the **PrimaryCauseType** typelist.

Primary Counsel Section

The **Primary Counsel** section contains the following information used by all matter types except **Mediation**:

- **Plaintiff Attorney**
- **Plaintiff Law Firm**
- **Defense Attorney**
- **Defense Law Firm**

You enter these contacts either by selecting a contact from the list or by searching for or entering a new contact. Use the picker  by each entry to search for or create a contact. Searching returns results only if a contact management system, like ContactManager, is integrated with ClaimCenter. See “ContactManager Integration”

on page 519.

Additionally, there are two entries related to defense attorneys:

- **Defense Appointed Date** – The date a defending attorney was appointed. You can enter a date by clicking the calendar .
- **Sent To Defense Date** – The date the matter was sent to the defending law firm or attorney. You can enter a date by clicking the calendar .

Trial Details Section

The **Trial Details** section contains the following information used by **General** and **Lawsuit** matter types:

- **Trial Date** – The date that the trial is scheduled or already took place. You can enter a date by clicking the calendar .
- **Trial Venue** – Pick an existing venue or add a new one by clicking the contact picker icon. There is a **Legal Venue** contact subtype. Use the picker  to search for or create a venue. Searching returns results only if a contact management system, like ContactManager, is integrated with ClaimCenter. See “ContactManager Integration” on page 519.
- **Room** – Enter text identifying the room where the trial is to take place.
- **Judge** – Pick an existing judge or add a new one. There is an **Adjudicator** contact subtype. Use the picker  to search for or create a contact. Searching returns results only if a contact management system, like ContactManager, is integrated with ClaimCenter. See “ContactManager Integration” on page 519.

Arbitration Details Section

The **Arbitration Details** section contains information used by **General** and **Arbitration** matter types. This information is analogous to that for **Trial Details**:

- **Hearing Date** – The date on which the arbitration hearing is scheduled or took place. You can enter a date by clicking the calendar .
- **Arbitration Venue** – Pick an existing venue or add a new one. There is a **Legal Venue** contact subtype. Use the picker  to search for or create a venue. Searching returns results only if a contact management system, like ContactManager, is integrated with ClaimCenter. See “ContactManager Integration” on page 519.
- **Room** – Enter text identifying the room where the arbitration is to take place.
- **Arbitrator** – Pick an existing arbitrator or add a new one. There is an **Adjudicator** contact subtype. Use the picker  to search for or create a contact. Searching returns results only if a contact management system, like ContactManager, is integrated with ClaimCenter. See “ContactManager Integration” on page 519.

Hearing Details Section

The **Hearing Details** section contains information needed by **General** and **Hearing** matter types. This information is analogous to that for **Trial Details**:

- **Hearing Date** – The date on which the hearing is scheduled or took place. You can enter a date by clicking the calendar .
- **Hearing Venue** – Pick an existing venue or add a new one. There is a **Legal Venue** contact subtype. Use the picker  to search for or create a venue. Searching returns results only if a contact management system, like ContactManager, is integrated with ClaimCenter. See “ContactManager Integration” on page 519.
- **Hearing Room** – Enter text identifying the room where the hearing is to take place.
- **Hearing Judge** – Pick an existing judge or add a new one. There is an **Adjudicator** contact subtype. Use the picker  to search for or create a contact. Searching returns results only if a contact management system, like ContactManager, is integrated with ClaimCenter. See “ContactManager Integration” on page 519.

Mediation Details Section

The **Mediation Details** section contains information needed by the **Mediation** matter type. This information is analogous to that for **Trial Details**.

- **Mediation Date** – The date on which the mediation meeting is scheduled or took place. You can enter a date by clicking the calendar .
- **Mediation Venue** – Pick an existing venue or add a new one. There is a **Legal Venue** contact subtype. Use the picker  to search for or create a venue. Searching returns results only if a contact management system, like ContactManager, is integrated with ClaimCenter. See “ContactManager Integration” on page 519.
- **Room** – Enter text identifying the room where the mediation is to take place.
- **Mediator** – Pick an existing mediator or add a new one. There is an **Adjudicator** contact subtype. Use the picker  to search for or create a contact. Searching returns results only if a contact management system, like ContactManager, is integrated with ClaimCenter. See “ContactManager Integration” on page 519.

Additional Details Section

The **Additional Details** section contains information that can be required by all matter types except **Mediation**. All fields are optional:

- **Docket Number** – Enter text in the field.
- **Filing Date** – The date that the matter was filed. You can enter a date by clicking the calendar .
- **Filed By** – Pick an existing contact or add a new one. Use the picker  to search for or create a contact. Searching returns results only if a contact management system, like ContactManager, is integrated with ClaimCenter. See “ContactManager Integration” on page 519.
- **Service Date** – The date that legal documents are scheduled to be served or were served on the recipient. You can enter a date by clicking the calendar .
- **Method Served** – The method used to serve legal documents on the recipient. Values available in the base configuration are **Certified Mail** or **Sheriff**, which come from the **MatterMethodServed** typelist.
- **Response Due, Response Filed** – Enter these dates by using the calendar icon. You can enter a date by clicking the calendar .
- **Ad Damnum?** – Click **Yes** if there are any actual or anticipated costs so far. Click **No** if you know that none will be coming.
- **Punitive Damages?** – Click **Yes** if punitive damages are being claimed. Click **No** if you know that none will be claimed.

Resolution Section

The **Resolution** section, shown in all matter types, tracks:

- **Resolution** – The outcome of the matter, such as **Summary judgment**, **Verdict for the plaintiff**, or **Dismissed**. The values in this drop-down list come from the **ResolutionType** typelist.
- **Final Legal Cost, Final Settlement Cost** – You must enter these costs directly.
- **Final Settlement Date** – The date on which the settlement became final. You can enter a date by clicking the calendar .

Budget Lines Screen

Legal costs can be considerable, and knowing what they are, or could become, can be critical in deciding if and how to pursue legal action. ClaimCenter provides a **Budget Lines** screen to estimate legal costs and track payments made on them. This screen tracks all reserve lines that have the cost category of Legal.

In the base configuration, the **Budget Lines** screen is not visible. For information on making this screen visible and using it, see “Organizing Financial Legal Information” on page 250.

ClaimCenter defines a number of line item categories and associates these categories with matter types. For example, there are **Deposition** and **File Review** line items for all matter types, but the **Hearing** line item is available only for General, Hearing and Lawsuit matter types. See the **LineCategory** typelist for the complete list. After you create exposures, ensure that you use the cost category of Legal, so that these line item categories are available.

Payments and Matters

ClaimCenter not only enables you to estimate and track legal payments, but also creates checks for legal matters that include the matter type and the line category. Both check wizards require that you enter a line item category when making a payment on a reserve line with a legal cost category. The printed check also reflects this information.

Working with Matters

You can use the matters screens of ClaimCenter both to track legal related financial costs and to organize people, venues, and dates.

Organizing Legal Information into Matters

To open or create a matter

In a claim, clicking **Litigation** in the sidebar opens a list view showing all matters pertaining to that claim.

1. Open a claim and click the **Litigation** menu item.
2. Click a matter name in the table to open it.

You can create matters by opening a claim and using the **Actions** menu or by clicking the **New Matter** button on the **Matters** screen, as follows:

- Open a claim and click **Actions** → **New** → **Matter**.
- Open a claim and click **Litigation** to open the **Matters** screen, and then click **New Matter**.

You can assign each new matter you create by specifying the **Owner** as you create it. By default, a new matter is assigned automatically. After creating the matter, you can also click the **Assign** button to assign it.

To close or reopen a matter

Click **Close** to close a matter. You are prompted to choose a **Resolution** from that drop-down list, which gets its values from the **ResolutionType** typelist. You can optionally enter a note describing the reason for closing the matter.

You can use the **Reopen** button to reopen a closed matter. You are prompted to choose a **Reason** from that drop-down list, which gets its value from the **MatterReopenedReason** typelist. Additionally, you can enter an optional note describing the reason for reopening the matter. Reopening a matter removes its **Close Date** from the **Matter** section and fills in the **Reason Reopened** item chosen from the **Reason** drop-down list.

To use a matter type

You select a matter type by clicking the **Type** field in the **Matter** section of a matter. If the matter begins as a negotiation, and then becomes a lawsuit, and is finally settled by a binding arbitration, you can track these changes in several ways:

- Open and close in turn a Negotiation, then a Lawsuit, and finally an Arbitration matter type.
- Open a single **Matter** and edit its **Type** as the matter progresses.
- Open a **General** matter, which contains all panes in all matter types, and use it until there is a resolution.

Organizing Financial Legal Information

The **Budget Lines** screen has a list view that shows the following for each line item category of reserve lines that has a legal cost type:

- The estimated cost for each line item of that reserve line
- The sum of all payments made on that reserve line

To display the Budget Line screen

With administrative privileges, you can set the `UtilizeMatterBudget` script parameter. Navigate to **Administration** tab → **Utilities** → **Script Parameters** to change the value of this script parameter.

After setting the `UtilizeMatterBudget` script parameter to `true`, each time you open a matter, you see a **Budget Lines** card. Click this card to open the **Budget Lines** screen.

To add, modify, or delete a line in the Budget Lines screen

The Budget Lines list view is initially empty. After you click **Edit**, you can:

- Click **Add**, and then choose a **Type** to add a line with the line item category you have chosen. Budget line types include Court Costs, Deposition, Hearing, and Investigation. These values are typecodes in the `LineCategory` typelist and have the `legal` cost category and the `mattertype` category list.
- Enter **Estimated Expenses** on the line you add, or change **Estimated Expenses** on the other lines while in edit mode. An estimated expense is independent of the reserve amount of that reserve line.
- Delete a line from the table by selecting the check box for the line and clicking the **Delete** button.

You cannot edit the actual payments made. ClaimCenter adds this information when you write a check that includes a payment with the line item category that matches the category of a line in this table.

To make payments connected to a matter

After you write a check, both check wizards detect payments made on reserve lines with the `legal` cost category. You must enter the category—the line item. You enter the line item category on page two of the **Check** wizard and on page one of the **Quick Check** wizard. ClaimCenter updates the **Total Payments** column of the **Budget Lines** list view when the check status becomes submitting or notifying.

Notes

One of an adjuster's tasks is adding notes that track the progress of a claim and associate detailed information with the claim. Notes enable you to keep a detailed record of all of the information, actions, and considerations related to the processing of each claim. Notes cannot exist independently, but are always associated with a specific claim or one of the claim's parts.

Use the Notes feature to:

- Create a note in most claim related screens, including all claim, exposure, financial, and matter screens, as well as all **New Claim** wizard screens.
- Create general notes without a note template.
- Create notes with a note template for specific note types.
- Attach a note to a single claim or to one of its exposures, activities, matters, or claim contacts.
- Make a note confidential and give it additional security with ACLs.
- Edit and delete notes, if you have the proper permission.
- Search for notes with a wide variety of filters.
- Link external documents to a note.
- Create a note while performing an activity.
- Create a note with rules or in workflows.
- Create new note templates.

This topic includes:

- “Differences Between Notes and Documents” on page 252
- “Working with Notes” on page 252
- “Notes Security” on page 255
- “Configuring Notes and Note Templates” on page 255

Differences Between Notes and Documents

Notes and documents have distinct functions in ClaimCenter, and the application handles them differently. The following table highlights the main differences. See also “Document Management” on page 525.

Characteristics of Notes	Characteristics of Documents
Written in plain text.	Can have many different MIME types, such as PDF, Word, or Excel.
Created by a user or through Gosu.	Created by a user, or through Gosu, or in an external document management system.
Stored only in the ClaimCenter database.	Stored either in the ClaimCenter database or in a document management system.
Related to one claim or claim entity.	Can be related to one claim, linked to many others, and attached to notes.

Working with Notes

The primary screens and worksheets related to notes are:

- **Notes** – This screen has a search area in its upper part with fields that enable you to search by text, author, topic, and date range. You can also search by related exposure, activity, matter, or claim contact. The main screen shows the results of the last search in its lower section.
To reach this main **Notes** screen, you can click **Notes** in the sidebar if you have either a claim or the **New Claim** wizard open.
- **New Note** – This worksheet is where you create notes. You can optionally use a template. You can also search for note templates. To access this worksheet, click **Actions** → **New** → **Note**.
- **Activity Detail** – This worksheet is where you create notes that are related to an activity. For example, you can navigate to **Desktop** tab → **Activities**. If you then click the **Subject** of an activity assigned to you, **Activity Detail** worksheet of that activity opens below the list of activities. The worksheet has a **New Note** section.
- **Summary** – This screen, opened by clicking **Summary** in the sidebar, has a **Latest Notes** section that displays notes related to the claim.
- **Matters Details** – This screen, opened by clicking **Litigation** in the sidebar and then clicking a matter **Name** field, has a **Latest Notes** section that displays notes related to the matter.

This topic includes:

- “Searching for Notes” on page 252
- “Viewing Notes” on page 253
- “Viewing Notes Related to an Activity or Matter” on page 253
- “Editing or Deleting a Note” on page 253
- “Printing a Note” on page 254
- “Creating a Note” on page 254
- “Creating a Note from a Note Template” on page 254
- “Creating a Note in an Activity” on page 254
- “Linking a Document to a Note” on page 254

Searching for Notes

To search for notes, open a claim and click **Notes** in the sidebar to open the **Notes** screens. Use the search section at the top of the **Notes** screen to search for notes. The only required field is **Related To**, which in the base configuration defaults to **Claim**. You can use the following filters and search fields:

- **Find Text** – Search for a word or text string in the subject or body of the note.

- **Author** – The user who wrote the note. ClaimCenter attaches the name of the user to a note when it is created. You cannot change the author of a note.
- **Related To** – A note created in an exposure, activity, or matter is related to that entity. This required filter finds notes related to the claim or to a specific exposure, activity, matter, or claim contact. A note can be related to just one entity.
- **Topic** – A typecode that classifies the note, which you choose from a drop-down list. This list is populated from the NoteTopicType typelist, which has typecodes with names like First notice of loss, Coverage, and Medical issues, Litigation, Denial, and General.
- **Date Range** – Search for a preselected time period, such as Today or Last 7 Days, or enter a range of dates.
- **Sort By** – Sort the results by author, date, exposure, subject, or topic in either ascending or descending order. These values are typecodes from the SortByRange typelist. In the base configuration, the default sort is by date in descending order.

Note: In the base configuration, you cannot search for the Note fields SecurityType or Confidential.

Viewing Notes

Use the **Notes** screen to see the most recent notes, up to 25, and use the upper search section of the screen to find notes. If the note appears in a list, click it to see it. The most recent notes related to an exposure, a matter, or an activity are also visible on the claim **Summary**, **Matter**, and **Activity** screens.

To view the details of a note, click **Edit**. All the note's attributes display in the **Edit Note** screen.

You can configure the **Notes** screen to show more than the default information available in the base configuration. See “Configuring Notes and Note Templates” on page 255.

Viewing Notes Related to an Activity or Matter

A note created in an **Activity** worksheet or in the **Notes** editor for an existing matter is linked to that activity or matter. You can view these notes as follows:

- Clicking **View Notes** on the **Activity Detail** screen opens a search screen similar to the **Search** pane on the **Notes** screen that can find notes linked to that activity.
- If you click **Litigation** and open the detail view of a **Matter**, you can see notes for that matter in the **Related Notes** section.

Editing or Deleting a Note

If you have the appropriate permissions, you can click **Edit** and **Delete** for each note.

To edit a note

1. Click **Edit** to start editing. You must have the **noteedit** permission to edit a note's attributes, in addition to needing the **noteeditbody** permission to edit the note's text.
2. Click **Update** to save.

To delete a note

Click **Delete** to delete a note. The note is deleted immediately, so be sure you want to delete it before clicking **Delete**. You must have the **notedelete** permission to be able to delete a note.

See “Permissions Related to Notes” on page 255.

Printing a Note

You can print a note from the **Notes** screen's list of notes. Click **Print** for any note you see in the list. The note is converted to a PDF file. You can view the PDF file in Acrobat Reader and print from that application, or you can save the file.

Note: To print a note, you must have permission to view it.

Creating a Note

1. Choose **Actions** → **New...** **Note** to open a **Note** worksheet
2. Choose values for the required attribute fields—**Topic**, **Related To**, and **Confidential**—and optionally fill in the **Subject** and **Security Type** attributes. The **Security Type** field specifies the access control list (ACL) for the note.
3. Enter the note text. Notes must always contain some text.
4. Click **Update** after you are finished with your note.

Creating a Note from a Note Template

You can use a template to create a note. Before using a template, you must first find one.

1. Choose **Actions** → **New** → **Note**.
2. In the **Note** worksheet, click **Use Template**.
3. In the **Find Note Template** screen, optionally select template attributes to limit the search, and then click **Search**. The search returns a list of templates matching your search criteria, or all templates if you enter no criteria.
4. Click **Select** to choose the template to use for creating the note.
After you select a template, the template's attributes and text populate the **Note** worksheet.
5. Change any information added by the template and edit other fields and body text as needed.
6. Click **Update** when you are finished.

Creating a Note in an Activity

You can create notes while working on activities by using either of the following techniques:

- To create a note associated with the activity, use the **New Note** section in the **Activity Details** worksheet.
- To create a note not associated with the activity, navigate to **Actions** → **New** → **Note** and create the note in the **Note** worksheet. See “Creating a Note” on page 254.

See also

- “Viewing Activities” on page 223

Linking a Document to a Note

While creating or editing a note, you can click **Link Document** to embed a link to a document in the body of the note at the cursor position. While in edit mode, a document link has a particular format containing the ID of the document, such as `$ccDocLink(1)`. After you save the note, when you view the note, this link is rendered as a readable link, the name of the file. Clicking this link displays the document in a new window.

Note: You can link only to documents that already exist in your document management system.

Notes Security

ClaimCenter provides a set of system permissions to provide security for all notes, listed in “Permissions Related to Notes” on page 255. Use these permissions to define different security types for notes and assign permissions to users that relate to these ACLs. See “Access Control for Documents and Notes” on page 456.

Select the ACL to which you want the note to belong by specifying its **Security Type** when you create the note.

Permissions Related to Notes

The following system permissions provide security for notes.

Permission	Code	Description
Create notes	notecreate	Permission to add notes
Create notes on closed claims	notecreateclsd	Permission to add notes on closed claims
Delete medical note	delmednote	Permission to delete a medical note
Delete notes	notedelete	Permission to remove notes
Delete private note	delprivnote	Permission to delete a private note
Delete sensitive note	delsensnote	Permission to delete a sensitive note
Edit medical note	editmednote	Permission to edit a medical note
Edit note	noteedit	Permission to edit any part of a note
Edit note body	noteeditbody	Permission to edit the body of notes
Edit private note	editprivnote	Permission to edit a private note
Edit sensitive note	editsensnote	Permission to edit a sensitive note
View claim Notes page	viewclaimnotes	Permission to view the Notes page of a claim or matter
View confidential notes	noteviewconf	Permission to view confidential notes
View medical note	viewmednote	Permission to view medical notes
View notes	noteview	Permission to view notes
View private note	viewprivnote	Permission to view private notes
View sensitive note	viewsensnote	Permission to view sensitive notes

Confidential Notes

After you create a note, you can mark it *confidential*. A confidential note that you create is visible only to:

- You, the creator of the note.
- The chain of supervisors in the claim’s assigned group.
- Anyone with `noteviewconf` permission, which enables viewing of confidential notes.

All users have the permission to set the **Confidential** field of notes they write. You can find, edit, and delete confidential notes that you write. However, the `noteviewconf` permission is required to view and edit a confidential note that you did not write, unless you are in that claim’s assigned group’s supervisory hierarchy. ACLs are independent of this field.

Configuring Notes and Note Templates

The Notes feature requires little configuration. The file `config.xml` supports the following configuration parameters:

- **MaxNoteSearchResults** – The maximum number of note search results to display before showing a warning in the user interface. The default in the base configuration is 25. If the limit is exceeded, the user sees a warning and no search results.
- **CreateNoteWithArchiveUpgradeIssues** – Indicates if a note will be created for a restored claim that required upgrading, but the upgrade encountered problems. The default value of this parameter is **true**. If a claim was archived in a previous release of ClaimCenter and then ClaimCenter was upgraded and the claim is restored, the claim must be upgraded during the restore. If there were problems with the upgrade that did not prevent the restore from succeeding, they are recorded in a note that is attached to the restored claim. Setting this parameter to **false** prevents the note from being created.

You cannot add and delete search filters in the `search-config.xml` file, as you can for other types of searches.

Note Plugin Interfaces

There are two plugin interfaces associated with notes. They do not affect the primary use of notes, which are stored in the database and do not require an external system similar to a document management system. They are related to note templates, which can be a customized method of creating notes. The plugin interfaces are:

- **INoteTemplateSource** – Retrieves note templates—`INoteTemplateDescriptor` objects—that are used to help create notes. The default implementation is `gw.plugin.note.impl.LocalNoteTemplateSource`. This Gosu class retrieves templates from the server file system, but can also be customized to get them from a document management system.
- **INoteTemplateSerializer** – Customizes reading and writing of `INoteTemplateDescriptor` objects.

Note Fields

Notes and note templates have a set of fields, also called properties. ClaimCenter uses these fields to attach the notes to various claim entities and to search for notes and note templates.

For information on note template fields, see “Creating a Note Template” on page 257

The following table describes the fields of a Note that are visible in ClaimCenter screens:

Attribute Name	Definition of Attribute	How Set	Search for Note?	Editable?
Author	Logged-in user who wrote the note	By ClaimCenter	yes	no
Body	Contents, the text of the note	By author in editor	yes - any string	yes
AuthoringDate	Date the note was originally written	By ClaimCenter	yes - and by range	no
NoteRelatedTo	Must exist and be unique	By author in editor	yes	yes
Confidential	Boolean value in note	By author in editor	no	yes
SecurityType	Value from the NoteSecurityType typelist	By author in editor	no	yes
Topic	Value from the NoteTopicType typelist	By author in editor or by template	yes	yes
Subject	Defined in the template and given to its notes	By author in editor or by template	no	yes

The author, body, date, related to, confidential, and security type are fields unique to notes and are not a part of note templates.

The following fields are used in note templates. The first two are applied by the note template to a note created from it:

Field Name	Definition of Field	Search for Template?	Search for Note?	Editable in Note?
Subject	The subject of the template and of notes created from it.	no	no	yes
Topic	The topic of the template and of notes created from it. A typecode of the NoteTopicType typelist.	yes	yes	yes
Type	A typecode of the NoteType typelist, such as diagram, action plan, or status report. You can add others.	yes	no	no

Creating a Note Template

A note template is a pair of Gosu files, a .gosu file and a .gosu.descriptor file. To access the files, open Guidewire Studio and navigate in the Project window to **configuration** → **config** → **resources** → **notetemplates**.

The easiest way to create a new template is to modify copies of two existing files for one of these templates. Then save the two files with new, matching names in the same location as the other note template files.

Note Template Files

A note template consists of two separate files:

- A descriptor file with a name ending in .gosu.descriptor. The file contains metadata about the template. For example, ActionPlan.gosu.descriptor.
- A template file with a name ending in .gosu. This file contains the text for the body of the note. For example, ActionPlan.gosu.

In the base configuration, a note descriptor file has the following fields:

Field	Description
name	A String value that is a unique, readable name for the template. Can be used in template search.
type	A String value that is the type of the note, a string that matches a typecode from the NoteType typelist. Can be used in template search. Base configuration values include actionplan, diagram, interviewreport, reviewactivity, and statusreport.
lob	The loss type that the note is associated with, a String value that matches a typecode from the LossType typelist. For example, AUTO, GL, PR, TRAV, or WC. Can be used in template search.
keywords	A String value, a comma-separated list of keywords that can be used to search for the template.
topic	The topic of the note, a String value that matches a typecode from the NoteTopicType typelist. For example, general, fno1, medical, salvage, or settlement. Can be used in template search.
subject	The subject of the notes created with this template, a String value.
body	A String value that is the name of the Gosu file containing the body of the note. Be sure to include the .gosu extension.

Note Template Example

The sample file ActionPlan.gosu.descriptor defines an Action Plan descriptor file:

```
<?xml version="1.0" encoding="UTF-8"?>
<serialization>
  <notetemplate-descriptor
    name="Action Plan"
    type="actionplan"
    lob="gl"
    keywords="claim"
    topic="evaluation"
    subject="Case Action Plan"
    body="ActionPlan.gosu"
  />
</serialization>
```

The ActionPlan.gosu.descriptor file pairs with the template file ActionPlan.gosu, which contains:

Claim Number: <%= claim.ClaimNumber %>

Case Strategy:

Brief statement (a few words or a sentence at most) about the direction of the case at this particular time.

Examples might be "Investigate", "Settle", "Deny" or "Defend"

Current Status/Liability Assessment:

Brief statement on where the case stands. What's been established so far.

Example might be "Liability probable, damages unknown" or "Liability questionable, soft tissue injuries alleged".

This is not a recap of the entire file.

Target Investigation ACES:

What area of the claim do we need to focus on to bring it to conclusion?

Examples might be "Obtain damages" or "Investigate liability, obtain damages".

This section is intended to be a brief statement on the direction or target of the planned future claim activity.

Action Items:

This is a list of specific items or tasks that need to be completed in order to address the "Target Investigation ACES" above.

This is a "to do" list which gets us to the targeted issues.

Each item should have its own due date based on reasonable time needed to complete that task.

Due dates should be proactive, but realistic.

Avoid batching items such as "Complete liability investigation".

Instead show the actual items you need to complete and when they are to be completed.

Is LCE/ECE adequate?

Should reserves be updated in view of any newly developed information?

Holidays and Business Weeks

Holidays, weekends, and business weeks define the ClaimCenter business calendar. Holidays can vary according to zone, such as country. For example, some countries might have an accepted practice of working half the day on Saturdays. You can also, for example, define a zone to be a state or ZIP code in the United States. Business weeks and business hours can vary by zone. A large international company might need to track differing business days and holidays of multiple locations to ensure that work is handled in a timely manner. The ClaimCenter business calendar calculates these dates and ensures the correct usage of holidays, weekends, and business weeks.

Some examples

- Activities usually reach their due dates and escalation dates after a defined number of business days. The activity patterns calculate the number of business days by using the holidays of the area in which the activity is performed.
- A regulatory agency specifies the maximum number of business days to perform an activity. The corresponding activity can use the holiday schedule of that agency's area to calculate the due date.
- Auto-assignment of an activity by location can determine who is assigned the activity. It can also consider how much time can be allocated for the activity based on the business calendar, or holiday schedule, of the claim's region.
- Recurring checks use business days to schedule checks. Checks need to arrive on time, and the mail is affected by the holiday schedules of all countries the mail passes through. Determining how long it normally takes for international mail to arrive must take into account the mail holidays of all these countries.

This topic includes:

- “Specifying Holiday Dates” on page 260
- “Working with Holidays, Weekends, and Business Weeks” on page 260
- “Using Gosu Methods to Work with Holidays” on page 261
- “Business Weeks and Business Hours” on page 261
- “Holiday Permissions” on page 264
- “Business Week Permissions” on page 264

Specifying Holiday Dates

In the base configuration, ClaimCenter determines weekends and work days by using configuration parameters in the `config.xml` file. However, you specify holidays through the user interface. Using the user interface gives you more flexibility in defining holidays, and you can make changes without having to restart the server.

To specify the holidays observed by your business, navigate in ClaimCenter to the **Administration tab → Business Settings → Holidays** screen. ClaimCenter stores all holidays you define in this screen in the database. All holidays are editable. With administrator privileges, you specify:

- **Name** – There is no limit on the holidays or on the names you give them. Each holiday is one day, so you must enter all the actual days if a holiday results in multiple days off. For example, you must specify two holidays for Thanksgiving in the United States if the company gives employees Thursday and Friday off.
- **Date** – The dates of some holidays vary each year, so this screen enables annual updates.
- **Applies to All Zones** – Determines who observes the holiday. You can further select the type of zone, such as state, county, or city in the United States if the holiday does not apply to all zones.
- **Types** – Provides one way to categorize holidays. You can also define other types.

Default values in the base configuration, defined in the `HolidayTagCode` typelist, include **General**, **Federal Holidays**, and **Company Holidays**.

Holiday Types

You can give holidays different classifications, or categories, which their **Type** field captures. For example, after deciding when to mail a letter, a rule can consider excluding only holidays when mail is not delivered. The **Federal Holidays** type, which refers to federal holidays, describes this subset. If you are sending mail to another country, you can have another type to describe days when mail is not delivered in that country as well. You can write Gosu code that checks a mail address. If going to another country, the code could consider both types of holidays to determine the correct number of business days to allow for mail delivery.

As another example, if your company grants a holiday to all employees on the birthday of the company founder, you can create a **Birthday** holiday type. This rule avoids scheduling due dates on that date.

Holiday Zones

You can configure zones to apply to any area. In the United States, for example, you can define zone type by jurisdiction, city, county, and ZIP code. To correctly add Martin Luther King Day as a holiday, you must include every state where it is observed.

ClaimCenter provides zone data for the United States and Canada in the base configuration. You can configure ClaimCenter to have other zones.

Working with Holidays, Weekends, and Business Weeks

This topic describes how to work with holidays in the user interface.

To add a holiday

1. Log in to the application as a user with administrator privileges, and then navigate to **Administration tab → Business Settings → Holidays**.
2. Click **Add Holiday** in the **Holidays** screen to create a new holiday. Enter the holiday name, date, and type into the screen.

If you choose **No** for **Applies to All Zones**, you can further refine your choices of the zones that apply by specifying **Zone Type** and **Zones**.

To edit a holiday

1. To edit a holiday, including its **Date**, **Type**, and **Zone**, click it on the **Holidays** screen, and click **Edit**.
2. Make your edits and click **Update** to save.

You can assign both **Type** and **Zone** to any choices that already exist, but you cannot create new choices for **Type** or **Zone** in this screen.

Note: You might need to change the **Date** of some holidays annually.

To delete a holiday

You can delete any holiday on the **Holidays** screen. Select its check box and click **Delete**.

See “Managing Holidays” on page 481 for more information about adding, editing, and deleting regional holidays.

To create a new zone or type

In Guidewire Studio, navigate to the typelist that you want to modify.

- **Zone Type** – Defined by the **ZoneType** typelist, includes the typecodes **city**, **county**, **state**, **province**, **postalcode**, and **fsa**. You can add other types to this typelist.
- **State** – Defines the states of the United States, Australia, and Germany, provinces of Canada, and prefectures of Japan that are in the **State** typelist.
- **Type** – Defined by the **HolidayTagCode** typelist. You can add other types to this typelist.

The **HolidayTagCode** typelist includes the typecodes **General**, **FederalHolidays**, and **CompanyHolidays**.

Using Gosu Methods to Work with Holidays

You can write Gosu code to set business days differently for various tasks. For example:

- A regulatory requirement mandates that a task be completed within a defined number of business days. Your code can take into account the holiday schedule of an agency in a certain jurisdiction.
- After auto-assigning a task to be completed in a certain number of business days, Gosu code can take into account the holiday schedule of the assignee.
- Gosu code can check General holiday types in all zones through which the mail passes to determine the correct number of days to allow for mail to be delivered. Use this code for determining when to send time-sensitive mail.

Use Gosu methods that use **Holiday Type** and **Zone** to determine the correct number of business days.

Gosu Holiday Methods that Use Zones and Types

The methods **getConfiguredHolidays**, **addBusinessDays**, and **businessDaysBetween** on the **Date** entity get lists of holidays, add business days to dates, or compute business days between dates. Depending on the parameters, these methods can take into consideration holiday types or zones. You can find these methods in **gw.util.GWBaseDateEnhancement**, and you call them by using a **Date** object.

See also

- “Gosu Methods for Business Hours” on page 263

Business Weeks and Business Hours

ClaimCenter can accommodate your business schedule by specifying your exact work week and hours. For example, the normal business hours of a carrier begin on Monday and end on Saturday. For this carrier, you configure ClaimCenter to have the hours from Monday to Friday begin at 8 a.m and end at 7 p.m. For Saturday, you configure the business hours to begin at 10 a.m and end at 2 p.m.

The `config.xml` file contains business calendar parameters. ClaimCenter applies these parameters system-wide. These parameters are the default values. For a complete list, see “Business Calendar Parameters” on page 39 in the *Configuration Guide*.

The business calendar parameters enable you to specify:

- For each day of the week, whether it is a business day. For example, to make Monday a business day, set `IsMondayBusinessDay` to `true`.
- The time that each business day starts and ends. Set `BusinessDayStart` and `BusinessDayEnd`.
- The day that is the end of the business week. Set `BusinessWeekEnd`.
- The time that marks the start of a new business day. Set `BusinessDayDemarcation`.

You can configure business weeks at a more granular level and in one place on the **Administration tab → Business Settings → Business Week** screen. The values you set in this screen override the configuration parameters in `config.xml`. See “Working with Business Weeks” on page 263.

A result of setting the business week on the **Business Week** screen, thereby overriding the configuration parameters, is that you can define business weeks based on zones. For example, your main claim office is based in California and is open Monday through Friday 8:00 a.m. to 5:00 p.m. However, the customer service center in Arizona is open until 9:00 p.m. on weeknights and on Saturdays from 8:00 a.m. to 3:00 p.m. You can define by zone how business weeks and hours are defined.

See also

- “Business Calendar Parameters” on page 39 in the *Configuration Guide*

Business Week Implementation

`BusinessWeek.eti` defines the table schema for the `BusinessWeek` entity. This entity stores data identifying the days of the week that are business days and what the business days’ business hours are. You can also specify the zones to which a business week applies or specify that it applies to all zones. You accomplish these tasks in the **Business Weeks** screen by navigating to **Administration tab → Business Settings → Business Week**. See “Working with Business Weeks” on page 263.

There are `config.xml` parameters that ClaimCenter uses when no `BusinessWeek` entity exists in the database. If at least one `BusinessWeek` is active in the database, ClaimCenter uses the `BusinessWeek` that best matches the relevant zone. The relevant zone can be explicitly passed in as a parameter or inferred from a passed-in address.

For example, the `BusinessWeek` entity has the following behavior:

- If at least one `BusinessWeek` is active in the database, ClaimCenter uses the `BusinessWeek` that best matches the relevant Zone. You can explicitly pass in the relevant Zone as a parameter, or ClaimCenter can infer it from a passed-in address.
- If only one `BusinessWeek` is in the database and its `AppliesToAllZones` field is `true`, all business calendar calculations use this defined business week. The `config.xml` parameters are ignored.
- If the database contains a business week that is linked to the zone Arizona and a business calendar calculation specifies the same zone, then this Business Week is used.
- If the database contains two Business Weeks, matching is first attempted on zones of deeper granularity of `ZoneType`. For example, the first Business Week has the California zone and the second has the San Francisco zone. Additionally, a business calendar calculation specifies an Address with

State="California" and City="San Francisco". In this case, the San Francisco BusinessWeek is used. In this example, City is a more granular ZoneType than State.

IMPORTANT If a BusinessWeek entity does not exist in the database, ClaimCenter uses the business week parameters defined in config.xml.

Business Day Demarcation

The BusinessDayDemarcation field on BusinessWeek is a time value, such as 5:00 p.m., that is helpful when a time falls between the business hours of two days.

For example, your business days start at 8:00 a.m. and end at 5:00 p.m., and a claim is called in at 6:00 p.m. ClaimCenter uses BusinessDayDemarcation to determine whether that claim is considered part of the previous business day or the following business day. You can define the demarcation as described in the topic “Working with Business Weeks” on page 263.

Note: BusinessDayDemarcation cannot be set to a time that is within your defined business hours.

Working with Business Weeks

To define business weeks in ClaimCenter, perform the following steps.

1. Navigate to Administration tab → Business Settings → Business Week.
2. Click Add Business Week. The New Business Week screen opens.
3. Enter a business week name and indicate if it applies to all zones. If you select No, you must define the zones to which this business week applies.
4. You must define the day that ends your business week and the business day demarcation. Also define for each day of the week if it is a business day and, if so, the hours in that day.
5. Click Update to save your work.

Business Hours

Business hours are defined in the BusinessDayStart and BusinessDayEnd configuration parameters. These times are based on the server clock. ClaimCenter provides Gosu methods that calculate elapsed hours by using these defined business hours. However, these defined hours do not deal with holidays accurately.

Specifying holidays affects only dates, not hours. However, you can write Gosu code for a task usually accomplished in hours rather than in days by using Gosu business hour methods. These methods take holidays into consideration after calculating business hours. They are completely separate from business day methods.

For example, a carrier promises to respond to all inquiries and claims within two hours after receiving an inquiry. You call the carrier on Friday at 4:30 p.m., and Monday is a holiday. The carrier must respond by Tuesday, one and a half hours after the business day starts.

Gosu Methods for Business Hours

The methods addBusinessHours and businessHoursBetween on the Date entity add business hours to dates or compute business hours between specific dates. Depending on the parameters, these methods can take into consideration holiday types or zones. The methods also use the settings for business hours, days, and weeks in the config.xml file.

The methods are defined in gw.util.GWBaseDateEnhancement, and you call them by using a Date object.

Notes

While certain methods might appear to be similar, they can have different results. For example,

- The method `addBusinessDays` works differently from `addBusinessHours`. For example, in the base configuration, a business day runs from 8:00 a.m. to 5:00 p.m. Adding one business day to Sunday 12:00 a.m. results in Monday 12:00 a.m. However, adding nine business hours to Sunday 12:00 a.m. results in Tuesday 8:00 a.m. In the base configuration, for calculation purposes, a business day includes the times 8:00 a.m. through 4:59 p.m. Therefore, adding 9 hours to a weekend day goes past the next business day, Monday, to 8:00 a.m. the following day, Tuesday.
- The method `businessDaysBetween` works differently from `businessHoursBetween`. If the business day is between 8:00 a.m. and 5:00 p.m., calling `businessDaysBetween` for Sunday 12:00 a.m. and Monday 12:00 a.m. returns a value of 1. Calling `businessHoursBetween` for Sunday 12:00 a.m. and Monday 12:00 a.m. returns 0.

Holiday Permissions

The following system permissions control whether you can view the **Holidays** screen and edit the holidays:

- `holidayview`
- `holidaymanage`

In the base configuration, the Superuser role has these permissions.

Business Week Permissions

The following system permissions control whether you can view and edit the **Business Week** screen:

- `buswkview`
- `buswkmanage`

In the base configuration, the Superuser role has these permissions.

Vacation Status

ClaimCenter assigns work to users, such as work on claims, exposures, or activities, either through assignment rules, such as by round robin, or by manual assignment. Vacations and other time off must be taken into account in assigning and reassigning work. If you are unable to work on claims because you are not in the office, ClaimCenter can redistribute your work load through the vacation status feature. You can change your vacation status and designate a backup user in your absence.

Vacation status can affect both current and new work assignments. These statuses are available in the **Vacation Status** worksheet, as described in “Setting Your Vacation Status” on page 266. They are defined in the **VacationStatusType** typelist, which in the base configuration provides typecodes supporting the following statuses:

- **At work** – You receive new assignments. This setting is the default value.
- **On vacation** – You continue to receive new work, but current work assignments go to your designated backup. Your backup must check the **Vacation** tab to see these assignments.
- **On vacation (inactive)** – This status is identical to **On Vacation** with one exception: You are not assigned new work by an assignment rule that considers multiple assignees. For example, the `assignToCreator` method assigns work, but the `assignUserByRoundRobin` method does not.

These rules apply to claims, exposures, and activities of the person who is on vacation.

If you have administrative permissions, you can change vacation status and backup users through the **Administration** tab.

Additionally, a user who has the group’s load factor permission **View** can see load factors, vacation statuses, and backup users for all team members in the **Load and Vacation** screen. Navigate to **Desktop** → **Actions** → **Load and Vacation**. A user who has the load factor permission **Admin** for the group can also edit this screen and change load factor, vacation status, and backup user for any team member. For information on setting these two permissions, see the discussion of the **Load and Vacation** screen at “Team Management Overview” on page 403.

This topic includes:

- “Setting Your Vacation Status” on page 266
- “Accessing the Vacation Tab as a Backup User” on page 266
- “Backup Users and Permissions” on page 266

- “Backup Users and Activities” on page 267

Setting Your Vacation Status

Use the following steps to change your status.

1. Navigate to Desktop tab → Actions → Vacation Status.
2. On the **Vacation Status** worksheet, select the status **At work**, **On vacation**, or **On vacation (Inactive)** from the **Vacation Status** drop-down list.
3. To select a backup user to do your work while you are on vacation, use the **Backup User** drop-down list or select a user by using the picker  drop-down menu. If possible, choose a user with the same permissions, from the same security zone, and with the same authority limits as you.
 - The **Backup User** drop-down list shows users in your group.
 - The picker enables you to:
 - Search for a User – Useful if you know someone in another group who can fill in for you.
 - Select User – Shows a hierarchical list of all the groups in your organization.
4. When you return from vacation, navigate to the **Vacation Status** worksheet and select **At work** from the **Vacation Status** drop down menu.

Accessing the Vacation Tab as a Backup User

To view work assigned to you as a backup by another user currently on vacation, click the **Vacation** tab. This tab is not available if there is no work for you. This tab is where you select any activities, claims, or exposures assigned to you to work on as a backup for another user who is on vacation.

Backup Users and Permissions

Generally, the Backup User feature works best if the backup user is in the same office and has the same level of responsibility as the person going on vacation.

System permissions are not inherited by the backup user from the user who is on vacation. Therefore, ideally, the backup user would have the same set of permissions as the person on vacation so the backup user can assume the same level of responsibility. For example, if the user on vacation can work on sensitive claims, but the backup user does not have those permissions, the backup user cannot work on those sensitive claims.

Additionally, security zones cannot be inherited, so it makes sense to have a backup user from the same security zone as the user going on vacation.

Another factor to consider is authority limits. Ideally, the backup user would have the same authority limits as the user on vacation. If the backup user does not have the same or greater authority limits, the backup user cannot see any activities that require those authority limits. For example, if the backup user does not have the appropriate authority limit, the user cannot see the activity to approve reserves on the **Vacation** tab → **Activities** screen.

IMPORTANT If you are designated as a backup user, and you go on vacation, ClaimCenter does not send any activities to your backup. The system also does not warn you of this behavior.

Backup Users and Activities

The person designated as a backup user can edit activities owned by the vacationing user. Backup users can update, complete, skip, assign, or link a document to an activity. They can also view notes on an activity, but only if they have the same permissions. However, backup users cannot approve *approval type* activities unless they have the `actapproveany` permission. For example, a supervisor wants to assign his or her manager as the backup user, but the manager has not been assigned the supervisor's role.

In the base configuration, you can do the following:

- If you are the backup user and you have the permissions and authority limits to approve a certain type of activity, you can reassign the activity to yourself. Then, in the your **Desktop** tab → **Activities** screen, you can find the reassigned activity and approve it.
- An administrator can add the permission *Approve any approval activity* (code is `actapproveany`) to the backup user's role. This permission grants the user approval rights to *any* approval activity and is not restricted to being used in the backup role. The backup user still must have the correct authority limits. In the base configuration, this permission is not found on the supervisor's role, but on the manager's role. While this choice is an option, it might not best serve your business requirements.

Question Sets

Question sets are defined sets of questions used to help an interviewer obtain complete information. They regularize the information gathering and create a searchable record of the answers. In ClaimCenter, question sets are used:

- To help build a database of recommendations for service providers.
- To help assess the risk that a claim is fraudulent.

IMPORTANT Question sets are not designed to be substituted dynamically based on changes in the user interface. After a user has answered any questions in a question set, the question set is static and cannot be switched out for another question set.

This topic includes:

- “Fraud Question Sets and Points” on page 270
- “Working with Question Sets” on page 270
- “Question Set Entities” on page 274

Service Provider Question Sets

IMPORTANT This feature requires that ClaimCenter be integrated with ContactManager. For more information, see “Integrating ContactManager with Guidewire Core Applications” on page 45 in the *Contact Management Guide*.

A claims adjuster for an auto claim might have to choose a body shop from a list of providers. To help in this selection, the adjuster can rely on question sets that do the following:

- Find out from the claimant how much value is placed on perfect work versus rapid body work, or if the claimant has previous experience from a particular provider.
- Find out the claimant’s level of satisfaction after the work is completed for entry into the list of providers.
- Find out from the adjuster a way to sort the provider’s list on the basis of good performance.

ClaimCenter calculates the average scores from question sets for individual service providers. The application then displays these results for each provider, ranks providers by score, and searches on the scores to select service providers.

This feature is described in detail in the Contact Management Guide. See “ClaimCenter Service Provider Performance Reviews” on page 215 in the *Contact Management Guide*.

Fraud Question Sets and Points

An adjuster or special investigator can determine whether a claim is fraudulent. The score of a question set, containing a list of questions similar to the ones in the following table, can help in that determination:

Risk points	Possible questions in the Fraud Evaluation question set for auto claims
none	Is claimant familiar with insurance claims terminology and procedures?
no = 10	If yes to the previous question, then would claimant's business give claimant this knowledge? (Show only if the previous answer is yes.)
yes = 5	Does claimant refrain from using mail, fax, or other traceable types of communication?
yes = 15	Is claimant aggressively demanding settlement?
yes = 30	Will claimant accept a partial settlement if it is immediate?
yes = 10	Is claimant experiencing financial problems?
yes = 20	Are there discrepancies between claimant's statements and official accident reports?
yes = 10	Are there discrepancies between claimant's statements and those of witnesses?
yes = 10	Is the claimant's lifestyle inconsistent with the claimant's income level?
yes = 20	Has the claimant provided an excess of documentation and supporting material for the claim?

Grouping and saving these questions in a single place (a question set) ensures that all questions are asked. By assigning risk points to each question, ClaimCenter can calculate their sum, a *suspicious claim* score. Using the full set of questions and the risk point feature ensures that all claims can be examined in a uniform and fair way.

See also

- “Using Question Sets” on page 145

Working with Question Sets

You create QuestionSets and their related entities by creating XML files and then importing them through the application.

Importing Question Sets and Questions

With administrative permissions, you can import question sets by navigating to **Administration** → **Utilities** → **Import Data** and then choosing the file to import. See “Importing and Exporting Administrative Data from ClaimCenter” on page 115 in the *System Administration Guide*.

Importing a question set XML file adds the QuestionSet and its Question, QuestionChoice, and QuestionFilter entities to your installation. The import can occur while the server is running.

IMPORTANT If you import a question set XML file, ClaimCenter creates instances of the entities defined in the file. Do not delete these instances in a production environment, because doing so will prevent ClaimCenter from starting. Additionally, while it is possible to retire entities, do not retire the QuestionSet, Question, QuestionChoice, or QuestionFilter entities that are part of a service provider performance review. Existing reviews might still be using them. See “Retiring a Review Type” on page 226 in the *Contact Management Guide*.

Exporting Question Sets

With administrative permissions, you can export question sets by navigating to **Administration** → **Utilities** → **Export Data** and then choosing **Questions** in the **Data to Export** field. See “Importing and Exporting Administrative Data from ClaimCenter” on page 115 in the *System Administration Guide*.

Creating a Question Set

Each QuestionSet consists of Question entities, which can in turn point to the allowed set of answers to the question, a QuestionChoice entity. The Question entities you create have the following requirements:

- Each Question must have a foreign key back to the QuestionSet it appears in.
- To be scored, the QuestionType field must have the value Choice. You can use other values, such as Boolean, Integer, or String, but questions with these types will not be scored.
- Any Question with its Required field set to true must be answered before the QuestionSet is complete.
- Priority sets the order in which the question is listed in its QuestionSet. The values start with zero, and count upwards.
- The QuestionFormat field is optional and can be ChoiceSelect or ChoiceRadio or null. The field can be null only for a QuestionType other than choice.
- Each Question entity of type Choice must point to a QuestionChoice entity.

Define a Question in an XML file as follows:

```
<Question public-id="question13">
    <DefaultAnswer/>      <!-- answer to use if none is given; set to null for a blank answer --&gt;
    &lt;Indent&gt;0&lt;/Indent&gt;      <!-- not used, but will be to indent when displayed --&gt;
    &lt;Priority&gt;12&lt;/Priority&gt;  <!-- order in which this Question appears in the QuestionSet --&gt;
    &lt;QuestionSet public-id="generalquestionset"/&gt;  <!-- points to Questionset it belongs to --&gt;
    &lt;QuestionType&gt;Choice&lt;/QuestionType&gt;  <!-- boolean, choice, string, or integer --&gt;
    &lt;Required&gt;false&lt;/Required&gt;  <!-- if question must be answered or have non-null default --&gt;
    &lt;ShouldRetireFromImportXML&gt;false&lt;/ShouldRetireFromImportXML&gt;  <!-- if retired or active --&gt;
    &lt;Text&gt;Did the claimant present excessive documentation?&lt;/Text&gt;  <!-- actual question text --&gt;
    &lt;!-- If QuestionType=Choice, then ChoiceRadio displays an array of radio buttons, --&gt;
    &lt;!-- and ChoiceSelectBox displays answers in a select dropdown box. --&gt;
    &lt;!-- question.xml is a typelist containing all display choices --&gt;
    &lt;QuestionFormat&gt;ChoiceRadio&lt;/QuestionFormat&gt;
&lt;/Question&gt;</pre>
```

Similarly, a QuestionSet looks like this:

```
<QuestionSet public-id="AssignValue">
    <Name>Repair Timeliness</Name>          <!-- the name to display --&gt;
    &lt;Priority&gt;0&lt;/Priority&gt;  <!-- order in which this QuestionSet appears in user interface --&gt;
    &lt;QuestionSetType&gt;autorepair&lt;/QuestionSetType&gt;  <!-- typecode of QuestionSetType.xml --&gt;
    &lt;!-- this typecode is used to make sure only the appropriate QuestionSets are displayed--&gt;
    &lt;ShouldRetireFromImportXML&gt;false&lt;/ShouldRetireFromImportXML&gt;  <!-- if retired or active --&gt;
&lt;/QuestionSet&gt;</pre>
```

Creating a QuestionChoice

A QuestionChoice is one of the allowed answers for a Question of QuestionType=Choice. You must create one of these entities for each choice of each question, as defined in XML as follows:

```
<QuestionChoice public-id="carquestion11yes">
  <Code>Yes</Code>          <!-- value to store in the database for this choice -->
  <Description>Yes</Description>    <!-- not currently used in the user interface -->
  <Name>Yes</Name>        <!-- the string shown for this choice in the user interface -->
  <Priority>0</Priority>    <!-- the order to display this choice with other choices -->
  <Question public-id="question11"/>  <!-- reference to question this is a choice for -->
  <Score>0</Score>          <!-- the score assigned to this choice -->
</QuestionChoice>
```

Creating a Conditional Question

You can create conditional follow-up questions by using a question filter. Conditional questions can be useful for tailoring a single question set to obtain information from a number of similar cases. Consider the following partial sequence of questions that determine if an auto claim needs special investigation:

- Question **siucarquestion1**: “Was vehicle stolen?”
 - If yes to **siucarquestion1**, then conditional **siucarquestion2**: “Was vehicle purchased outside of State?”
 - If yes to **siucarquestion1**, then conditional **siucarquestion3**: “Does the stolen vehicle have salvage title?”

The following example is in the questions sets available if you import ClaimCenter sample data. It uses **QuestionFilter** elements at the bottom and shows how to code this sequence of questions:

```
<Question public-id="siucarquestion3">
  <DefaultAnswer/>
  <Indent>20</Indent>
  <Priority>2</Priority>
  <QuestionFormat>ChoiceRadio</QuestionFormat>
  <QuestionSet public-id="siucarquestionset"/>
  <QuestionType>Choice</QuestionType>
  <Required>false</Required>
  <ShouldRetireFromImportXML>false</ShouldRetireFromImportXML>
  <Text>Does the stolen vehicle have salvage title?</Text>
</Question>
<QuestionChoice public-id="siucarquestion3no">
  <Code>No</Code>
  <Description>No</Description>
  <Name>No</Name>
  <Priority>1</Priority>
  <Question public-id="siucarquestion3"/>
  <Score>0</Score>
</QuestionChoice>
<QuestionChoice public-id="siucarquestion3yes">
  <Code>Yes</Code>
  <Description>Yes</Description>
  <Name>Yes</Name>
  <Priority>0</Priority>
  <Question public-id="siucarquestion3"/>
  <Score>1</Score>
</QuestionChoice>
<Question public-id="siucarquestion2">
  <DefaultAnswer/>
  <Indent>20</Indent>
  <Priority>1</Priority>
  <QuestionFormat>ChoiceRadio</QuestionFormat>
  <QuestionSet public-id="siucarquestionset"/>
  <QuestionType>Choice</QuestionType>
  <Required>false</Required>
  <ShouldRetireFromImportXML>false</ShouldRetireFromImportXML>
  <Text>Was vehicle purchased outside of State?</Text>
</Question>
<QuestionChoice public-id="siucarquestion2no">
  <Code>No</Code>
  <Description>No</Description>
  <Name>No</Name>
  <Priority>1</Priority>
  <Question public-id="siucarquestion2"/>
  <Score>0</Score>
</QuestionChoice>
```

```

</QuestionChoice>
<QuestionChoice public-id="siucarquestion2yes">
  <Code>Yes</Code>
  <Description>Yes</Description>
  <Name>Yes</Name>
  <Priority>0</Priority>
  <Question public-id="siucarquestion2"/>
  <Score>1</Score>
</QuestionChoice>
<Question public-id="siucarquestion1">
  <DefaultAnswer/>
  <Indent>0</Indent>
  <Priority>0</Priority>
  <QuestionFormat>ChoiceRadio</QuestionFormat>
  <QuestionSet public-id="siucarquestionset"/>
  <QuestionType>Choice</QuestionType>
  <Required>false</Required>
  <ShouldRetireFromImportXML>false</ShouldRetireFromImportXML>
  <Text>Was vehicle stolen?</Text>
</Question>
<QuestionChoice public-id="siucarquestion1no">
  <Code>No</Code>
  <Description>No</Description>
  <Name>No</Name>
  <Priority>1</Priority>
  <Question public-id="siucarquestion1"/>
  <Score>0</Score>
</QuestionChoice>
<QuestionChoice public-id="siucarquestion1yes">
  <Code>Yes</Code>
  <Description>Yes</Description>
  <Name>Yes</Name>
  <Priority>0</Priority>
  <Question public-id="siucarquestion1"/>
  <Score>0</Score>
</QuestionChoice>
<QuestionFilter public-id="siucarfilter1">
  <Answer>Yes</Answer>
  <FilterQuestion public-id="siucarquestion1"/>
  <Question public-id="siucarquestion2"/>
</QuestionFilter>
<QuestionFilter public-id="siucarfilter2">
  <Answer>Yes</Answer>
  <FilterQuestion public-id="siucarquestion1"/>
  <Question public-id="siucarquestion3"/>
</QuestionFilter>

```

This series of questions looks like the following for an auto claim. The user navigated to the **Loss Details → Special Investigation Details** screen and clicked **Edit** to fill out the questionnaire:

Special Investigation Details

[Update](#)
[Cancel](#)

Section One - Possible fraud indicators detected

Description	Additional Information	Point Value
No police report or on-scene report is available for this claim.	None	1

Section One Score: 1

Section Two - SIU Questionnaire

Auto SIU

Was vehicle stolen?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Was vehicle purchased outside of State?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Does the stolen vehicle have salvage title?	<input type="radio"/> Yes <input checked="" type="radio"/> No

Reusing Questions

You can use the same question set in various settings. Questions can be used by only one question set. A question is associated with only one question set, and a question choice must be associated with a single question.

Internationalization of Question Sets

Question sets are not internationalized. If you want to configure multiple question sets for different locales or languages, use the `gw.api.util.LocaleUtil.getCurrentUserLanguage` method. Then use that result to select the correct question set to use.

Question Set Entities

The following entities relate to question sets:

Entity	Description
Answer	Answers to questions can be text, boolean (yes or no), dates, numbers, or a question choice. This entity has foreign keys to Question, QuestionChoice, and AnswerSet.
AnswerSet	A group of answers that correspond to a user answering one question set form. There is a foreign key to QuestionSet.
QuestionChoice	A type of answer, designated in the question by setting the question's type. Question choices can be scored. There is a foreign key to Question.
Question	A question the user sees on the screen. ClaimCenter typically uses questions to gather information regarding fraud and service provider recommendations. Question types can be boolean, choice, string, and integer and are defined in the <code>QuestionType</code> typelist.
QuestionFilter	A filter that controls the visibility of a question based on the answer to a previous question in a question set. Has foreign keys to Question and QuestionFilter.
QuestionSet	Question sets are groups of questions, typically used in the risk qualification process or to develop supplemental underwriting information. The value of the typekey <code>QuestionSetType</code> , which uses values defined in the typelist <code>QuestionSetType.ttx</code> , determines what kind of question set it is.
SubQuestion	In the user interface, a subquestion is the text that displays as a bulleted list following a question. Has foreign key to Question.

The fraud investigation question set is an array, `SIAnswerSet`, in the `Claim` entity. This array field points to an array of `SIUAnswerSet` entities, which correspond to sets of answers for the claim.

IMPORTANT While the `QuestionSetFilter` entity exists in the product, Guidewire recommends that you not use it. It is reserved for future use.

Subrogation

Subrogation is the legal technique by which one party represents another party, using their rights and remedies against a third party. In the insurance industry, a carrier sometimes settles a claim, knowing that another party can be liable for the costs. The carrier then attempts to recover those costs from the other party on behalf of their insured. Most insurance policies cede the insured's recovery rights to their carriers.

A common example is pursuing recovery after an insurer pays its insured client for accident costs for which a third-party person or insurer is liable. The insurer then has the right to pursue a recovery effort from the third-party person or the third party's insurance company. In other words, the insured client subrogates these recovery rights to the insurance company.

Another use of subrogation is to recover damages from a company that has made a defective product. For example, if a tire failure due to a manufacturing defect causes an accident, a carrier's subrogation rights enables them to sue the tire manufacturer.

Subrogation typically involves recovering costs from the liable party's insurance company, usually through informal negotiations between the two carriers involved. If the third party has no insurance, however, subrogation can involve legal action or collection agencies.

This topic includes:

- “Working With Subrogation” on page 275
- “Enabling Subrogation” on page 282
- “Subrogation Data Model” on page 283

Note: In ClaimCenter, the third party is also known as the *Adverse* or *Responsible Party*. The data model uses *Adverse* for brevity, and the user interface uses the term *Responsible* because it is less confrontational.

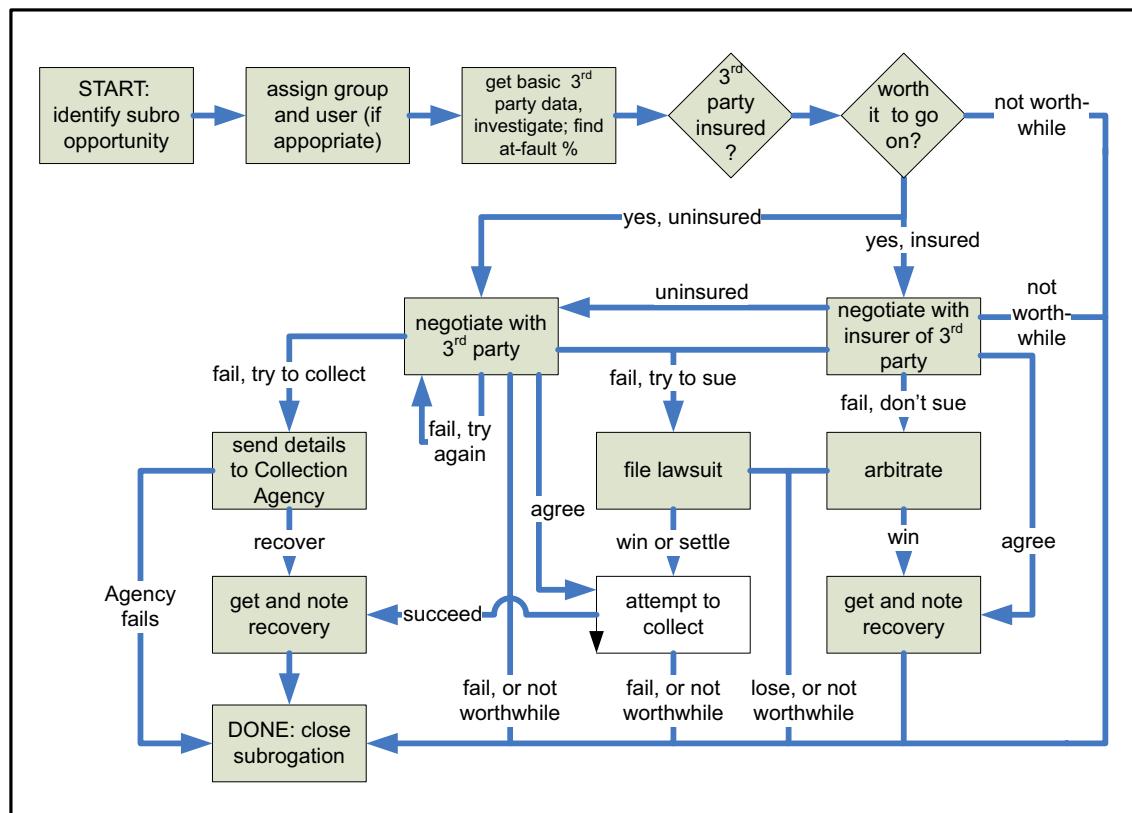
Working With Subrogation

Subrogation involves primarily the following activities:

- “Starting a Subrogation” on page 276
- “Assigning a Subrogation” on page 277

- “Recording a Subrogation Investigation” on page 277
- “Pursuing a Subrogation Strategy” on page 280
- “Working with Subrogation Recoveries and Recovery Reserves” on page 281
- “Promissory Notes and Arbitration Settlements” on page 281
- “Closing a Subrogated Claim” on page 282

The following figure is a conceptual overview of a subrogation process:



Starting a Subrogation

You access the **Subrogation** screen by opening a claim and clicking **Subrogation** in the sidebar. This menu item is not visible until you start a subrogation, either by editing the **Loss Details** screen or by setting **Subrogation Status** to **Open** or **Review**.

This topic includes:

- “Editing the Loss Details Screen for Subrogation” on page 276
- “Setting Subrogation Status” on page 277

Editing the Loss Details Screen for Subrogation

Typically, to start a subrogation, you edit the **Loss Details** screen. To open this screen, with a claim open, click **Loss Details** in the sidebar. To start a subrogation, you can:

- Set the **Fault Rating** field to **Other party at fault**.

Note: This field is not available in workers' compensation claims.

- Set the **Fault Rating** to **Insured at fault** and the **Insured's Liability %**, which then displays just below it, to less than 100%. In this case, someone else shares responsibility, and a claim contact with a Responsible Party role exists.
 - **Fault Rating** – Determines whether some other party bears some responsibility for the loss. Values come from the **FaultRating.ttx** typelist that you can extend in Guidewire Studio. In the base configuration, the values you can select are **<none>**, **Other party at fault**, **Fault unknown**, **Insured at fault**, and **No fault**.
 - **Insured's Liability %** – The amount of responsibility the insured bears for the loss. The field displays directly under **Fault Rating** after you set the **Fault Rating** field to **Insured at fault**.

Especially in auto claims, subrogation is possible only if the other driver, or another party, bears a significant amount of responsibility for the loss. Determining this value and deciding whether another party is mostly at fault are critical in identifying whether there is an opportunity for subrogation. In auto claims, police reports are often a good first source of information.

Note: You can write rules in Guidewire Studio that evaluate values in the **Loss Details** screen to determine if subrogation is to be pursued.

Setting Subrogation Status

In addition to setting the fault rating as described in the preceding topic, you can make the **Subrogation** menu item visible by setting the **Subrogation Status**. After setting this value, you can click **Subrogation** in the sidebar and edit the **Subrogation** screens. You can initially set the **Subrogation Status** as follows:

1. Open a claim and navigate to **Summary** → **Status**.
2. On the **Claim Status** screen, click **Edit**.
3. Set the **Subrogation Status** field to **Open** or **Review**.
4. Click **Update** to save your changes.
5. The **Subrogation** menu link becomes visible in the sidebar.

Note: After you have started a subrogation, **Subrogation Status** is also available from the **Subrogation** screen.

Assigning a Subrogation

You create and assign a subrogation activity just like any other activity on a claim. Additionally, you can write rules in Guidewire Studio to perform the assignment. You can use manual or rule-based assignment. To assign subrogation activities to experts in subrogation, first identify the experts in one of the following ways:

- Put them in a special group, such as a **Subrogation Specialists** group.
- Grant users a special user role in the **UserRole** typelist.
- Define and use a new user attribute of **UserAttributeType**.

You can instead create a manual assignment activity by using an Activity Pattern.

See also

- “Working with Activities” on page 217.
- “Users, Groups, and Regions” on page 437

Recording a Subrogation Investigation

ClaimCenter provides **Subrogation** screens that can help you organize each subrogation investigation. The screens are available from the **Subrogation** menu link in the sidebar.

This topic includes:

- “General Subrogation Screen” on page 278
- “Responsible Party Detail Subrogation Screen” on page 278
- “Financials Subrogation Screen” on page 279

General Subrogation Screen

Use **General** to record:

- **Fault** – Determines whether some other party bears some responsibility for the loss. Values come from the **FaultRating.ttx** typelist that you can extend in Guidewire Studio. In the base configuration, the values you can select are **<none>**, **Other party at fault**, **Fault unknown**, **Insured at fault**, and **No fault**. This field is the same as **Fault Rating** in the **Loss Details** screen. See “Editing the Loss Details Screen for Subrogation” on page 276.
- **Insured’s Liability %** – The amount of responsibility the insured bears for the loss. The field displays directly under **Fault Rating** after you set the **Fault Rating** field to **Insured at fault**. Same as **Insured’s Liability %** in the **Loss Details** screen. See “Editing the Loss Details Screen for Subrogation” on page 276.
- **Subrogation Status** – This field has the following possible values, three of which are defined in the **SubrogationStatus.ttx** typelist:
 - **<none>** – No subrogation has been attempted for this claim.
 - **Closed** – The subrogation attempt has been completed or abandoned.
 - **Open** – A subrogation pursuit has been started.
 - **Review** – The subrogation opportunity or pursuit is awaiting review by the adjuster’s manager or another ClaimCenter user, such as a member of a subrogation team.
- **Externally Owned** – Indicates whether subrogation for this claim has been assigned to an outside firm, like a collection or arbitration agency. If you answer **Yes**, enter the name of the **External Subrogator**.
- **Referral - Refer to Subro?** – If you answer **Yes**, you must enter a **Referral Comment**. After you click **Update**, **Referral Date** and time of the referral also appear on this screen. You cannot change **Refer to Subro?** to **No** after you have entered **Yes** for this field.

In addition to these fields, the **General Subrogation** screen gives summaries of:

- **Responsible Parties** – This editable list view displays all responsible parties with a few of their characteristics, such as their responsibility percentages. You can add or remove responsible parties in this screen, or you can use the **Responsible Party Detail** screen to add, remove, or provide more information about them. See “Responsible Party Detail Subrogation Screen” on page 278.
- **Statute of Limitations** – It is important to track the statute of limitations laws that govern the time after which subrogation is no longer possible. These laws are different for injuries and property damage, and governments are governed by different statutes. In the list view on the subrogation screen, you can add and remove statutes of limitations, and you can view and enter the following information:
 - **Type** – The subrogation type can be **Medical costs**, **Property Damage**, or **Other**.
 - **Jurisdiction State** – The state, province, or other jurisdiction of the statute, depending on the country.
 - **Description** – Text describing the subrogation.
 - **Statute Deadline** – The deadline imposed by the statute.
- **Subrogation-related Notes** – You can view the latest notes affecting subrogation, but you cannot enter them in this screen. To add notes, navigate to **Actions** → **New Note** and choose **Subrogation** as the **Topic**.

Responsible Party Detail Subrogation Screen

This screen shows the same information as the **Responsible Parties** list view in the screen at **Subrogation** → **General**. Select any party and edit information that is important for deciding whether to attempt to collect from this party, and, if so, how to pursue collection. The fields are:

- **Name** – The name of the responsible party. You can pick from a list of names already associated with the policy or enter a new name.
- **Liability %** – Your estimate of the legal percentage of fault for the loss, often based on police reports or precedents from similar situations. The sum of these percentages from all responsible parties must be no more than 100%.
- **Expected Recovery %** – This field is your estimate of the actual amount that you expect to recover. If the configuration parameter `UseRecoveryReserves` is set to `true`, entering a percentage enables the **Set Open Recovery Reserve to Expected Recovery %** button in the **Subrogation Financials** screen. Clicking that button sets the open recovery reserves to the amount based on that percentage. If you edit that amount, you must click the button again so ClaimCenter can recalculate new values.
- **Classification** – These values, from the `SubroClassification.ttx` typelist, are limited in the base configuration to the values `<none>`, **Insured**, and **Uninsured**, which govern the **Strategy** choices that you see. If you select **Insured**, you must also specify at least the name of the responsible insurance company in the contact information for the party.
- **Strategy** – What to do in pursuing a subrogation recovery against this responsible party. The choices come from the `SubroStrategy.ttx` typelist. The strategy choices are often set or reset after a review, usually by the subrogator's manager. The party's **Classification** categorizes these choices. Different strategies are available for the insured and uninsured. See "Pursuing a Subrogation Strategy" on page 280.
- **Government Involved?** – If a government agency is a responsible party, or if a private responsible party is performing work for a government agency, then other information must be collected. This information includes the name and jurisdiction of the government agency, a description of the agency's involvement, and any time limitations due to a statute of limitations restriction. Enter the actual information in the **Statute of Limitations** table in the **General** tab of the **Subrogation** screen.
- **Primary Contact** – Optional information about the person to contact. It can be the same as the responsible party.

Finally, this screen contains a summary of the recoveries already received and to be received from each party. The summary values are:

- **Total Amount Recovered** – This amount includes all recoveries from this contact for all cost types, such as expenses and claim costs. Although you might not expect any recoveries of this kind from the responsible party, any non-subrogation recovery types, such as Salvage, are included in the total.
- **Total Claim Costs Recovered via Subrogation** – The portion of the **Total Amount Recovered** for the cost type **Claim Costs** and the recovery category **Subrogation**.
- **Scheduled Payment - Applicable?** – Choosing **Yes** opens additional fields that can help in tracking the expected recovery receipts. See "Promissory Notes and Arbitration Settlements" on page 281 for details.

Financials Subrogation Screen

The **Financials** tab shows the primary financial information of interest to a subrogation adjuster. This information is a subset of the application's total financials and shows the integration of subrogation recoveries and recovery reserves into the application's financial accounting system. Use this screen to create recovery reserves to account for expected recoveries. See "Working with Subrogation Recoveries and Recovery Reserves" on page 281 for more information.

The **Financials** tab shows the following list views:

- **By Responsible Parties** – Contains for each party the **Liability %**, **Expected Recovery %**, **Subro Recoveries**, and the **Actual % Recovered**, based on the total payments made.
- **By Reserve Lines** – Contains information for each claim cost reserve line. The information includes the **Open Recovery Reserves**, amount **Paid**, **Net Paid (excluding Subro Recovery)**, **Subro Recoveries** amount, **Anticipated Recovery %**, and **Actual % Recovered** of the amount **Paid**.

Following are some industry best practices that the base configuration of ClaimCenter uses to display financial information related to recoveries. This feature will require configuration if your organization handles matters differently.

- Claim costs are more likely to be recovered than claim expenses, so the **Financials** tab shows reserve lines only for non-expenses. Additionally, the reserve lines shown are only for the claim cost types supplied with the application. If you want to show expenses, or if you have added other non-expense cost types that you want ClaimCenter to show, you must configure ClaimCenter to do so.
- It is important to know the true net cost of the claim to the insurer after recoveries, such as salvage, and prior to any recoveries from subrogation. Hence, the field titled **Net Paid (excluding Subro Recoveries)**.

Pursuing a Subrogation Strategy

After identifying and deciding to pursue a subrogation opportunity, you must decide on a strategy and pursue the actions it specifies. See the diagram in “Working With Subrogation” on page 275 for a visual representation of these strategies.

You enter the **Strategy** in the **Responsible Party Detail Subrogation** screen, described at “Responsible Party Detail Subrogation Screen” on page 278. The **Strategy** field lists options for the common ways to proceed. The values listed depend on the value of the **Classification** field, **<none>**, **Uninsured**, or **Insured**.

You can choose to add rules in Guidewire Studio that use the strategy value as a **Strategy** condition to create activities to further the strategy. For example, a rule indicates that if the strategy is **Pursue** and no letter has been sent to ask for payment, then create an activity to send the first one. Already available strategies are in the **SubroStrategy.ttx** typelist.

Classification for Liable Party Is Uninsured

A value of **Uninsured** in the **Classification** field of the **Responsible Party Detail Subrogation** screen limits choices to the following **Strategy** values:

- **Pursue** – Send a series of collection letters. Negotiate directly with the party. You can write a series of dunning letters and create activities to send the letters at predetermined times.
- **Utilize Collection Agency** – Use a collection agency and share any recovery with that agency. If you select this option, you must enter the name and other contact information for the agency. Also, the **Strategy** value can trigger a rule to create the activity to contact the selected agency.
- **Lawsuit** – Take legal action and absorb the costs of litigation. Use the **Matters** screen, available from the **Litigation** menu link.
- **Drop Pursuit** – Do not pursue subrogation. The time and cost of recovery are not worth the effort.

If the result of these strategies is a promissory note, a section of the **Financials** tab can track the note and its received payments. See “Promissory Notes and Arbitration Settlements” on page 281.

Classification for Liable Party Is Insured

A value of **Insured** in the **Classification** field of the **Responsible Party Detail Subrogation** screen limits choices to the following **Strategy** values:

- **Pursue against Insurer or Negotiate against Insurer** – These strategies are similar to the previous **Pursue** strategy.
- **Arbitration** – Use the services of an arbitrator or arbitration agency.
- **Lawsuit** – Take legal action and absorb the costs of litigation. Use the **Matters** section.
- **Drop Pursuit** – Do not pursue subrogation. The time and cost of recovery are not worth the effort.

As part of some of these strategies, you record all recoveries in the **Financials** tab of the **Subrogation** screen.

Working with Subrogation Recoveries and Recovery Reserves

This topic is applicable if your company sets recovery reserves. You can set recovery reserves directly, and you can record subrogation recoveries and let ClaimCenter generate corresponding recovery reserves. You might want to set a recovery reserve directly if you want to track an expected total recovery amount and no recoveries have yet come in.

For more information on recoveries and recovery reserves, see “Recoveries and Recovery Reserves” on page 311.

Setting a Subrogation Recovery Reserve

To enter a subrogation recovery reserve directly, you can navigate to **Actions** → **New Transaction** → **Other** → **Recovery Reserve**. You can click **Add** to create a new recovery reserve and set the **Recovery Category** to **Subrogation** and the other fields as appropriate. Or, for an existing subrogation recovery reserve, you can set the value of the **New Open Recovery Reserves** field to the expected total recovery amount.

Alternatively, on the **Financials** tab of the **Subrogation** screen, you can use the button **Set Open Recovery Reserve to Expected Recovery %** to update recovery reserves.

The **Set Open Recovery Reserve to Expected Recovery %** button is visible, but not available if one of the following conditions is true:

- The total **Expected Recovery Percentage** from all responsible parties is equal to or more than the **Anticipated Recovery %**.
- The current recovery is already greater than the expected percentage in one or more reserve lines.
- **Net Paid (Excluding Subro Recoveries)** is zero or less.

Note: If a recovery on an individual reserve line exceeds the **Expected Recovery %**, ClaimCenter does not recalculate this value. Instead ClaimCenter shows the message, “Current recovery is already greater than the expected percentage in one or more reserve lines.” For example, you have already recovered 65% of the costs on one reserve line and 15% on a second reserve line, and the expected recovery is 50%.

- Multicurrency reserving is turned on. That is, **EnableMulticurrencyReserving** is set to **true** in **config.xml**.

Entering a Subrogation Recovery

To enter a subrogation recovery, navigate to **Actions** → **New Transaction** → **Other** → **Recovery**. Set the **Recovery Category** to **Subrogation** and enter the recovery information. ClaimCenter also generates a recovery reserve to bring the recovery reserve to the same amount if necessary.

Note: When you set the **Recovery Category** to **Subrogation**, the **On Behalf Of** field opens, where you can enter the party on whose behalf the recovery is being paid. This field enables a third party insurance company to submit a check directly to your company and have the correct responsible party be credited for this payment. In this case, the insurance company of the responsible party is the **Payer**, and you would enter the responsible party in the **On Behalf Of** field. You can then see on the **Financials** tab that the payment is applied to the correct **Responsible Party**.

Promissory Notes and Arbitration Settlements

Sometimes, the result of a subrogation is that an uninsured responsible party agrees to make a recovery payment, but cannot do so immediately. Alternatively, a responsible party agrees to binding arbitration, the result of which is that a recovery payment must be made. In both cases, a subrogation feature helps you track the expected recovery payments.

To use this feature

1. With the claim open, navigate to **Subrogation** → **Responsible Party Detail**.

2. Select the **Responsible Party** to open the **Detail** card.
3. Set **Scheduled Payment is Applicable?** to Yes.
4. Enter the **Type**, either **Promissory Note** or **Arbitration Settlement**.
5. If you selected **Promissory Note**, enter the **Note Sent** and the signed **Note Received** dates. These fields do not appear if the **Type** is **Arbitration Settlement**.
6. Under **Scheduled Payments**, click **Add** and then add **Date of Planned Payment** and **Installment Amount** for each recovery you expect.

Closing a Subrogated Claim

Typically, you do not close a claim while a subrogation is pending. ClaimCenter prevents you from closing a claim if any condition in the following list is true:

- The claim has a subrogation status of **Open** or **In Review**. To close the claim, the status must be **Closed**.
- A payment has been made on the claim and the **Fault Rating** is **Unknown** or **Other Party at Fault**.
- If you select **Other Party at Fault** and the total **Liability %** is less than 100%.
- If you select **Insured at Fault** and the **Insured's Liability %** is less than 100%.

Although it is not mandatory, set the **Strategy** to **Drop Pursuit** before closing the claim.

Enabling Subrogation

To enable the full subrogation functionality in ClaimCenter, you must set the first parameter in the following table. The other parameters are already set in the base configuration.

Parameter	Location	Description
UseRecoveryReserves	The Financial Parameters section in the config.xml file in Studio.	Setting this parameter to true enables recovery reserves to show in the Financials tab of the Subrogation screen. Additionally, a setting of true enables the Set Open Recovery Reserves to Expected Recovery % button, the Open Recovery Reserves field, and Anticipated Recovery % on the ReserveLine list view.
Financials	See the Financials section in the config.xml file in Studio.	This parameter set to entry enables use of all financial screens.

Permissions

The following permissions govern subrogation and are added to both the Adjuster and the Claims Supervisor roles in the base configuration:

- `viewsubrodetails`
- `editsubrodetails`

Roles Used in Subrogation

The subrogation feature uses the following claim roles in the base configuration:

- Subrogation Owner (exclusive to exposure)
- External Subrogation Firm
- Subrogation responsible party insurer

- Collection agency
- Investigator
- Third party (accident participant, the base role for a responsible party)

Subrogation Rules and Scenarios

You can find the financial rules governing subrogation in Guidewire Studio. Navigate to **configuration** → **config** → **Rule Sets** → **Preupdate** → **ClaimPreupdate**.

The following descriptions are scenarios for subrogation rules you could add to your application.

Flag a claim as a Possible Subrogation Opportunity

- **Condition** – The claim's subrogation status has not been set and the loss cause is a rear-end collision.
- **Action** – Set the claim's subrogation status to **Review** and the reason to **Rear-end collision**.

You can add more conditions that flag a claim for possible subrogation, or you can add an action to create an activity to review the claim.

Create an Activity to Send the First Subrogation Letter

- **Condition** – The **Strategy** is **Pursue**, and this activity does not exist.
- **Action** – Create an activity that creates and sends the first dunning letter with a particular template.

Create an Activity to Send the Second Subrogation Letter

This rule can be part of the **Activity Closed** rule set. An activity to send a third demand letter would be similar.

- **Condition** – The previous activity is complete and a certain time has passed.
- **Action** – Create an activity that completes and sends the second dunning letter by using its particular template.

Subrogation Data Model

Subrogation uses the following typelists:

Subrogation Typelist	Values
AdversePartyDenialReason.ttx	License Suspended, Policy Lapsed
MatterType.ttx	Arbitration or Lawsuit
StatuteLimitationsType.ttx	State Involved, Federal Involved, City Involved, Medical, Damage, Other
SubroClassification.ttx	Insured, Uninsured
SubroClosedOutcome.ttx	Full Recovery, Compromised, Uncollectable, Discontinued
SubrogationStatus.ttx	Review, Open, Closed
SubroGovernmentInvolved.ttx	Yes or No. Categories of StatuteLimitationsType.ttx.
SubroSchedRecoveryType.ttx	Promissory Note, Arbitration Settlement
SubroStrategy.ttx	Pursue against insurer, Negotiate against insurer, Arbitration (against insurer), Pursue, Utilize Collection Agency (against uninsured), Lawsuit, Drop Pursuit (both insured and not)

The following entities support subrogation:

Entity	Description
Claim	<p>There are three fields on Claim that are related to subrogation:</p> <ul style="list-style-type: none"> • SubrogationStatus – Typekey to SubrogationStatus • SubrogationSummary – Foreign key to SubrogationSummary • subrogator – Derived property returning Contact, the external subrogation firm for the claim
Matter	<p>There are two fields on Matter that are related to subrogation:</p> <ul style="list-style-type: none"> • SubrogationSummary – Foreign key to SubrogationSummary • SubroRelated – Boolean indicating if the matter has a related subrogation
StatuteLimitationsLine	<p>Represents a statute of limitations for a subrogation. The field SubrogationSummary is a foreign key to the associated SubrogationSummary entity. There is also a derived key for the associated claim.</p> <p>The SubrogationSummary entity has an array key, StatuteLine, to support multiple statute limitations.</p>
SubroAdverseParty	<p>Stores subrogation related information for a third party who is the subject of a subrogation recovery for a claim. This entity does not represent the third party's insurance company. This entity has a derived field for the associated claim, and it has an AdverseParty foreign key to Contact and a foreign key to SubrogationSummary.</p> <p>The field SubroAdverseParty on SubroPaymentSchedule is a foreign key to this entity. Additionally, the SubrogationSummary entity has an array key, SubroAdverseParties, to support multiple adverse parties.</p>
SubrogationSummary	<p>Represents a subrogation for a claim. An object of this type is instantiated when a subrogation is initiated on a claim.</p> <p>Configuration points include the Claim Preupdate rule CPU10800 - Create Subro Summary, which calls a configurable enhancement method to determine if subrogation is activated. The method is ActivateSubroModule in GWSubroNonFinancialClaimEnhancement.gsx.</p>
SubroPaymentSchedule	<p>Represents a promissory note schedule for an adverse party who is the subject of a subrogation. The field SubroAdverseParty is a foreign key to the associated SubroAdverseParty entity.</p>

part VI

ClaimCenter Financials

Claim Financials

The financial features of ClaimCenter focus entirely on the monetary aspects of settling a claim. These aspects include estimating settlement costs, making payments, and optionally recovering money from other sources to offset certain costs. You can use the ClaimCenter financials features to provide estimates of potential claim costs. You can also track and put financial controls on the flow of money used to satisfy the claim.

This topic includes:

- “Financial Overview” on page 288
- “Transactions” on page 288
- “Reserves” on page 290
- “Reserve Lines” on page 295
- “Payments” on page 296
- “Checks” on page 301
- “Electronic Funds Transfer (EFT)” on page 309
- “Recoveries and Recovery Reserves” on page 311
- “Working With Transactions and Checks” on page 314
- “How Transactions Affect Financial Values” on page 316
- “Lifecycles of Transactions” on page 319
- “Lifecycles of Checks” on page 321
- “Financial Holds” on page 325
- “Integration with External Financial Systems” on page 326
- “ClaimCenter Financial Calculations” on page 329
- “Financial Transactions Outside the User Interface” on page 329
- “Financials Data Model” on page 330
- “Transaction Business Rules” on page 332
- “Financial Permissions and Authority Limits” on page 334

See also

- “Configuring ClaimCenter Financials” on page 611 in the *Configuration Guide*
- “Financials Integration” on page 363 in the *Integration Guide*
- “Multiple Currencies” on page 335
- “Bulk Invoices” on page 353

Financial Overview

The financial component is critical to the ClaimCenter application. Not only does the system tracks claims, but it also records the finances associated with each claim or exposure. You can create reserves for claims, make payments, and create recovery reserves.

Example

An adjuster receives a claim for an auto accident, and as part of the claim process, the adjuster creates several exposures and the reserves that are affiliated with each exposure. There is a reserve line for potential auto damage costs and a reserve line to estimate medical costs of an injured driver. These reserve lines enable the adjuster to track each type of potential payment. Payments consist of transactions. As these costs become clear, the adjuster approves these payments and issues checks against these reserves, decreasing the reserves. The adjuster readjusts reserve levels and then determines that another driver was at fault. The adjuster then creates a recovery reserve for the amount expected from that driver’s insurance carrier. After the carrier sends the adjuster a check, the adjuster notes this amount as a recovery, which decreases the claim’s recovery reserve.

To manage these financial tasks, ClaimCenter uses these concepts:

Financial concept	Description
Reserve Lines	ClaimCenter uses reserve lines to track specific costs that are related to a claim. A reserve line represents the categorization or coding of a transaction, and is a combination of exposure, cost type, and cost category.
Reserves	Estimates of how much money might be needed to satisfy future claim liabilities and associated costs.
Transactions	Modify the amount of money in a reserve line. A reserve transaction modifies the amount of money set aside for the reserve line. A payment transaction moves money from a reserve line to a payment to a claimant or other party.
Payments	Records of all claim related disbursements made to satisfy the claim, in part or whole.
Checks	A single transfer of money from one or more reserve lines to one or more individuals or organizations.
Recovery Reserves	Estimates of how much money might be recovered from others while settling the claim.
Recoveries	The receipt of claim costs from others, including salvage and subrogation.

Transactions

The transaction is the basic unit of all financial operations in ClaimCenter. The *Transaction* object is the main financial entity in ClaimCenter. It has the following subtypes:

- Payment
- Reserve
- Recovery
- RecoveryReserve

The following list describes the transaction subtypes:

Financial Item	Description
Reserves	Can be created, updated, approved, or deleted. Payments usually decrease them.
Payments	Can be created, updated, and approved or canceled. Payments are usually made by checks.
Recovery Reserve	Transactions similar to negative reserves. Recoveries always decrease recovery reserves.
Recoveries	Negative payments—checks received. Recoveries can be entered, updated, approved, or deleted.

Note: See “Financials Data Model” on page 330 for more information.

Transaction Approval

ClaimCenter contains transaction approval rules, which ensure that you have authorization to submit certain financial transactions. A transaction set contains one or more transactions that are submitted as a group for approval. If you attempt to save a transaction set, ClaimCenter rules can ensure that the transaction be marked as requiring approval.

You can write rules that allow transactions based on a financial condition. See “ClaimCenter Financial Calculations” on page 329 for more details.

You can give a user a role that contains permissions and approval limits to do the following:

- Govern the upper limit of reserves the user can set.
- Set the payments the user can approve.
- Set the checks the user can write.

See “Security: Roles, Permissions, and Access Controls” on page 447.

Checks and Payments

ClaimCenter distinguishes checks from payments. A *payment* is closely associated with a reserve and is the way ClaimCenter tracks the claim’s settlement costs. A *check* is the physical transfer of funds to make a payment.

One check can make more than one payment to a claimant. For example, an insured can receive payments for both medical costs and car damage in one check. However, several checks can be issued to make one payment. An example is compensation payment for an injury that is split into a check for the injured person and a percentage going to the injured’s lawyer through a second check.

Transactions and Transaction Line Items

The transaction is the main financial entity in the ClaimCenter data model. It is an abstract entity with the final subtypes *Payment*, *Reserve*, *Recovery*, and *RecoveryReserve*. Every transaction contains one or more *transaction line item* objects that hold the monetary amount, or a part of the monetary amount, of the transaction.

Payments and recoveries can contain more than one transaction line item. Reserves and recovery reserves can contain only one transaction line item. The amount of a transaction is the sum of all its transaction line item amounts. Each transaction line item contains a *line category* field that further categorizes the amount beyond the *CostType* and *CostCategory* of the entire transaction.

For example, the *LineCategory* field of a *TransactionLineItem* on a *Payment* or *Recovery* can further divide the transaction amount. You might have a reserve line with a cost category called Fees, and you might set aside money for all fees by creating reserves on that reserve line. By adding line categories of Management Fee, Surveyor Fee, and so on, you can make more granular distinctions when creating a payment or recovery. However, you cannot access the line categorizations through financial calculations. Financial calculations track amounts only at the reserve line level.

See also

- “Payments” on page 296
- “Recoveries and Recovery Reserves” on page 311

Transaction Sets

All transactions made at the same time are grouped together in a transaction set. The `TransactionSet` entity also groups together checks created at the same time to make a payment. This grouping occurs even if the checks are issued on separate dates or to different payees or both. See also `TransactionSet` entry in the “Financials Data Model” on page 330.

Reserves

Reserves are estimates of how much it will cost to satisfy a claim or part of a claim. Reserves are the primary way a carrier estimates its future liabilities. Such estimates are required both for internal business decisions and for regulatory purposes. A unique reserve line categorizes each of a claim’s reserves. Initially, reserves are estimates. As the claim process progresses, a reserve amount can be updated for better accuracy or if higher liabilities seem probable.

Note: Increasing reserves can also indicate a problem, such as fraud.

Unless defined otherwise, payments decrease reserves. See “Eroding and Non-eroding Payments” on page 297. If the reserve levels have been set correctly, payments deplete them by the time the claim is settled.

This topic includes:

- “Reserve Overview” on page 290
- “Definitions of Reserve Calculations” on page 292
- “Definitions of Total Incurred Calculations” on page 292
- “Setting Reserves” on page 292

Reserve Overview

This topic includes:

- “Estimating Reserve Amounts” on page 290
- “Uses of Reserves” on page 291
- “Effect on Reserves of Closing a Claim or Exposure” on page 291
- “Payments and Available Reserves” on page 291

Estimating Reserve Amounts

There are two ways to estimate reserve amounts: *Case Reserves* and *Average Reserves*.

Case Reserves – Use case reserves to estimate reserves and then adjust them on a case-by-case basis. To be most effective, first subdivide claims into exposures, cost types, and cost categories, each with its separate reserves. Estimating these smaller pieces makes the overall estimate of the needed reserves more accurate. After applying case reserves, you can monitor the decrease of reserves as payments are made to determine if a claim is resolved within normal cost limits. This method is the one used in the base configuration.

Average Reserves – Use average reserves to estimate claim or exposure reserves based on actuarial information about the cost to settle similar claims in the past. The claim’s liability estimate does not change and is not affected by any payments made. Business rules can even set reserves levels automatically. In this case, you segment the claim into exposures, such as vehicle collision. Rules classify the exposure into high, medium, or

light damage, and then set reserves by using this classification. The average reserves method works best when allocating reserves to each exposure rather than to the claim as a whole.

Many carriers base their current claim liability on the sum of reserves tailored to the specific claim that are still remaining, plus the payments already made. Other carriers set reserves to averages based on actuarial information from similar claims. They continue to use this initial value in estimating their liabilities, not altering this initial estimate as normal payments are made, only considering extraordinary payments to it.

Note: The base configuration is set up for case reserves. You can configure the system for average reserves.

Uses of Reserves

Reserves drive the application's financials. Specifically, reserves do the following:

- **Categorize liabilities by coverage (exposure)** – You can subcategorize reserves into smaller divisions, such as a bodily injury exposure dividing into physician, hospital, therapy, and administrative costs. Categorizing reserves makes tracking of specific claim costs more accurate.
- **Track projected costs of claims as soon as they are created** – This tracking enables timely and more compete estimates of a carrier's liabilities. Regulatory agencies often require up-to-date estimates of expected claim liabilities to compute carrier solvency. They want to include claims whose details are not yet well known.
- **Prevent excessive payments made on a claim** – ClaimCenter controls who can set or increase reserve levels and can stop payments in excess of reserves. These actions can help identify fraud.
- **Ensure that a claim can be paid** – After a reserve is associated with an exposure, and therefore a coverage, it is easy to compare the policy's coverage limit with the potential claim amount.
- **Help in assigning claims** – For example, steer claims with large potential liabilities away from inexperienced adjusters.
- **Assess adjusters' performance** – You can compare actual settlements to the amount of reserves.

Effect on Reserves of Closing a Claim or Exposure

After a reserve lines's claim or exposure is closed, its open reserves are set to zero. Zeroing the open reserves reduces total reserves to the sum of all eroding payments made against it. On closing of the claim or exposure, total reserves become equal to all eroding payments, and total incurred becomes the total of all payments, eroding and non-eroding. For example, a reserve is set to \$1000, payments of \$600 are made, and the claim is closed. Total Reserves would no longer be \$1000, but rather \$600. Open Reserves remain at zero.

- For more information on open reserves, total reserves, and total incurred, see "Definitions of Reserve Calculations" on page 292.
- For information on eroding and non-eroding payments, see "Eroding and Non-eroding Payments" on page 297.

Payments and Available Reserves

Payments can exceed reserves when the `AllowPaymentsExceedReservesLimits` configuration parameter in `config.xml` is set to `true`. Large enough payments can produce negative values for available reserves and remaining reserves. Negative values for these reserves typically result from a payment that is scheduled for the future, eroding its reserve before a requested reserve increase is approved.

However, open reserves cannot be negative. If the system escalates a check, such as through the `FinancialsEsc` batch process, its payments can make open reserves negative. ClaimCenter then creates the offsetting reserves to keep the open reserves at zero.

For other ways for reserves to be negative see:

- "Payments and Negative Reserves" on page 297
- "Negative and Zero Dollar Transactions and Checks" on page 300

Definitions of Reserve Calculations

Reserves can decrease as payments are made against them. ClaimCenter defines several reserve calculations that differ depending on when the payments that decrease reserves are recognized.

The following are calculations used in reserves.

- **Total Reserves** – All Approved reserves, with no payments deducted. Total Reserves is never changed by payments while the reserve line's claim or exposure is open. On a closed claim, the Total Reserve value is equal to the sum of all eroding payments. See "Effect on Reserves of Closing a Claim or Exposure" on page 291.
- **Open Reserves** – Total Reserves minus all eroding payments made today or earlier.
- **Remaining Reserves** – Open Reserves minus all Approved eroding payments to be made after today.
- **Available Reserves** – Remaining Reserves minus all eroding payments that are Pending Approval.

Note: Payments on open claims never decrease Total Reserves, and recoveries never change any reserves. Eroding payments do decrease Remaining Reserves. See "Eroding and Non-eroding Payments" on page 297.

For a full list of financial calculations, see "Predefined Financial Calculations" on page 623 in the *Configuration Guide*.

Definitions of Total Incurred Calculations

The **Total Incurred** value on the title bar of each **Financials** screen provides a quick indicator of a claim's current cost. **Total Incurred** on these screens is the financial calculation **Total Incurred Net** described in the following definitions.

ClaimCenter defines three types of **Total Incurred**:

- **Total Incurred Gross** – Open Reserves plus Total Payments.
- **Total Incurred Net** – Total Incurred Gross minus Total Recoveries.
- **Total Incurred Net Recovery Reserves** – Total Incurred Gross minus Total Recovery Reserves.

Eroding payments do not affect **Total Incurred** on open claims, but supplemental payments on a closed claim or exposure do affect **Total Incurred**.

The following terms are used in the definitions of **Total Incurred**:

- **Open Reserves** – See previous topic, "Definitions of Reserve Calculations" on page 292.
- **Total Payments** – Sum of all Submitted payments and payments Awaiting Submission with a scheduled send date either before or on the current date.
- **Total Recoveries** – Sum of all Submitted recoveries.
- **Total Recovery Reserves** – Sum of all Submitted recovery reserves.

For a full list of financial calculations, see "Predefined Financial Calculations" on page 623 in the *Configuration Guide*.

Setting Reserves

You can set reserves by opening a claim, clicking **Actions**, and under **New Transaction**, clicking **Reserve** to open the **Set Reserves** screen. Double-click each drop-down field to select an exposure, a cost type, and a cost category. Then enter the available reserves, optionally enter a comment, and click **Save** to add the reserve. The reserve is added with Pending Approval status, or, if it does not need approval, it is immediately escalated to Submitting status.

A new reserve transaction is created every time you change the amount of reserves for a reserve line. You can see this on the **Financials → Transactions** screen by selecting **Reserves** from the drop-down list. A new entry exists with the new date, amount, and current status.

How ClaimCenter Shows Reserves

In most of its financial screens, ClaimCenter typically shows either Open Reserves, or both Remaining Reserves and Future Payments.

ClaimCenter shows Available Reserves when you are creating or updating reserve amounts. It shows:

- **Currently Available Reserves** – Same as Available Reserves.

- **New Available Reserves** – New available reserve amount that you enter.

Available Reserves is the most conservative estimate of unused reserves. All payments—current, future, and not yet approved—have been deducted.

- **Change** – Defined as New Available Reserves minus Currently Available. This value will be the amount of the newly created reserve transaction.

On the **Set Recovery Reserves** screen, the **Change** column is equal to New Open Recovery Reserves minus Open Recovery Reserves.

Configuring the Set Reserves Screen

The **Set Reserves** screen can run in two modes depending on the **SetReservesByTotalIncurred** configuration parameter in the **config.xml** file.

In the base configuration, the **SetReservesByTotalIncurred** parameter is set to **false**, and the **Set Reserves** screen shows the **New Available Reserves** column. This default mode focuses on how much reserve you have left to make payments.

You can configure the **Set Reserves** screen to show **Current Total Incurred** and **New Total Incurred** columns by setting the configuration parameter **SetReservesByTotalIncurred** to **true**. The column **New Total Incurred** replaces **New Available Reserves**. This mode puts the focus on how much you are increasing the Total Incurred of the claim by increasing reserves.

Note: **Total Incurred** on this screen is the calculation **Total Incurred Net**, which takes recoveries into account.

For more information, see “Configuring Reserve Behavior” on page 649 in the *Configuration Guide*.

See also

- “Definitions of Total Incurred Calculations” on page 292
- “Recoveries” on page 311

Setting Reserves in Multiple Currencies

In ClaimCenter, financial calculations are typically conducted in the *Claim Currency*, the currency inherited by the claim from the associated policy. You can write checks, create reserves, and make payments in the claim currency. Although you can conduct financial transactions in other currencies, in all calculations, this currency is effectively converted to the claim currency.

ClaimCenter configuration also allows you to specify if you want to use multiple currencies in your financial transactions. If you enable multicurrency, you can create reserves, checks, and make payments in different currencies. Apart from the claim currency, each reserve, then, has a designated *Reserving Currency*. Payments erode reserves in the corresponding reserving currency.

Create reserves in multiple currencies in the **Set Reserves** screen. To access the **Set Reserves** screen, open a claim and click **Actions**, and under **New Transaction**, click **Reserve**. Select **Add** to add a new reserve and select the currency of choice in the **Reserving Currency** column. When you select a currency, the **New Available Reserves** column is updated to show the new currency symbol. Enter the desired reserve amount.

Once you specify the reserving currency, ClaimCenter shows all amounts and calculations for the reserve in this currency.

IMPORTANT Once you save a reserve, the currency selection, like the cost type and cost category, cannot be changed.

Setting Reserves in a Single Currency

If multicurrency is disabled in ClaimCenter, the reserve currency defaults to the claim currency specified in the configuration file. All financial calculations are conducted in the claim currency. You can now use the **Enter an amount in another currency** icon as a convenience to calculate and create a reserve in another currency. For example, an adjuster planning to create payments in another currency could use this feature to set a reserve to that currency.

This icon is enabled only when the claim currency equals the reserve currency and is illustrated in red in the following figure.

Exposure ↑	Coverage	* Cost Type	* Cost Category	Currently Available	Pending Approval	* New Available Reserves	Change	Comments
(1) 1st Part...	Collision	Claim Cost	Auto body					
(2) 3rd Part...	Liability - Bodily Injury ...	Claim Cost	Auto body	\$4,700.00		\$4,700.00		
(3) 3rd Part...	Liability - Bodily Injury ...	Claim Cost	Medical	\$3,000.00		\$3,000.00		
none (Clai...	<none>	<none>						
Sum:				\$7,700.00		\$7,700.00		

Note: In the base configuration, ClaimCenter tracks reserves only in the claim currency. You can create a reserve in another currency to help you determine the amount of claim currency to put aside to make a payment. Multicurrency payments are made against the reserve in claim currency.

For information on enabling multicurrency, see “Configuring Multiple Currencies” on page 337.

The following figure shows the **Enter Reserve Amount in Another Currency** screen that displays when you click the multicurrency icon. In this screen, you can change the currency in the **Currency** column and choose whether the new exchange rate is entered manually or looked up automatically.

Exposure	* Coverage	* Cost Type	* Cost Category	Currently Available	Pending Approval	* Currency	* New Available Reserv	Change	Comments
(2) 3rd Part...	Liability - Bodily Injury a...	Claim Cost	Auto body	\$3,592.40 = \$4,700.00		EUR	€3,592.40 = \$4,700.00		

Exchange Rate

Exchange Rate Mode Manual Automatic

Exchange Rate: 1 EUR = 1.308318 USD

Exchange Rate Description: Sample data current market rates set.

Exchange Rate Effective Date: 09/06/2012

Amounts are shown in two currencies with the primary amounts in the selected currency. In this example, the primary amount is in Euros. The selected currency becomes the transaction currency for the new reserve. Secondary amounts are in the claim currency and are shown under the transaction amount.

Exchange Rates and Setting Reserves

If you change the currency to a non-claim currency, the screen shows exchange rate information with the automatic exchange rate mode button selected.

This button is enabled if you have the Exchange Rate Manual Override permission, `exchratemanual`. If you do not have that permission, the **Exchange Rate Mode** button is disabled.

Reserve Lines

A *reserve line* represents a unique combination of exposure, cost type, and cost category. It is used to categorize and track transactions.

All transactions are related to a reserve line. A reserve line, in a sense, categorizes a transaction, which is a combination of an exposure or claim, a cost type, and a cost category. Each transaction, whether setting or changing a reserve amount, making a payment against a reserve, creating a recovery reserve, or recording a recovery, is marked against one reserve line. There is a `ReserveLine` entity created for each unique combination of `Exposure` or `Claim`, `CostType`, and `CostCategory` if a transaction has been created with that combination.

The `Exposure` entity can be `null`, which means that the reserve line is not at the exposure level, but rather at the claim level. In fact, that is how you set a claim level reserve on the **Set Reserves** screen. If you do not select an exposure, the system creates the reserve line at the claim level.

However, `CostType` and `CostCategory` are both required values. On that same screen, you must select a cost type and cost category. You can select an **Unspecified Cost Type** and **Unspecified Cost Category** from the drop down menus.

ClaimCenter refers to the combination of exposure, cost type, and cost category fields as the transaction's *coding*. These fields exist on both the `Transaction` and `ReserveLine` entities. You categorize a transaction by setting up those coding fields, and then the transaction is associated with the `ReserveLine` that uniquely represents that coding. As a result, transactions with the same coding are associated with each other through a reserve line, to track their totals for financial calculations.

The `ReserveLine` is the most granular level at which ClaimCenter tracks financial calculations. You can filter the totals for financial calculations in many different ways, such as Total Payments with a cost type of `claimcost`, which applies across the entire claim. This filter would select all reserve lines on the claim with a cost type of `claimcost`, and then add up the Total Payments value for each reserve line. There are additional fields for further categorization of transaction amounts, such as `RecoveryCategory` on `Recovery` and `LineCategory` on `TransactionLineItem`. However, the `ReserveLine` entity, and hence financials calculations, do not take these fields into account. There are no breakdown amounts.

If you save a new transaction, ClaimCenter either finds the existing reserve line that matches the transaction's coding or creates a new one. You do not create reserve lines directly. The `Exposure`, `CostType`, and `CostCategory` values for the `ReserveLine` derive from the same fields on the `Transaction` entity. These values are set either by you through the user interface or by Gosu code.

In the user interface, you can see how reserve lines are created. When you create a new transaction from **Actions** → **New Transaction** → **Reserve**, the **Set Reserves** screen opens. In this screen you can either edit or add to the Available Reserves on a reserve line. Rows that are pre-populated represent a claim's existing reserve lines with their corresponding reserve amounts. If you add a new row, you create a new reserve transaction on a new reserve line coding combination, causing ClaimCenter to create a reserve line.

Note: The reserve line is created during transaction setup, so the reserve line on a transaction will have been set up when the PostSetup and PreUpdate rule sets were run. See “Rule Set Categories” on page 37 in the *Rules Guide* for additional information.

When you make a payment or you record receipt of a recovery, if no reserve or recovery reserve yet exists, ClaimCenter creates a reserve line.

Viewing reserve lines on the Financials Summary screen

Multiple reserve lines itemize different kinds of costs for the claim. The **Financials Summary** screen, which displays one reserve line on each row, shows how reserve lines logically categorize a claim's financial information.

Financials (Total Incurred: \$18,400.00): Summary			
Summary Transactions Checks			
Exposure	Open Recovery Reserves	Remaining Reserves	Futur
(1) 1st Party Vehicle - Ray Newton - Collision	Exposure	\$400.00	
Claim Cost	Cost type	\$400.00	
Auto body		\$400.00	
Expense - A&O	Cost categories	-	
Other		-	
(2) 1st Party Med Pay - Stan Newton - Medical Payments		\$2,000.00	
Claim Cost		\$2,000.00	
Medical		\$2,000.00	
Expense - A&O		-	
Other		-	
(3) 3rd Party Vehicle - Bo Simpson - Liability - Bodily Injury and Property Damage		\$5,000.00	
Claim Cost		\$4,000.00	
Auto body		\$4,000.00	
Expense - A&O		\$1,000.00	
Vehicle inspection		\$1,000.00	

This figure illustrates the following:

- There are three exposures visible, which are numbered.
- There are no claim-level reserve lines. If there were, you would see what looks like a fourth exposure labeled **Claim Level**.
- Cost types divide each exposure's costs into two major areas, administrative expenses and claim costs.
- Cost categories further subdivide these major areas, making them unique.
- There are six reserve lines visible. Each reserve line is a unique combination of exposure, cost type, and cost category, as shown in the following table:

Exposure	Cost Type	Cost Category
(1) 1st Party Vehicle - Ray Newton - Collision	Claim Cost	Auto body
(1) 1st Party Vehicle - Ray Newton - Collision	Expense A&O	Other
(2) 1st Party Med Pay - Stan Newton - Medical Payments	Claim Cost	Medical
(2) 1st Party Med Pay - Stan Newton - Medical Payments	Expense A&O	Other
(3) 3rd Party Vehicle - Bo Simpson - Liability - Bodily Injury and Property Damage	Claim Cost	Auto body
(3) 3rd Party Vehicle - Bo Simpson - Liability - Bodily Injury and Property Damage	Expense A&O	Vehicle Inspection

Payments

Payments encompass all monetary amounts paid to satisfy a claim. This money includes the claim's liabilities and its associated LAE (Loss Adjustment Expenses) and other administrative expenses. Payments have the following associations:

- Every payment is associated with a specific reserve line to categorize the payment amount.
- Every payment belongs to a check.

A payment is classified as either eroding or non-eroding. An eroding payment decreases the amount of available reserves on its reserve line. If you create an eroding payment that exceeds the amount of available reserves, ClaimCenter creates a new reserve transaction to bring the reserves back up to zero. An exception is payments that you schedule to be sent on a future date.

Note: Payments are not the same as checks. See “Checks” on page 301.

The remainder of this topic describes different types of payments and when each can be used. It includes:

- “Eroding and Non-eroding Payments” on page 297
- “Partial, Final, and Supplemental Payment Types” on page 297

Eroding and Non-eroding Payments

ClaimCenter defines two kinds of payments:

- **Eroding** – A payment that decreases the available reserves on its reserve line by the payment amount.
- **Non-eroding** – A payment that does not affect available reserves.

Every payment, independent of its type, can be denoted as eroding or non-eroding. The following are examples of non-eroding payments:

- Supplement payments made after a claim or exposure is closed and therefore has zero reserves. There are no more reserves to erode.
- If a carrier does not include its LAE estimates in its reserves, it can make LAE payments non-eroding.
- If the carrier measures its liabilities by using Total Incurred instead of Open Reserves, eroding reserves are not important. Only non-eroding payments increase Total Incurred.

Payments and Negative Reserves

All eroding payments reduce their associated reserves. If the `AllowPaymentsExceedReservesLimits` parameter in `config.xml` is set to `true`, payments can exceed the amount of available reserves.

To prevent negative reserves, ClaimCenter creates an offsetting reserve for such payments. However, these reserves are not created until the scheduled send date for the payment's check. Therefore, reserves remain negative from the time the payment is approved to the day it is sent in the case of a future-dated check. Otherwise, an offset will be created when the check is issued.

The offset reserve is created as soon as an eroding payment is in Awaiting Submission status. An offset reserve is not created for non-eroding payments.

Partial, Final, and Supplemental Payment Types

During the check writing process, a payment type is applied to a payment. Payment types complement reserve lines in providing an additional way to classify payments. In the New Check wizard, the Payment Type drop-down list choices can be **Partial**, **Final**, and **Supplemental** depending on the situation. For example, the **Partial** option is available if the open claim or exposure has reserves.

Note: It is not possible to add other types to the `PaymentType` typelist.

This topic includes:

- “Partial Payments” on page 298
- “Final Payments” on page 298
- “Supplemental Payments” on page 298

Partial Payments

A partial payment transaction is a transaction that usually pays for some of, but not all, the financial obligation of the reserve line on an open claim or exposure. The available reserves remaining in the reserve line will presumably be used in some future check to complete the financial obligation. These partial payments are eroding unless you specify otherwise. If you are creating eroding partial payments and the

`AllowPaymentsExceedReservesLimits` parameter is set to `false`, the reserve line must have the available reserves to cover those amounts. If it does not, then you must either increase the reserves to cover that amount or create a new reserve.

Partial payments are not allowed when the reserve line does not already have reserves and the `AllowPaymentsExceedReservesLimits` parameter is set to `false`. This setting is the default in the base configuration. Setting this parameter to `true` means that you can make a partial payment with available reserves that are less than the partial payment amount. In that case, ClaimCenter automatically adds reserves to the reserve line to prevent the available reserves from becoming negative.

Final Payments

A final payment transaction is a transaction that completes the financial obligation of the reserve line. Because the financial obligation has been met, there is no need to keep money set aside in the reserve line. The purpose of final payments is to close exposures and, potentially, even close the claim. Final payments can be either eroding or non-eroding.

On creation, the final payment zeroes out the Open Reserves on its reserve line. ClaimCenter automatically creates an additional reserve transaction that zeroes out the reserve line.

A final payment performs the following actions when its check is escalated by the Financials Escalation batch process:

- If there are no reserves on the exposure and the `CloseExposureAfterFinalPayment` configuration parameter in the `config.xml` file is `true`, the final payment attempts to close the payment's exposure. Other reserve lines on the exposure with non-zero reserves prevent closing of the exposure. If the Close Exposure Validation rules fail while closing the exposure, a warning activity is created and the exposure is not closed.
- If all exposures on the claim are closed and there are no claim level reserves and the `CloseClaimAfterFinalPayment` configuration parameter is `true`, ClaimCenter attempts to close the claim. If the Close Claim validation rules fail while closing the claim, a warning activity is created and the claim is not closed.

To automatically close claims and exposures, two financial parameters in the `config.xml` file must be enabled, `CloseClaimAfterFinalPayment` and `CloseExposureAfterFinalPayment`. These parameters are enabled by default in the base configuration. For more information, see “Financial Parameters” on page 58 in the *Configuration Guide*.

Note: ClaimCenter does not ensure that a final payment is the last payment. Generally, if a final payment has not been escalated, you can make an additional partial payment. If it has been escalated, you can make a supplemental payment.

You can also use final payments to quickly deal with small, simple claims. They can even be made before a reserve has been specified. For example, a single First and Final payment can often settle a personal auto claim. If reserves have not been set, a final payment creates an offsetting reserve to cover it.

Supplemental Payments

Supplemental payments are additional payments that are made on an already closed claim or exposure. They are the only way to make a payment on a closed claim or exposure without opening the exposure or claim. They are

always non-eroding. A closed claim's or exposure's available reserves will have already been zeroed, so there is nothing to erode.

Note: A supplemental payment must be submitted on the date it is created. It cannot be scheduled for future payment, for historical reasons. If you think you have a future liability, do not make a supplemental payment on a closed claim. Instead, reopen the claim, create a reserve, and make payments against it.

Supplemental Payments Without Any Previous Payments

If the `AllowNoPriorPaymentSupplement` configuration parameter in `config.xml` is set to `true`, then you can make supplemental payments if no prior payments existed. In this case, the reserve line drop-down list in the **New Check** wizard shows the reserve lines of all closed exposures, including those with and without a prior payment.

Modifying Payments

Depending on its Transaction Status, you can edit, delete, void, or stop a payment or a check. You can also recode and transfer a check. See “Transaction Status and Check Status” on page 317.

Editing or Deleting Payments

You can edit or delete a payment as long as it belongs solely to ClaimCenter. The check must not have been sent to be entered into an external accounting system. Editing and deleting are possible when a payment is Pending Approval, is Awaiting Submission, or has Rejected status. The claim or exposure must be open to edit or delete a payment in Rejected status. See also “Lifecycles of Transactions” on page 319.

Recoding a Payment to Another Reserve Line

You can move a payment to another reserve line, or change the line category of its transaction line items, after the payment is sent downstream. This process is called *reencoding*. It is available on the **Payments** screen of the **Transactions** tab of the **Financials** screen. You can consider a check to be recoded when you recode its payments, but checks are unaffected by recoding—their amount is unchanged.

Note: If a check is in Awaiting Submission status or an earlier status, you can edit the check and its payments any way you like, but you cannot recode. After the check is escalated to Requesting status and is sent downstream to the check processing system, the only way to fix a coding error is to recode the payment. For more information on check statuses, see “Lifecycles of Checks” on page 321.

Using **Recode**, you can split an amount from one payment into multiple payments, but you cannot consolidate multiple payments on an escalated check into fewer payments. However, multiple payments on the same check can have the same reserve line, so you can always recode the right amount of money onto the proper reserve line. The amount might be split across multiple payment transactions with that same reserve line.

To recode a payment, do the following:

1. Select a claim.
2. Click **Financials** in the left-hand links.
3. Click a payment amount to open the **Transactions** screen.
4. Click the **Amount** link of a **Payment** transaction. This action opens the **Payment Details** screen.
5. Click **Recode**.

In the **Recode Payment** screen, you can do the following:

- Change the reserve line.
- Enter a comment.
- Add additional line items and set the line category and amount for each line item.

- Click **Add Payment** and then edit the reserve line and amounts of the payments to reflect the new reserve line and amount on each. Their amounts must add up to the original payment's amount.

Note: If you are using multicurrency reserving, only reserve lines in the same currency as the reserve line of the payment will be available for selection. All payments on a check must be from reserve lines with the same reserving currency.

Transferring a Payment to Another Claim

You cannot transfer a payment to another claim, at least not directly. You can transfer a check, and when you do so, all payments on the check are also transferred. For more information, see “Transferring Checks from One Claim to Another” on page 305.

Voiding or Stopping a Payment

After a check is submitted to an external check writing application to be issued, its payments are also submitted. While they can no longer be edited or deleted, ClaimCenter does provide both a Void and a Stop mechanism. Their details depend on your implementation. However, these actions are more common to checks. When you void or stop a check, ClaimCenter also creates offsets that void the associated payments and reserves for you.

ClaimCenter generates offset transactions for all voids and stops and their payments. The description field of the offset reads **Offsetting transaction for voided check to Payee on Date**.

Negative and Zero Dollar Transactions and Checks

There are times when you want to make zero-dollar or negative transactions. For example, you can receive an invoice containing credit or no-cost items, and then create a payment to record that it was paid. Or, if you make an overpayment to a claimant, the claimant’s next check can have a line item for that reserve line. The line item would show a negative amount to offset the overpayment.

In ClaimCenter, you can create:

- A check with a negative amount.

If you want to create the check manually, the configuration parameter `AllowNegativeManualChecks` in the `config.xml` file must be set to `true`.

- A check for \$0.
- A check with a negative amount as one or more of its payments.
- A payment with a negative amount on one or more of its line items.
- A check with \$0 entries on one or more of its payments.
- A payment with \$0 entries on one or more of its line items.
- A recovery with a negative amount, but only if the recovery does not result in negative total recoveries on the reserve line or the claim.
- A recovery with \$0 entries on one or more of its line items.
- A recovery of \$0.
- A reserve of \$0.

Making Payments with Rules

You must use the `setAsNonEroding` and `setAsEroding` methods on `Payment` to change whether automatic payments or other payments made by using a Gosu rule that erodes reserves. Instead of your directly setting the field itself, ClaimCenter must handle the underlying offsets to the reserves’ T-accounts. See also “Transaction Business Rules” on page 332.

Checks

ClaimCenter uses checks to make payments. You create and edit payments in the check wizard.

Note: You can also use electronic fund transfers to make payments. See “Electronic Funds Transfer (EFT)” on page 309 for details.

ClaimCenter must be integrated with an external financial application that prints and sends checks to make claim payments. To make a claim-related disbursement, you create the necessary check descriptions in ClaimCenter to pay the disbursement. After the check issue date occurs, ClaimCenter sends a request to your check writing application, which in turn writes the actual check. Instead of issuing a check, your external system can send an electronic funds transfer, wire transfer, or credit a credit card.

This topic includes:

- “Payments and Checks” on page 301
- “Types of Checks” on page 301
- “Manual Checks” on page 303
- “Working with Checks” on page 303

Payments and Checks

The terms check and payment in ClaimCenter refer to separate things. A payment is a transaction that you perform in ClaimCenter that is applied against a specific reserve line. ClaimCenter uses payments to track the financial status of a claim. Fundamentally, payments track how funds set in reserve are paid to settle a claim and pay its settlement expenses.

A check is a request that ClaimCenter creates and then sends to an external check writing or financial management application. ClaimCenter records all the salient details of the check. These details include to whom the check was made out and for how much, and against which reserve line the check is written. The application then requests that the external system create and issue the physical check.

A single check, check group, or check set can comprise one or more payments of the same claim. Also, a single payment can be made by more than one check, provided that all the checks are part of the same check group or check set. However, a payment cannot be split among multiple check sets.

Types of Checks

You create checks in ClaimCenter by using the [New Check](#) wizard. After they are approved and when their issue date is reached, ClaimCenter sends them to its check writing system to be issued. See “Transaction Status and Check Status” on page 317 for a description of the statuses that describe a check’s lifecycle. ClaimCenter recognizes that checks created in the same use of the [New Check](#) wizard are related, and manages them together.

In some cases, you can issue a check that is not directly related to any other check. A common example is a payment to a body shop, which is typically a one-time payment to a single vendor. The vendor repairs the damage. You send the vendor a check to cover the fee. In most cases, there is only a single payee, so the [New Check](#) wizard writes only one check.

However, when a payment must be divided among several payees, a different check can be issued to each of them. Multiple checks created at the same time are organized into check sets and check groups. Some definitions:

- **Check** – A ClaimCenter request to generate a single physical check. Each check has a primary payee and can also have one or more joint payees. A check can represent one or more payments.
- **Check set** – All the checks created by a single execution of the [New Check](#) wizard. The set includes checks that will be issued at different times, such as a recurring check set. All the checks in a check set are submitted together, and they must be approved or rejected as one. A single-payee, non-recurring check belongs to its own check set.

- **Check group** – All the checks created by a single execution of the **New Check** wizard that are scheduled to be issued at the same time. If a single payee check is written, it is in its own check group.

For a set of recurring checks, check groups organize the checks into groups to be issued at the same time. A check group contains multiple checks when there are multiple payees.

A way to see the difference between a check and a check set is to compare them to joint payees and multiple payees.

- **Joint payees** – Two or more different payees that are listed in the same **Pay To** field of a single check. An example of a check written to joint payees might be an auto claim, where the insurer pays a body shop for repairs to the insured's car. The insurer might write the check to both parties as joint payees. This is because both parties are then required to sign the check before it can be deposited or cashed. This is one check, because the names of the payees appear on a single physical check.
- **Multiple payees** – Unique payees, each of whom receives separate checks for one payment. For example, a workers' compensation claimant gets one check, while the claimant's ex-spouse receives another for court-mandated child support. The claimant is the primary payee, and the ex-spouse is a secondary payee.

The multiple payee example also illustrates check groups. In this case, both checks are in one check group. The **Grouped Checks** section of a check detail screen lists them together. If these checks were to recur 12 times, there would be 12 groups of two, and all 24 checks would be contained in one check set.

In the data model, checks are not a transaction subtype, but sets of checks are grouped into check sets, which are a subtype of transaction sets.

Note: If a check is created in the Auto First and Final wizard and its associated exposure or claim is not at the Ability to Pay validation level, it requires approval.

Recurring Check Sets

You can create a check set that includes a series of checks that ClaimCenter issues periodically. A typical use for recurring checks is for a workers' compensation claim. Damages for lost wages are paid on a monthly or weekly basis. A single use of the **New Check** wizard can create a check set containing check groups, which in turn contain single instances of the recurring checks.

The following table describes the recurrence types available in the **Set check instructions** step of the **New Check** wizard.

Recurrence Type	Description
Single	Use to specify a single payment only, an occurrence of one. This type is the default in the base configuration.
Weekly	<p>Use to select the following:</p> <ul style="list-style-type: none"> • Weekly frequency—for example, every week, or every two weeks • Day of week • Number of days in advance to send the check • Total number of checks to create <p>ClaimCenter shows the total recurrence amount after you specify the total number of checks.</p>
Monthly	<p>Use to select the following:</p> <ul style="list-style-type: none"> • Monthly frequency—for example, every month or every third month • Day of the month or the day of a week in a month to send the check • Number of days in advance to send the check • Total number of checks to create <p>ClaimCenter shows the total recurrence amount after you specify the total number of checks.</p>

Notes

- After you initially create them, recurring checks must be written to the same payees and be for the same amount. However, you can edit and clone check sets and make changes to either payees or amounts if necessary.
- If you have enabled multicurrency in ClaimCenter, you cannot change the exchange rate of multi-payee checks in a recurrence. The exchange rate on the checks is locked in for the entire recurrence. Because the fixed amount on a check portion can be shared across multiple checks in a recurrence, the exchange rate for all the checks in the recurrence must be identical. To learn about check portions, see the definition for **CheckPortion** in the section “Multicurrency Data Model” on page 602 in the *Configuration Guide*.

See also

- “Configuring the Check Wizard Recurrence Settings” on page 655 in the *Configuration Guide*

Service Dates and Periods

A check can have a *service date* or a *service period*. A service date identifies the date on which a loss occurred that results in a payment. A service period identifies the period of time over which a payment represented in a check is earned. Whether a payment applies to a service date or a service period depends on the nature of the exposure to which the payment applies.

The most common example of a check’s service period is found in workers’ compensation claims. A primary type of loss in this kind of claim is for the worker’s lost wages. In this case, the insured is entitled to all or part of the wages they would have earned had they been physically able to work. For example, if that period of time was from August 1 – 14, the check’s service period would be August 1 – 14. The payment in the check identifies the time period over which the damage—in this case, lost wages—occurred.

Another example of a service period is an auto policy that includes rental car benefits that apply if the insured’s vehicle is not drivable. The insured rents a car for six days, and you send a check for reimbursement. The six days of the rental are the service period for the check.

Manual Checks

In most cases, if you need to make a payment, you create a check in ClaimCenter, which records the payment and sends a request to your check writing system. But you might need to quickly write out a check by hand and bypass ClaimCenter. If ClaimCenter does not create the check, it does not know about it, and the check is not counted against reserves. Thus, writing a check by hand can cause confusion in the application’s financial records.

You can account for checks written by hand by creating a *manual check*, a check record you create within ClaimCenter to acknowledge a check that you write outside ClaimCenter. After a manual check reaches its issue date, ClaimCenter changes its status to Notifying and sends a message, rather than a print request, to its external check writing application.

Working with Checks

This topic describes at a high level how to modify checks.

If a check has the appropriate status, you can edit, delete, transfer, clone, reissue, void, or stop payment on it. “Lifecycles of Checks” on page 321 defines the states for which these operations are available. To modify a check, use the **New Check** wizard and select the check.

This topic includes:

- “Deleting Checks” on page 304
- “Editing Checks” on page 304
- “Cloning Checks” on page 304

- “Recoding Checks” on page 305
- “Reissuing Checks” on page 305
- “Transferring Checks from One Claim to Another” on page 305
- “Voiding or Stopping Checks” on page 306
- “Deducting from Checks” on page 307
- “Check Deductions Versus Multiple Payee Checks” on page 308
- “Negative and Zero Dollar Checks and Payments” on page 309
- “Bulk Invoice Checks” on page 309
- “Effect on Checks of Closing a Claim or Exposure” on page 309

Deleting Checks

You can delete any check until its status becomes Requesting. You can also delete a check in Rejected status if its reserve line is in a claim or exposure that is still open. If you have written recurring checks, you can delete any in the series that have not been sent downstream to the external check writing application.

Editing Checks

You can edit a single check before its status becomes Requesting, but editing such a check after it is approved can return its status to Pending Approval. You can also edit a Rejected check if its reserve line is part of a claim or exposure that is still open.

After editing a check recurrence, you cannot change the amount after it is approved. Instead, you can indirectly edit the total amount by changing the number of checks in the recurrence, which forces the underlying check set to be resubmitted for approval. You can edit a check in a recurrence on the **Check Details** screen in two ways:

- If you click the **Edit** button, your changes apply only to that check.
- If you click the **Edit Recurrence** button, your changes apply to all remaining checks in the recurrence.

Note: You must have the `resdelete` permission to edit a final check. Otherwise, the check wizard cannot delete and recreate the offsetting reserve.

Cloning Checks

Cloning is a time-saving device that enables you to use an existing check or check set as a template to create a new check or check set. You can clone an existing check set that is either single or recurring and then use the **New Check** wizard to make changes.

One typical use for cloning a single check is that you already have one or more checks written to joint payees. If you want to create a new check for the same payees, clone an existing check and then modify the clone as necessary. Cloning a recurring check set can save even more time. You might have set up a recurrence to pay through the end of the year. Later, you could be informed that a cost of living increase (COLI) will apply for next year. You can clone one of the checks in the existing recurrence, add an additional payment to provide for the COLI, and save the new recurrence.

Notes on cloning checks

- Cloning creates a new check set for the same claim.
- Cloning creates a new check group. The check group and all checks in it are cloned and added to the new check set.
- All payments are copied to the cloned checks, as are their line items.
- All payees are copied to the new checks.
- Deductions on the check being cloned are not copied to the new check.

- If the check is part of a recurrence, the recurrence is cloned as well. The first due date of the cloned recurrence is the scheduled send date of the last check of the existing recurrence plus one service period.
- Cloned recurring checks retain the same service period as the original recurrence.

To clone a check

1. Open the claim the check is in and navigate to **Financials → Checks**.
2. Click the check number for the check you want to clone to open the **Check Details** screen.
3. Click the **Clone** button to open the **New Check** wizard.
4. Enter information for the **Payee**, **Payments**, and **Instructions**, and on the final screen of the wizard, click **Finish** to save the check.

Recoding Checks

You cannot recode a check. However, you can move a check's payments and make a payment against a different reserve line at any time. This process is called *recoding* a payment. To learn more about recoding, see “[Recoding a Payment to Another Reserve Line](#)” on page 299.

Reissuing Checks

You can reissue a check to correct a single check in a check group without having to eliminate all the checks in the group. For example, you divide a payment into multiple checks, and one of them is incorrect. You can reissue the incorrect check instead of voiding and recreating the entire check group.

Notes on reissuing checks

- You cannot change the amount of a reissued check.
- You must not void or stop the check before reissuing it. The reissue process first voids the existing check. Voiding a check yourself prevents you from reissuing it.
- You cannot reissue a check if it is the only member of the check group. Since there are no other checks to void, reissuing does not do anything useful.
- You cannot reissue a bulk check.

Transferring Checks from One Claim to Another

Sometimes a single person or entity is a payee on multiple claims. The single person or entity might receive a check in the correct amount, but the wrong claim is charged. For example, an attorney represents insured parties on behalf of the carrier in third-party litigation. The attorney can represent quite a few insured parties. In the process of paying the attorney's legal fees, it is possible to write a check against the wrong claim. In this case, you can transfer a check from one claim to another, rather than voiding it, and then recreate it in another claim.

Notes:

- Before transferring a check, ensure that the payee is linked to the contact management system in both claims, as described later in this topic. If the contact is not linked and the payee already exists in the target claim, ClaimCenter will create a duplicate contact in the target claim. See “[To transfer a check](#)” on page 306.
- ContactManager, when integrated with ClaimCenter, provides centralized management of your claim contacts and vendors. For more information, see “[Integrating ContactManager with Guidewire Core Applications](#)” on page 45 in the *Contact Management Guide*.

You can transfer the check with the following limitations:

- The check must have already been sent to the check writing application and have a status at least of **Requesting**.
- The check cannot be a member of a check group that has multiple payees.

- The check cannot be recurring.

To transfer a check

1. With the claim open, click **Financials** in the sidebar menu on the left to open the **Financials** screen.
2. Click **Checks** and click the **Check Number** for the check you want to transfer.
The **Check Details** screen opens.
3. Note the name in the **Pay To The Order Of** field. This name is the check's payee.
4. Ensure that this payee is linked to the Address Book in both the source claim and the target claim. To do so:
 - a. In the source claim, click **Parties Involved** in the sidebar menu on the left.
 - b. Select the check payee that you identified previously from the list of contacts.
ClaimCenter shows the payee's contact information below the list of parties involved.
 - c. On the **Basics** tab, determine if the contact is linked, and, if not, click the **Link** button or the **Relink** button.
If the contact is not linked, there will be a **Link** button or a **Relink** button. There will also be a message saying either that the contact is not linked or that the link is broken. A broken link means that the contact was deleted in ContactManager. Relinking creates that contact again.
If the contact is already linked, there will be a message saying that the contact is linked to the Address Book, and there will be an **Unlink** button. In this case, you do not need to link the contact.
 - d. Open the target claim and click **Parties Involved** in the sidebar menu on the left.
 - e. If there is a contact with the same name as the payee on the source claim and the contact is not linked as described previously, click **Link** or **Relink**. You might see a message saying that matches were found for the contact. If so, and there is a correct match, pick it from the list.
5. Open the source claim again.
6. Go back to the **Check Details** screen by navigating to **Financials** → **Checks** and clicking the **Check Number**.
7. Click the **Transfer** button.
8. To the right of the **Claim** field, click the **Search** icon and search for the claim to which to transfer the check.
9. In the list of claims returned by the search, click the **Select** button for the claim you want.
10. Click **Transfer** to transfer the check.

Transferring Checks from a Closed Claim

When a claim is closed, you can still transfer existing checks under certain conditions, as follows:

- You can transfer a supplemental payment from one closed claim to another.
- You can transfer a check from one closed claim to another, if there were payments made on the reserve line before the target claim was closed. The payment is transferred as a supplemental payment.

Voiding or Stopping Checks

The integration with the external check writing system determines the exact definition of voiding versus stopping payment on a check. ClaimCenter shows a **void** button or a **stop** button to tell you which is possible. Typically, the primary distinction is that you stop payment on a check if the check itself is no longer in your physical possession. Otherwise, you void it.

Note: When you stop or void one check in a check group, you stop or void all the checks in that group.

If you reissue a check, the reissue process first voids the check for you. If there are other checks in the group containing the reissued check, they are unaffected.

Check statuses determine when you can void or stop payment on a check. In general, you can void or stop a check after it reaches the status of Requesting. However, you can void, but not stop, a check with a status of Cleared. See “Transaction Status and Check Status” on page 317 for more information about which check statuses allow voiding and stopping. You must have a special permission to void or stop checks, and an additional permission to void a cleared check.

Deducting from Checks

ClaimCenter provides support for backup withholding from checks. You might be required to deduct estimated taxes from a check if the vendor has not provided you with full tax status information. You would then forward the deducted amounts to the tax authority.

In the first step of the **New Check** wizard, settings for the Primary Payee Type and the Report As field determine if ClaimCenter can deduct income tax from the check. If Type is Vendor and Report As is Reportable, ClaimCenter can withhold income tax from the check.

If you select a contact in the Name field that is a vendor, the Type and Report As fields are set automatically to Vendor and Reportable. You can change these fields in the wizard.

There are additional settings that determine if the amount is actually deducted from the check, as described in “ClaimCenter Backup Withholding Behavior” on page 308. The base configuration parameter settings for deductions allow deductions to be made from the check.

There are some things to note about how ClaimCenter handles checks with deductions:

- ClaimCenter calculates the net amount of a check as the gross amount minus the total deductions of the check.
- During check integration, the amount that is sent to the check printing system to be printed must be the net amount of a check.
- The gross amount continues to be reflected in ClaimCenter financials because the deduction will eventually be sent to a tax authority or other third party. The gross amount is the true cost on the claim.

The topics that follow describe in detail how deductions are handled by ClaimCenter.

Check Deductions

A Check can have one or more Deduction entities, each of which indicates an amount to be deducted from the check's amount. These Deduction entities are created for each check by a plugin implementation of one of the following plugin interfaces: either `IBackupWithholdingPlugin` or `IDeductionAdapter`.

You can write your own implementations of these plugin interfaces. The `IBackupWithholdingPlugin` plugin interface is preferred for creating all kinds of Deduction entities, even those not related to backup withholding. It is newer and easier to use than the `IDeductionAdapter` plugin interface. For more information, see “Deduction Plugins” on page 407 in the *Integration Guide*.

Backup Withholding Plugin

In the base configuration, ClaimCenter uses the plugin implementation `gw.plugin.taxframework.BackupWithholdingPlugin`. This class implements `IBackupWithholdingPlugin` and is registered with the `IBackupWithholdingPlugin` plugin registry. This plugin implementation provides support for backup withholding from checks. It calls the backup withholding utility class `gw.util.BackupWithholdingCalculator` to do the work. You can view and edit these Gosu classes if you want to understand or modify the behavior.

ClaimCenter Backup Withholding Behavior

ClaimCenter and the `BackupWithholdingPlugin` plugin implementation behave as follows in the base configuration.

1. The following settings on the first step of the `New Check` wizard determine if ClaimCenter can deduct income tax from the check:

- A payee `Type` of `Vendor`, which is stored in the `Check.Payee.PayeeType` field
- A `Report As` value of `Reportable`, which is stored in the `Check.Reportability` field

For more information, see “Deducting from Checks” on page 307.

2. After the user enters payment information on the second step of the `New Check` wizard and clicks `Next`, ClaimCenter runs the `BackupWithholdingPlugin` plugin. It inspects the payees on the check and deducts backup withholding if:

- The `Check.Payee.PayeeType` field is `vendor`.
- `Check.Reportability` field is `reportable`.
- Either of the following is true:

The vendor on the check has a `Contact.WithholdingRate` value. In this case, this custom withholding rate is used to calculate the backup withholding amount, and there is no need to check the next condition.

The vendor on the check has a `Contact.TaxStatus` value that is not `confirmed`—it is either `unconfirmed` or `unknown`. In this case the `StandardWithholdingRate` as defined in the `config.xml` file is used to calculate the backup withholding amount.

There are three configuration parameters in the `config.xml` file that affect deductions:

- `BackupWithholdingTypeCode` – Default value is `irs`.
- `CalculateBackupWithholdingDeduction` – Default value is `true`.
- `StandardWithholdingRate` – Default value is a percentage, `28.0`.

For more information, see “Deduction Parameters” on page 51 in the *Configuration Guide*.

Check Deductions Versus Multiple Payee Checks

As described at “Deducting from Checks” on page 307, deductions are one way to reduce the final amount of a check and collect money to send to a third party. Creating a multiple payee check is another way to reduce the final amount of the primary check and send money to a third party. You create a multiple payee check in the `New Check` wizard by clicking `Add Payee`, and thereby creating a secondary check that is part of a check group. For more on multiple payee checks and check groups, see “Types of Checks” on page 301.

Note: Neither of these approaches modifies the total of payments reflected in ClaimCenter financials. The deducted amounts are going to a third party, and the payment amounts reflect the true cost on the claim.

Take the following into consideration when deciding how to reduce a check's amount:

- A secondary check creates a separate `Check` entity that can be escalated downstream and result in printing a check or sending an EFT payment.
- Some functions of ClaimCenter cannot be performed on multiple payee checks, or are limited in their scope. For example:
 - You cannot transfer multiple payee checks to another claim.
 - If you void or stop one check in a check group, you void or stop all checks in that group. However, you can reissue a single check in a check group.
- The deduction plugin is called every time the check is edited in the `New Check` wizard. Any current deductions are retired, and new `Deduction` entities returned by the plugin are added to the check.
- Deductions are usually used with deducted amounts where the `Deduction.DeductionType` field clearly indicates the destination, such as the `irs` typekey for backup withholding. In this case a separate, secondary

check is not required to deliver the money. For example, a check is escalated that contains IRS deductions, and integration code notifies a downstream system that tracks backup withholding and sends a monthly payment to the tax agency.

See also

- “Reissuing Checks” on page 305
- “Transferring Checks from One Claim to Another” on page 305
- “Voiding or Stopping Checks” on page 306
- “Check Integration” on page 372 in the *Integration Guide*

Negative and Zero Dollar Checks and Payments

You can create negative and zero dollar checks and payments. See “Negative and Zero Dollar Transactions and Checks” on page 300.

Bulk Invoice Checks

Checks associated with bulk invoices cannot be edited, cloned, reissued, or deleted. Voiding or stopping a bulk invoice check also voids or stops all the bulk invoice’s payments. See “Bulk Invoice Checks” on page 363.

Effect on Checks of Closing a Claim or Exposure

When a claim or exposure is closed, any associated checks in **Awaiting Submission** status are automatically escalated.

Supplemental checks are not escalated.

Electronic Funds Transfer (EFT)

You can perform financial transactions electronically. These transactions are known as *electronic funds transfers*, or EFTs. In ClaimCenter, you work with EFTs mainly in the context of a contact. The topics that follow describe areas of ClaimCenter you can use to add bank data to a contact.

Note: The following topics refer to ContactManager, which, when integrated with ClaimCenter, provides centralized management of your claim contacts and vendors. For more information, see “Integrating ContactManager with Guidewire Core Applications” on page 45 in the *Contact Management Guide*.

New Claim Wizard

Navigate to the **New Claim** wizard and, under **Basic Info**, select either **New Person** or **Edit Contact**. At the bottom of the screen you can add EFT information under the **Bank Data** section.

This EFT information is duplicated in ContactManager to keep contact information synchronized. Since the array is available at the **Contact** supertype, the EFT information is available for all subtypes. However, it has not been exposed for the **Place** subtype.

New Check Wizard

In the **New Check** wizard, you can select EFT as a payment option and then select from one of the registered EFT accounts for the payee. The selected account data is copied to the check object to maintain an audit trail in case the contact is resynchronized with ContactManager and EFT information has changed.

Note: EFT is also available on FNOL Auto First and Final and Quick Check, but it is not exposed on a manual check.

New Person

If ClaimCenter is integrated with ContactManager, you can create a new contact with one or more EFT accounts, one of which can be marked as primary. Navigate to **Address Book** → **Actions** → **New Person**.

EFT Data Model

The following diagram illustrates the relationship between the EFTData entity and other related entities. Not all fields are listed in the diagram, only key ones that have impact on how the EFT data moves.

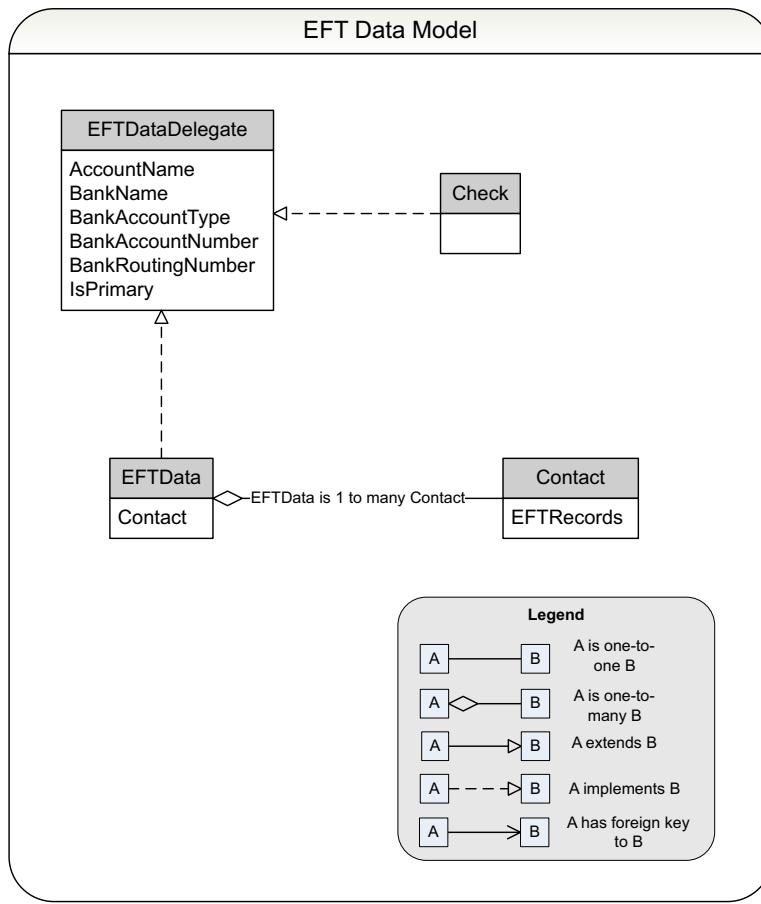


Diagram Specifics

- The entities EFTData and Check implement the EFTDataDelegate entity.
- The delegate EFTDataDelegate is defined in the base data model with no columns in it. All the columns are defined in extensions. This makes it configurable.
- EFTData has a non nullable Contact foreign key. Contact has an array called EFTRecords of EFTData.

Note: GWCheckEnhancement has the property EFTData with a Gosu setter and getter to copy EFT data from a contact to a check. These properties must be extended synchronously with any changes to the EFTDataDelegate entity.

Recoveries and Recovery Reserves

Recoveries and recovery reserves are analogous to payments and reserves, respectively, but refer to money received, rather than paid out, in the course of settling a claim.

This topic includes:

- “[Recoveries](#)” on page 311
- “[Recovery Reserves](#)” on page 311
- “[Modifying Recovery Records](#)” on page 313

Recoveries

A *recovery* is a transaction that accounts for money received by the carrier to help settle a claim. Recoveries can come from a variety of sources. Among them are:

- **Salvage** – If a claimant receives payment for a completely destroyed vehicle, the carrier can get back some of its cost by selling the vehicle for scrap.
- **Subrogation** – Money recovered by a carrier taking action against a liable party. For example, a carrier can pay its insured for vehicle damages, and then collect from the at-fault driver.
- **Deductibles** – Money that the insured must pay to satisfy the policy terms and conditions.

ClaimCenter reports Total Recoveries that have been received.

Recoveries are tracked separately from reserves and payments. Recoveries are included in the financial calculation **TotalIncurredNet** because they reduce total liability for the claim. The **Total Incurred** field at the top of the **Financials** screen is the Total Incurred Net value, which subtracts recoveries. For more information, see “[Definitions of Total Incurred Calculations](#)” on page 292.

Note: You can also create a negative recovery if it does not result in negative total recoveries on the reserve line or the claim. For example, you might have received a check for a recovery that was written for too large an amount, but was already deposited and entered in the system. Entering a negative recovery is one way you might handle accounting for the refund. For more information on negative transactions in general, see “[Negative and Zero Dollar Transactions and Checks](#)” on page 300.

Recovery Reserves

Recovery reserves are estimates of how much money might be recovered from others in settling the claim. They are analogous to reserves, but for recovery transactions instead of payments. They are estimates of the amounts likely to be received that diminish the carrier’s liability on a claim. Similar to all transactions, they are categorized by their unique reserve line.

Although permissions are needed to view, create, edit, or delete recoveries and recovery reserves, the permissions are assigned to all roles.

Recovery reserves are related to one reserve line. Recoveries and recovery reserves have an additional attribute, recovery category, similar to cost category but not part of the reserve line, that can further define them. For more information, see “[Assigning a Recovery Category](#)” on page 312.

Recovery Reserve Offsets

After a recovery is received, it decreases the open recovery reserve associated with that reserve line. This calculation, Total Recovery Reserves minus Total Recoveries, is analogous to payments’ decreasing open reserves.

If a recovery reserve does not exist or is not sufficient, a received recovery generates a matching recovery reserve to keep Open Recovery Reserves from becoming negative. This offset recovery reserve transaction also increases the Total Recovery Reserve.

This process is similar to the one in which a payment that exceeds reserves creates a reserve offset that keeps Open Reserves positive and so increases the matching Total Reserves. There is no configuration parameter for recovery reserves that is analogous to `AllowPaymentsExceedReserves`. You can always receive money to reduce a claim's cost.

If a received recovery is voided, the associated recovery reserve offset is also rolled back. The Total Recovery Reserve decreases by the previous offset amount and the Open Recovery Reserves return to the values they had before the recovery was created. Again, this process is analogous to what happens when payments exceed reserves.

The following table shows how these values can change for specific recoveries:

Claim is opened and no recoveries are expected			
Total Recovery Reserves	Open Recovery Reserves	Recoveries	Net Total Incurred
\$0	\$0	\$0	\$0
An unexpected recovery check is received			
Total Recovery Reserves	Open Recovery Reserves	Recoveries	Net Total Incurred
\$500	\$0	\$500	\$-500
Receive recovery check is voided			
Total Recovery Reserves	Open Recovery Reserves	Recoveries	Net Total Incurred
\$0	\$0	\$0	\$0

Configuring Recovery Reserves

You can configure ClaimCenter to suppress recovery reserves by setting the `UseRecoveryReserves` configuration parameter in the `config.xml` file to `false`.

You can also create recovery reserve transactions to track the expected level of recoveries in the future. As described previously, recovery transactions reduce the value of open recovery reserves. You can use and display the calculation `TotalIncurredNetRecoveryReserves` if you have a high confidence that all recovery reserves will be recovered. In this case, this calculation gives a more accurate and earlier indication of carrier liability. For more information on configuring financial calculations, see “ClaimCenter Financial Calculations” on page 619 in the *Configuration Guide*.

Assigning a Recovery Category

A recovery or recovery reserve transaction can be assigned a recovery category, which further categorizes the transaction beyond the standard `ReserveLine` components. In the base configuration, the `RecoveryCategory` property can have one of the following values: Credit to expense, Credit to loss, Deductible, Salvage, or Subrogation. These values are the names of typecodes defined in the `RecoveryCategory` typelist.

On a single reserve line, you can add transactions with more than one recovery category.

Because ClaimCenter tracks financial calculation amounts only at the reserve line level, you cannot normally access recovery totals based on the `RecoveryCategory` property. However, it is possible to filter amounts using the `RecoveryCategory` property for the `Total Recoveries` calculation only. For example, the following code would return the total amount of recoveries for a particular the `RecoveryCategory` property on the given claim:

```
FinancialsCalculationUtil.getTotalRecoveries().getAmount(claim, recoveryCategory)
```

Note: The `getAmount` methods that take a `recoveryCategory` argument use only transactions that have been saved to the database, which is different from the other `getAmount` methods. See “Different Ways to Retrieve an Amount” on page 622 in the *Configuration Guide*.

Modifying Recovery Records

To make corrections to recovery records, you can either recode or transfer a recovery.

This section includes:

- “Transferring a Recovery” on page 313
- “Recoding a Recovery” on page 314

Transferring a Recovery

You would need to transfer a recovery if someone entered a recovery amount on the wrong claim, and you need to associate it with the correct, and different, claim. It does not matter if the claims are closed.

Transferring a recovery does the following:

- Creates an offset recovery on the same reserve line.
- Creates an onset recovery on the new claim and reserve line.
- Sets the original recovery's status to Pending Transfer.

Setting the configuration parameter `UseRecoveryReserve` in the `config.xml` file to `true` has the following effects on recovery transfers:

- If a recovery has a zeroing offset recovery reserve, transferring this recovery creates a recovery reserve in the negative amount of that zeroing offset.
- A zeroing recovery reserve is created on the onset recovery's reserve line, if necessary.

The recovery status changes from Pending Transfer to Transferred after it is acknowledged by the downstream system.

To transfer a recovery

1. Navigate to a claim's **Financials** screen and click the **Transactions** tab to open that screen.
2. Set the filter to **Recoveries** to help identify which recovery is to be transferred, and then click the amount in the **Amount** column.
The **Recovery Details** screen opens.
3. Click **Transfer** to open the **Transfer Recovery** screen.
4. On the **Transfer Recovery** screen, find the targeted claim or enter the claim number if you know it.
If you search, you can select the claim from the active database or the archive, and you can enter a variety of parameters to narrow your search. View the search results in the bottom section of the screen.
5. Select the targeted claim and click **Select** to return to the **Transfer Recovery** screen.
6. On the **Transfer Recovery** screen, choose the **Reserve Line** from the drop-down list or create a new one.
7. Enter the **Exposure**, **Cost Type**, and **Cost Category**, then click **Transfer**.

Your changes are reflected in the **Financials → Transactions** screen. The status is Pending Transfer.

Note: If multicurrency is enabled, you can also select the **Reserving Currency**.

If the **Transfer** button is disabled, the following are typical causes:

- The recovery is an offset recovery, which cannot be transferred.
- The recovery has one of the following statuses: Transferred, Pending Transfer, Recoded, or Pending Recode.
- You do not have **Edit recoveries** permission.

Multicurrency and Transferring a Recovery

You can use the following indicators to determine the exchange rate used when you transfer a recovery:

- If the claim selected for the transfer has the same claim currency as the original claim currency, no exchange rate information displays. The same trans-to-claim exchange rate is used for the onset recovery.
- If the claim selected for the transfer has a different claim currency and the claim's currency is the same as the recovery's currency, no exchange rate information shows.
- If the target claim has a different claim currency and the claim's currency is different from the recovery's currency, ClaimCenter displays exchange rate information. The entered information is applied as the transaction-to-claim exchange rate for the onset recovery.

For more information, see “Multiple Currencies” on page 335.

Recoding a Recovery

Recoding a recovery is similar to transferring a recovery, but with a slight difference: You are assigning to the correct reserve line on the same claim. Recoding enables you to correct clerical mistakes.

Recoding has the following effects:

- Creating an offset recovery on the same reserve line.
- Creating an onset recovery on the new reserve line.
- Setting the original recovery's status to Pending Recode.

Note: Offset recoveries cannot be recoded. Recoveries with the following statuses also cannot be recoded: Transferred, Pending Transfer, Recoded, and Pending Recode.

If the configuration parameter `UseRecoveryReserve` in the `config.xml` file is set to `true`, a recovery has a zeroing offset recovery reserve. The recoding process creates a recovery reserve in the negative amount of that zeroing offset. There is also a zeroing recovery reserve created on the onset recovery's reserve line, if necessary.

The recovery status changes from Pending Recode to Recoded after it is acknowledged by the downstream system.

To create and then recode a recovery

1. Open a claim and click the **Financials** menu item on the left to open the **Financials: Summary** screen.
2. Click the **Actions** menu and, in the **New Transactions** section, click **Other → Recovery** to open the **Create Recovery** screen.
3. Select the **Payer** and the **Reserve Line** from those drop-down lists.
4. Enter an amount and click **Update**.
5. Click the recovery to open the **Recovery Details** screen.
6. Click **Recode** to open the **Recode Recovery** screen.
7. Change the **Reserve Line** by using the drop-down list, and then click **Recode** again.

Your changes are reflected on the **Financials → Transactions** tab. The status is Pending Recode.

Working With Transactions and Checks

You can quickly navigate in ClaimCenter to reach all screens that display existing transactions and checks, and all screens where you have the correct permissions to edit. This topic describes how to access and work with transactions and checks.

Viewing a Summary of a Claim's Existing Transactions

To view all transactions on a specific claim, do the following:

1. Navigate to a claim and open it.
2. Click the **Financials** menu item and select either the **Transactions** or **Summary** tab.

The Transactions View

If you select **Transactions**, you see a table showing all the claim's transactions of one type. To define the transaction type shown in the table, choose one of the following from the drop-down list: **Payments**, **Reserves**, **Recoveries**, or **Recovery Reserves**.

You can sort each table of transactions by any column by clicking that column's title. To view the details of any transaction, select its amount.

The drop-down list shows a **Custom** option that is not intended for your use. When you select a transaction from a table of transactions, the view becomes **Custom**.

The Summary View

If you select **Summary**, you see a condensed version of all transactions and checks. To further organize the contents of the **Summary** tab, choose one of the following items from the drop-down list in the upper left:

- **Claimant** – Organize this tab to show all transactions for each claimant.
- **Exposure** – Show all transactions for each exposure together.
- **Exposure Only** – Show all transactions by exposure. Do not show claim-level transactions.
- **Coverages** – Show all transactions for each coverage on the policy.
- **Claim Cost Only** – Same as **Exposure**, but with no claim expenses, such as a car appraiser's cost.

There is no option to view payments. They show next to the checks that make them.

Viewing Existing Checks

To view all checks on a specific claim:

1. Navigate to a claim and open it.
2. Click the **Financials** menu item and click the **Checks** tab.
3. A screen showing all checks written on the claim opens. The checks are sorted by **Check Number**, and for each check you can see **Pay To**, **Gross Amount**, **Issue Date**, **Scheduled Send Date**, **Status**, and **Bulk Invoice** number.

You can sort each table of transactions by any column by clicking the column's title. To view the details of any transaction, click its **Gross Amount**.

Creating a New Transaction or Check

To create a new check or transaction

1. Navigate to a claim and open it.
 2. Select **Actions** and, under the **New Transaction** section, select one of the following transaction types:
Reserve, **Check**, **Other → Manual Check**, **Other → Recovery**, or **Other → Recovery Reserve**.
- Note:** You can also create a check through the quick check option.

To create checks against a reserve you have selected

1. Navigate to a claim and open it.
2. Click the **Financials** menu item and select **Transactions → Reserves**.
3. Click a reserve **Amount**, and then click **Create Check**.

To create recoveries against a particular payment or recovery reserve

1. Navigate to a claim and open it.
2. Click the **Financials** menu item on the left.
3. Click the **Transactions** tab and choose **Recovery Reserves** from the drop-down list.
4. Select a transaction and click **Create Recovery**.

Modifying a Transaction or Check

To modify any existing check or transaction, find it and display its details. Examples of modifications include **Edit**, **Delete**, **Recode**, **Reissue**, **Clone**, **Transfer**, **Stop**, **Void**, and **Deduct**. Each screen has buttons only for modifications allowed for that check or transaction.

How Transactions Affect Financial Values

This example shows how transactions on the same reserve line change main financial values.

As eroding payments are made, reserves decrease, but non-eroding payments do not affect reserves. To see the sum of all non-eroding payments, subtract Total Eroding Payments from Total Payments. You obtain Total Eroding Payments by subtracting Open Reserves from Total Reserves. See “ClaimCenter Financial Calculations” on page 329.

ClaimCenter displays reserves in a manner that best conforms to your business practices. You generally see either Remaining Reserves and Future Payments, or Open Reserves, their sum. You can optionally display Available Reserves or Total Incurred.

Total Reserves	Open Reserves	Remaining Reserves	Future Payments	Total Payments	Recoveries	Net Total Incurred	Available Reserves
Initial reserve created for \$500; requires approval							
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
The reserve is approved							
\$500	\$500	\$500	\$0	\$0	\$0	\$500	\$500
<i>Eroding Payment is scheduled for \$300 at the end of the month; requires approval</i>							
\$500	\$500	\$500	\$0	\$0	\$0	\$500	\$200
Eroding Payment is approved							
\$500	\$500	\$200	\$300	\$0	\$0	\$500	\$200
End of the month arrives and \$300 eroding payment is made							
\$500	\$200	\$200	\$0	\$300	\$0	\$500	\$200
Non-Eroding Payment of \$50 is approved for payment today (has Awaiting Submission status)							
\$500	\$200	\$200	\$0	\$350	\$0	\$500	\$200
Non-eroding Payment of \$50 is made (has Submitting status)							
\$500	\$200	\$200	\$0	\$350	\$0	\$550	\$200

Total Reserves	Open Reserves	Remaining Reserves	Future Payments	Total Payments	Recoveries	Net Total Incurred	Available Reserves
Recovery of \$100 is received							
\$500	\$200	\$200	\$0	\$350	\$100	\$450	\$200

Lifecycles of Financial Objects

ClaimCenter uses status values to identify and control the flow of transactions and checks, from creation and approval to their subsequent submission to an external accounting system.

Transactions and checks pass through similar statuses as they pass through ClaimCenter. The following three statuses define where checks and transactions are in their lifecycles:

- **Approval Status** – Defines when a requested check or transaction has been approved or rejected. See “Approval Status” on page 317.
- **Check Status** – Defines when a check is written, approved, issued, cleared, or canceled. See “Lifecycles of Checks” on page 321.
- **Transaction Status** – Defines when a transaction passes through statuses similar to those of a check. See “Lifecycles of Transactions” on page 319.

These statuses also determine whether and how a transaction or check can be modified. Because ClaimCenter shares financial information with one or more external accounting systems, these statuses also synchronize transactions and checks with their statuses in those systems. A change in any of these statuses can trigger events in ClaimCenter. You can write business rules that run when a specific status change occurs.

Approval Status

Both checks and transactions always carry one of the following approval statuses:

- **Unapproved** – Entered or being entered into ClaimCenter by someone who does not have approval authority.
- **Approved** – Given permission to remain in ClaimCenter.
- **Rejected** – Not given permission to remain in ClaimCenter.

All financial entities—transactions and checks—move from Unapproved to Approved when their transaction statuses change from Pending Approval to Awaiting Submission.

Transaction Status and Check Status

Transaction status and check status are similar. They are visible in the user interface, and you can write Gosu code in rules to use them. The main differences are:

- Submitting and Submitted transactions are equivalent to Requesting and Requested checks.
- Payments and checks can move—be transferred—between claims. However, only payments can move—be recoded—to another reserve line.

Normal Lifecycle Events

During the early parts of their lifecycles, checks and all transactions have the same lifecycle. While being created, they are in Draft status. After they are first saved, they get Pending Approval status. After the checks or transactions are approved, the status changes to Awaiting Submission, or if the approver declines, Rejected status. During these stages, these entities belong to ClaimCenter alone, so you can edit and delete them. Finally, the transaction is given Submitting status and is sent to the external accounting system integrated with ClaimCenter, which returns the Submitted acknowledgement.

A check goes through a similar lifecycle, substituting Requesting and Requested status for Submitting and Submitted. After the downstream system returns the requested acknowledgment, it issues the check and sends Issued and Cleared notifications back to ClaimCenter.

Recoveries can be recoded and transferred and have a slightly different lifecycle. See “Modifying Recovery Records” on page 313 for details.

Unusual Lifecycle Events

Checks, payments, and reserves can deviate from their normal lifecycle if they are modified or canceled. Other statuses describe these changes.

The unusual lifecycle events are:

- **Recode** – Move a payment or recovery, or check, if all its payments have been recoded, to another reserve line. Bulk invoice checks cannot be recoded.
- **Reissue** – Correct a single check in a group of checks without having to void or stop all checks in the group.
- **Transfer** – Move a payment, a check, or a recovery to another claim.
- **Void or Stop** – Cancel a payment, reserve, check, or recovery already sent to a downstream system.

See also

- For details of these statuses and the allowed transitions between them, see “Payment Transaction Integration” on page 381 in the *Integration Guide*.
- “Check Integration” on page 372 in the *Integration Guide*.

Voiding Versus Stopping a Check

Typically you void a check that you can physically rip up, and stop payment on it when it is no longer in your possession. Except for manual checks, ClaimCenter cannot always determine whether to void or stop a check, and so provides both options. You can also void recoveries.

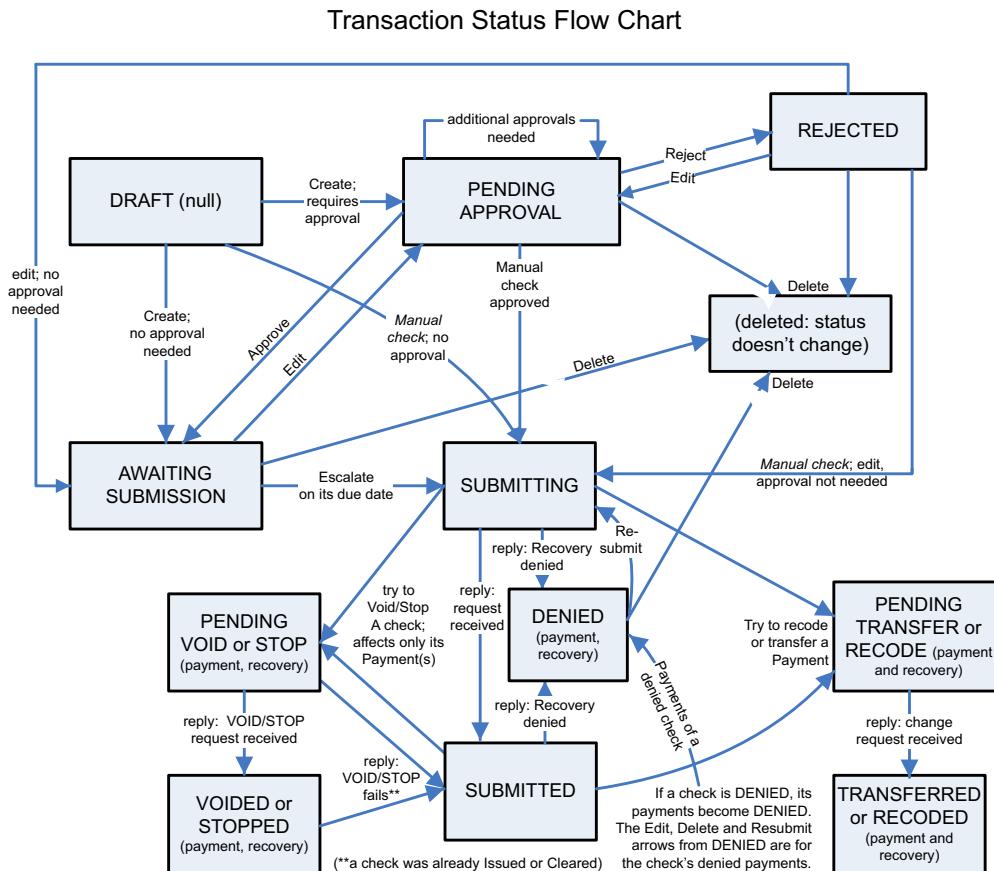
If you stop or void a check that is part of a check group, you also stop or void all checks in that check's check group. Any checks that are part of other check groups, even other check groups that are in the same check set, are not affected by the stop or void.

If you request to stop or void a check in the user interface, you cannot know its actual status. The downstream system might already have issued the check, and the check might even have been cashed. In all cases, ClaimCenter assumes that your action was successful and creates an offsetting transaction, called an *offset*. This transaction reverses the check amount. If the downstream system then notifies ClaimCenter that the check was indeed issued or cashed, ClaimCenter responds by creating yet another transaction, an *onset*, that reverses the offset. Voiding or stopping a final check returns the reserve to the original value it had before the final check made it zero.

If a check is transferred to another claim, ClaimCenter creates an offset and an onset at the same time. It does so by subtracting the amount from the original claim and adding it to the new one. ClaimCenter is configured to display the check transfer information in both the old and the new claims.

Lifecycles of Transactions

The following diagram and table summarize all transaction statuses and how they relate to approval status:

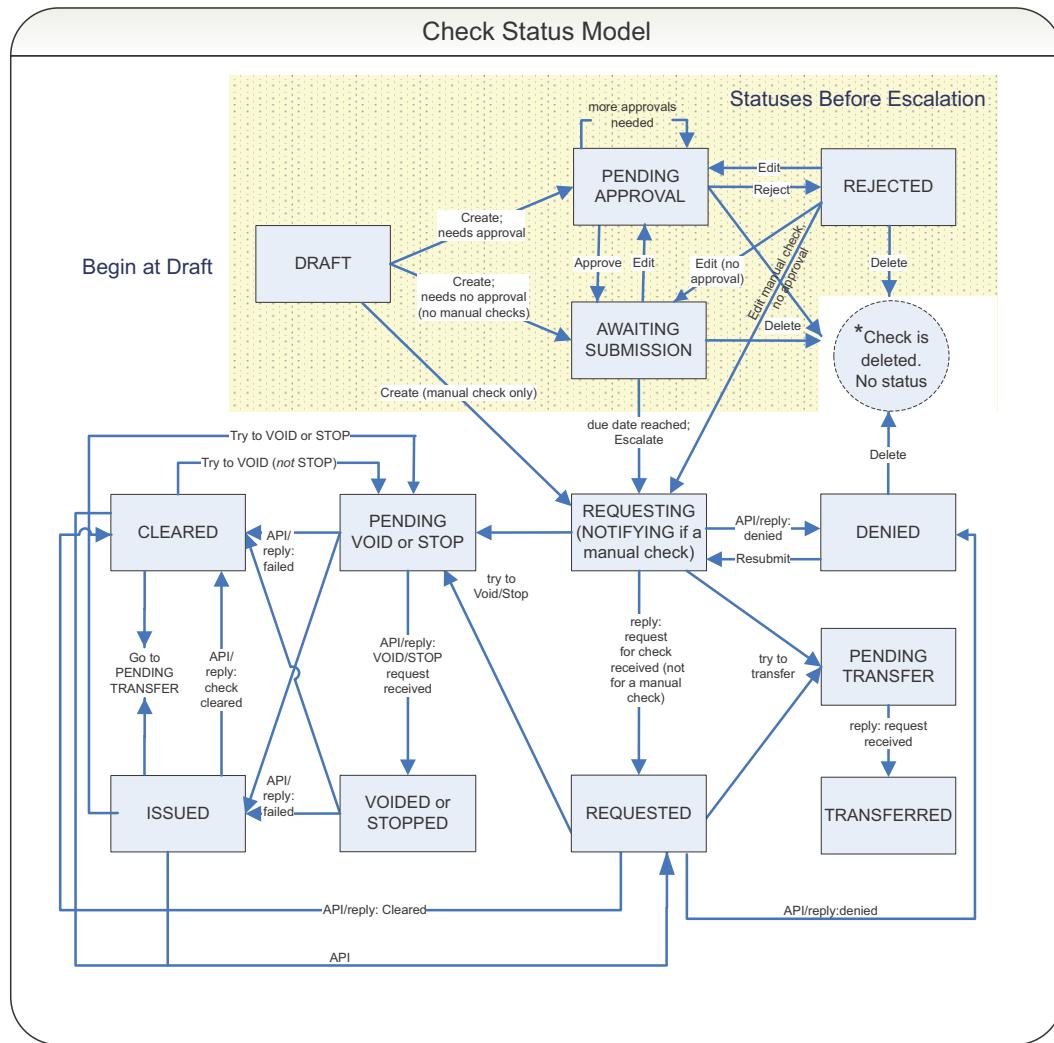


Approval status	Transaction status	Delete, Edit?	Comment
Unapproved	null (Draft)	yes	When finished, moves to Pending Approval.
Unapproved	Pending Approval—payments and reserves only	yes	On approval, moves to Awaiting Submission.
Approved	Awaiting Submission—payments and reserves only	yes	In queue, unsent to downstream system because transaction date not reached, or a current date, to be sent later.
Approved	Submitting	no	Transaction date reached, sent downstream today.
Approved	Submitted	no	Downstream reply, transaction received.
Approved	Pending Void—payments and recoveries only	no	The messaging plugin sends a request downstream to void the check. Not in the base configuration—you must set this up.
Approved	Voided—payments and recoveries only	no	Downstream reply that the transaction is voided.
Approved	Pending Stop—payments only	no	The messaging plugin sends a message downstream to stop the check. Not in the base configuration—you must set this up.

Approval status	Transaction status	Delete, Edit?	Comment
Approved	Stopped—payments only	no	Downstream acknowledgement that a stop occurred.
Approved	Pending Transfer—payments and reserves only	no	Notify downstream system to move it to another claim.
Approved	Transferred—payments and reserves only	no	Downstream reply—transfer notification received.
Approved	Pending Recode—payments and recoveries only	no	Move to another reserve line, notification sent.
Approved	Recoded—payments and reserves only	no	Downstream reply—recode notification received.
Rejected	Rejected	yes	Through Pending Approval—edit or delete only if claim open.
Approved	Denied—payments and recoveries only	no	For recoveries only—a reply from downstream.

Lifecycles of Checks

The following high level flow diagram and table summarize all check statuses and how they relate to approval status. Bulk invoice checks are not included in the diagram or the table.



Notes

- Some statuses advance either by SOAP APIs or through the user interface, which the diagram does not show explicitly. See:
 - "Financial Transaction Status and Status Transitions" on page 363 in the *Integration Guide*
 - "Check Integration" on page 372 in the *Integration Guide* for details.

- To modify a Denied check you must clone it.

Approval	Check Status	Edit?	Delete	Comment
Unapproved	Draft	yes, from cloned or reissued checks	yes	Saving the entity changes the status to Unapproved.
Unapproved	Pending Approval	yes, including recurrence settings	yes	Waiting for approval.
Approved	Awaiting Submission	yes, except payments, recurrences	yes	Approved, in queue to go downstream.
Approved	Requesting	no, but can reissue after stop/void	stop, void	Issue date reached and check request sent.
Approved	Requested	no, but can reissue after stop/void	stop, void	Downstream acknowledgement of check request.
Approved	Issued	no, check is issued	stop, void	Notification to ClaimCenter—check issued.
Approved	Cleared	no, check cashed or EFT completed	void only	Notification to ClaimCenter—check cleared. Not many integrations find this void only operation useful.
Approved	Notifying	no, for manual checks only, sent instead of Requesting	stop, void	Notification to ClaimCenter—check issued.
Approved	Pending Void	no	no	Void attempt sent downstream. Most integrations will use stop or void but not both.
Approved	Voided	no	no	Notification to ClaimCenter—check voided. Most integrations will use stop or void but not both.
Approved	Pending Stop	no	no	Stop attempt sent downstream. Most integrations will use stop or void but not both.
Approved	Stopped	no	no	Notification to ClaimCenter—check stopped. Most integrations will use stop or void but not both.
Approved	Pending Transfer	no, moving to another claim	no	Transfer attempt sent downstream.
Approved	Transferred	no	no	Sent to ClaimCenter—check transferred.
Approved	Reissued	no	no	From Stop/Void, Reissued, Pending Approval.
Rejected	Rejected	yes, all fields, if claim open	yes	From Pending Approval if Unapproved. From Requesting if NSF, or from Issued if payee rejects it.
former status	Denied	no	yes	Reply from downstream—affects Payments

Manual checks do not normally require approval and go directly to Notifying status. They cannot reach Pending Approval, Awaiting Submission, or Rejected status unless you write custom approval rules. You can also transfer a manual check in Notifying or later statuses, just as with a normal check.

Note: In the diagram, reply indicates that a transition changed from the downstream system. The `IClaimFinancialsAPI` can also change the status of the check where API is noted in the diagram.

Downstream Denials of Recoveries and Checks

A downstream system might refuse to issue a check or receive a recovery due to criteria it verifies against the requested check or recovery. For example, your check writing or general ledger system might be required to compare all check payee names against the Office of Foreign Assets Control (OFAC) watch list. This list has all persons who are barred from receiving or sending monetary payments. In this case, the downstream system can

tell ClaimCenter to deny the check through a message reply or web service call. The check then moves from Requested status to Denied status.

Note: Set up ClaimCenter so that denial of a check or recovery is a rare thing. As much as possible, incorporate all criteria for preventing inappropriate transactions into your ClaimCenter configuration rules so that they are caught and prevented as early as possible.

Recoveries and payments are the only type of transaction that can be denied. Payments are denied when the check that pays them is denied. Reserve and recovery reserve transactions cannot be denied, so any potential limitations from downstream systems on these transactions must also be enforced in ClaimCenter.

Denying a Check or Recovery

A Check or Recovery must be denied as soon as possible after being sent downstream. A check cannot be denied after it has been issued or cleared.

Only recoveries in Submitted or Submitting status can be denied. Similarly, only checks in Requesting or Requested status can be denied. Manual checks can also be denied when in Notifying status.

Denial occurs when the downstream system sends ClaimCenter a denial notification. This notification can occur in several ways:

- The downstream system can use the `denyRecovery` and `denyCheck` methods in `IClaimFinancialsAPI` to asynchronously notify ClaimCenter after the downstream system has received the recovery or check request.
- The `Recovery.denyRecovery` and `Check.denyCheck` methods can be called from a plugin-based message handler. This approach supports the use case of having the downstream system set a flag on the acknowledgement to the `RecoverySubmitted` or `CheckRequested` message. The message handler can then call the appropriate domain method to perform the denial.
- Gosu rules can use the `Recovery.denyRecovery` and `Check.denyCheck` methods.

Denied Recoveries

After a recovery is denied, the following happens in ClaimCenter:

- The recovery's status is set to Denied. On the **Claim → Financials → Recovery Details → Transactions** screen, the **Status** field is set to **Denied**.
- A new activity using the `recovery_denied` activity pattern is assigned to the user who created the recovery.
- The Recoveries T-account is credited and the Cash-In T-account is debited to reverse the recovery's balance contributions.
- Any zeroing offset recovery reserve that had been created for the Recovery will be retired.
- ClaimCenter automatically generates an offset Recovery Reserve to keep recovery reserves to zero if the following two conditions are true:
 - The Recovery's claim or exposure is already closed.
 - The Open Recovery Reserve value is zero for the Recovery's `ReserveLine`.
- Post-setup rules are executed for the recovery's `RecoverySet` and for the `RecoveryReserveSet` created to zero Open Recovery Reserves, if any.
- ClaimCenter prevents importing or adding the denied recovery to a staging table.

Take one of the following actions to respond to a denied recovery:

- Resubmit the recovery by using the **Claim → Financials → Transactions → Recovery Details → Resubmit** button, which is active only for denied recoveries. The new recovery then appears like any other recovery in this screen, with **Submitting** status.
- Delete the recovery by using the **Claim → Financials → Transactions → Recovery Details → Delete** button. Once deleted, you can create and edit another recovery.
- Do nothing. The recovery remains with its **Denied** status.

Denied Checks

To modify a denied check you must first clone the check and then edit the cloned check. The original denied check cannot be modified.

You can deny any single payee check, both recurring and non-recurring. You can also deny manual checks. You cannot deny a multiple-payee check. After you deny a check, the following things happen:

- The check's status is set to Denied. On the **Claim → Financials → Checks → Check Details** screen under the **Tracking** heading, the **Status** field becomes Denied.
- Each of the check's contributing payments is denied. A contributing payment is one that contributes to the gross check amount. Recoded and offsetting payments are not denied.
- ClaimCenter assigns a new activity using the **check_denied** pattern to the user who created the check.
- ClaimCenter executes post-setup rules for the check's **CheckSet**.
- You cannot import or add a denied check to a staging table.

ClaimCenter takes the following actions for all payments denied as a result of a check denial:

- Each payment's status becomes Denied.
- On each payment's reserve line, ClaimCenter credits the **Cash-Out T-account** and debits the corresponding **Committed eroding payments** or **Committed non-eroding payments** T-account, as appropriate, to reverse the payment's balance contributions.
- ClaimCenter retires any zeroing offset reserve that had been created for each payment.

Although you cannot edit a denied check directly, you can do the following.

- Resubmit the check by navigating to **Claim → Financials → Checks → Check Details** and clicking the **Resubmit** button. This button is active only for Denied checks. The new check is added to the screen with **Requesting** status.
- Modify the check by cloning it. After cloning the check, you can edit the clone and submit it through the normal processes. Cloning is configurable in the method **GWCheckEnhancement.resetCloneFields**.
- Delete the check by using navigating to **Claim → Financials → Checks → Check Details** and clicking the **Delete** button.

If you use the Deny Check feature, you must exercise care in allocating your check numbers. Resubmitting a denied check uses the same check number. Cloning a denied check to edit, and then resubmitting, clears out the check number. A new check number is allocated later. Cloning and resubmitting can also have a consequence, a missing check number.

However, denial of a check is meant to occur between the time the check is escalated and sent downstream and when it is issued by the check printing system. Allocating the check number and printing the check is normally an atomic action. After allocating a check number and printing the check, you could void the check if needed, but not deny it.

Denied Manual Checks

A manual check can be denied only if it is in **Notifying** status, which means it must be denied before its escalation message is acknowledged. ClaimCenter changes a manual check status from **Notifying** directly to **Issued** status upon message acknowledgement, when the **acknowledgeSubmission** method on the **Check** is called.

Closing a Claim or Exposure with a Denied Payment

After a check makes a final payment, ClaimCenter can close the associated exposure or claim if the configuration parameters **CloseClaimAfterFinalPayment** and **CloseExposureAfterFinalPayment** in the **config.xml** file are both **true**.

If a check with a final payment reaches Denied status:

- If the exposure was closed by the payment and the claim is still open, the exposure will be automatically reopened if the payment is denied.

- If both the exposure and claim were closed by the payment, both will be reopened when the payment is denied, first the claim and then the exposure.
- If the exposure or claim closed manually, or if the payment closed the exposure but the claim was closed manually, neither is reopened by the denial of the payment.
- If the claim or exposure or both remain closed after the denial of each payment, the system creates any necessary zeroing reserves to keep Open Reserves zeroed.
- If the claim or exposure or both are reopened due to the denial of a check, ClaimCenter adds a Reopened history event to the claim History. The reason for reopening is Payment Denied, a typecode of either the ClaimReopenedReason or ExposureReopenedReason typelist.

Financial Holds

ClaimCenter defines a *financial hold* as a way to mark a claim so that no indemnity payments can be made against it. A financial hold is different from simply keeping the claim from getting to the Ability to Pay validation level. A financial hold might be necessary to ensure that expense payments are made on the claim.

Applying Financial Holds to a Claim

In the base configuration of ClaimCenter, there are three ways that a claim can be marked for financial holds:

- **The claim's coverage is in question** – This condition exists when the **Coverage in Question?** field on the **Summary → Claim Status** screen is set to Yes. On the **Claim** entity, this field is **CoverageInQuestion**.
- **The claim is an incident-only claim** – This condition exists when the **Incident Only?** field on the **Summary → Claim Status** screen is set to Yes. On the **Claim** entity, this field is **IncidentReport**.
- **The claim policy is unverified** – This condition exists when the **Verified Policy** field on the claim's **Policy** screen is set to No. On the **Policy** entity, this field is **Verified**.

This behavior is configurable.

Note: Financial hold status is not stored in the database. The status is checked in rules as part of transaction validation. The status is also checked before initial reserves are created.

Coverage in Question

You can set the **Coverage in Question** field on the **Summary → Claim Status** screen either manually or automatically. Once set, the field can be cleared only by a user who has the **unsetcovinquestion** permission, typically a supervisor. In the base product, this permission is granted to the following roles:

- Claims Supervisor
- Manager
- New Loss Processing Supervisor
- Superuser

You can assign this permission as you like in your own configuration.

When the claim's coverage in is question, an icon showing a document overlaid with a question mark appears in the following locations:

- The **Info** bar
- The **High Risk Indicator** section of the claim's **Summary** screen

In the base configuration of ClaimCenter, the **Coverage in Question** field is automatically set in the following circumstances:

- Loss date is before the policy's effective date.
- Loss date is after the policy's expiration date.

- Status on the claim's Policy screen is something other than In force or Archived.

You can configure this functionality in Guidewire Studio in the **ClaimPreupdate** rule **CPU20000 – Coverage in question** and its children. See “Modifying the Automatic Setting of Coverage in Question” on page 656 in the *Configuration Guide*.

Incident Only

Sometimes the carrier receives information on claims that do not turn out to be claims. These claims are kept in case they later become claims. They are also kept for reporting purposes.

It is not always clear that claims are Incident Only when the claim is first filed. Before this status can be determined, some expenses might have been incurred, and it might be necessary to pay these expenses. Paying these expenses requires the use of financial holds rather than keeping the validation level below Ability to Pay.

In the base ClaimCenter configuration, the **Incident Only?** field on the **Summary → Claim Status** screen can be set only manually.

Unverified Claim Policy

ClaimCenter automatically marks the claim policy as Unverified in one of the following cases:

- The claim policy is edited in ClaimCenter.
- The claim's loss date is changed.

In these cases, the policy can no longer be deemed true to the policy snapshot that was taken from the policy system when the claim was filed. The only way to verify the policy again is to refresh the policy. For more information, see “Refreshing the Policy Snapshot on a Claim” on page 94.

ClaimCenter Handling of Financial Holds

When financial holds apply, ClaimCenter prevents any `claimcost` reserve or payment from being created or edited. Expense transactions are allowed, although ClaimCenter will warn the user that the claim is under financial hold. In the base ClaimCenter configuration, this functionality is enabled through transaction set validation rules.

Note: You can configure this functionality in Guidewire Studio in the transaction set validation rule **TXV15000 – Financial Holds** and its children. See “Modifying the Conditions for Applying Financial Holds” on page 657 in the *Configuration Guide*.

The base configuration of ClaimCenter also prevents any `claimcost` initial reserves from being created when financial holds apply. This functionality is handled by checking for financial holds status before creating initial reserves in rules in the **InitialReserve** rule set. These rules check the value of the `Claim.applyFinancialHolds` method. For more information, see “Modifying `claimcost` Initial Reserves” on page 657 in the *Configuration Guide*.

Integration with External Financial Systems

You typically integrate ClaimCenter with an external financial application that writes your physical checks. As you make a claim-related disbursement, you create the check information inside ClaimCenter. If a check with Awaiting Submission status reaches its issue date, or earlier if so configured, then ClaimCenter sends an escalation request to your check writing application. The check writing application in turn writes the actual check.

Transaction statuses and check statuses synchronize the communications between ClaimCenter and external accounting systems.

Financials Batch Processes

The following financials batch processes integrate ClaimCenter with external systems. Each has a specialized function:

- **Financials escalation** – Transmits checks that must be written to a check writing system, along with related accounting information.
- **T-account escalation** – Ensures that transactions inside ClaimCenter update all T-accounts and other internal financial values, so that the calculated values used throughout ClaimCenter are correct.
- **Bulk Invoice escalation** – Similar to financials escalation, but operates only on bulk invoice checks and their related payments and reserves.

See also

- “Configuring Checks and Payments” on page 654 in the *Configuration Guide* describes scheduling these batch processes.

Financials Escalation Process

The `financialsescalation` batch process moves checks whose send date has arrived to Requesting status. This process generates the `CheckStatusChanged` event, which ClaimCenter listens for and, when received, sends a request to the check writing system. After a check has Awaiting Submission status, if its issue date is today or earlier, this batch process escalates the check and its associated payments and reserves.

Specifically:

- T-accounts are updated.
- If needed, offsetting reserves are created. This change and any other associated reserve changes are given Submitting status. For example, if an eroding payment exceeds its open reserves, it requires an offset to keep its open reserves from becoming negative.
- If the payment is final and the exposure or claim can be closed, it will be.
- The check's status becomes Requesting, and a message to issue it can be sent to a check writing system.
- The check's payments' status become Submitting.
- Transaction post-setup rules run. If any result in a validation error or warning, ClaimCenter creates a reminder activity showing the errors. It then tries to assign the activity to the user that created the payment. If that assignment fails, ClaimCenter automatically assigns the activity. The activity's due date is today, its priority is Normal, and no escalation date is set.
- If the check is recurring and it is the second-to-last check to be submitted in the recurrence, ClaimCenter creates an activity. This activity alerts the user that the recurrence is ending soon.

The batch process `financialsescalation` by default runs daily at 6:05 a.m. and 6:05 p.m. If you want to escalate a check immediately, you can create a rule to do so by using the `Check.requestCheck` method.

Note: When entering the date for escalation, enter a day only, but not a time. If a time is present, the batch process delays escalation until the first time it runs on the next day.

Checks associated with a bulk invoice are escalated by the `financialsescalation` batch process only if their `PendEscalationForBulk` fields are set to `false`. If a check's `PendEscalationForBulk` field is `true`, the check is instead escalated by the `bulkinvoiceescalation` batch process. This field allows some bulk invoice checks to be processed normally. Others could be held, for example, so that other, newly arrived checks to the same vendor can be bundled with them. See “Bulk Invoice Escalation Process” on page 328.

T-Account Escalation Batch Process

The `taccountsescalation` batch process transitions payments and their offsetting reserves from `FutureDated` state to `AwaitingSubmission` state on the day that a future payment's `ScheduledSendDate` arrives. This process

updates certain financial calculations that include payments on checks scheduled to be sent today, financial calculations such as total reserves, open reserves, total payments, and so forth.

As the batch process runs, offsetting reserves are created if needed. This change and any other associated reserve changes are given Awaiting Submission status, which means that they can still be retired if their associated payments are retired or changed. For example, an eroding payment—a future-dated payment scheduled to be sent today—exceeds its available reserves. The eroding payment requires an offset to keep its available reserves from becoming negative.

The `taccountescalation` batch process updates T-accounts and summary financial values to reflect the fact that a check is going to be issued on that date, without the check's being issued. This update gives you time on the issue date of a check to make adjustments, while keeping summary financial values correct.

You can change the time when the batch process runs in the `scheduler-config.xml` file. In the base configuration, this process, `TAccountEsc`, is scheduled to run at 12:01 a.m. every day. If the server is down during this time, then manually run the process as soon as possible. The batch process exists primarily for configurations where financials escalation is configured to run only in the evening. In that way, on the day a check is scheduled to be sent, the financials calculations get updated in the morning. However, the check would still be editable until it was escalated in the evening.

Guidewire strongly recommends running this batch process as scheduled in the base configuration. Running the T-account Escalation batch process, while technically optional, affects financial totals on the **Financials Summary** screen. These totals might be wrong until the first run of the batch process, which successfully escalates any formerly future-dated checks.

See also

- “Foreign Exchange Adjustments in Custom Financials Calculations” on page 346

Using Financials Batch Processes

As described previously, in the default configuration, the batch process `financialsescalation` runs twice a day at 6:05 a.m. and 6:05 p.m. However, if your configuration does not run `financialsescalation` at 6:05 p.m. and the `taccountescalation` batch process runs at that time instead, there are likely to be inaccuracies. T-account entries and summary financial transactions would be incorrect from 6:05 p.m until 6:05 a.m. Running these batch processes at the default times makes the financial calculations correct for rules that reference them during the morning batch processes, such as the Claim Exception rules.

Depending on your implementation, you can schedule these two batch processes differently:

- Schedule one of these two processes to run before the calculated values need to be up to date.
- To keep checks editable for as long as possible during the working day, run the `taccountescalation` process soon after midnight. You can then schedule the `financialsescalation` process at your midday time or a few hours after your close of business.
- If you do not care about not being able to edit future dated checks that have reached their send date before `financialsescalation` runs, schedule `financialsescalation` to run just after midnight. You need not run `taccountescalation`.

Bulk Invoice Escalation Process

A separate batch process, `bulkinvoicesscalation`, affects bulk invoices. It changes the status of a bulk invoice's items from Awaiting Submission status to Submitting, and their associated checks to Requesting, when the Invoice reaches its send date. It also updates the checks and the check's payment. By default, this process runs daily at 6:35 a.m. and 6:35 p.m.

ClaimCenter Financial Calculations

ClaimCenter maintains a number of running totals of a claim's financial transactions and updates them as transaction statuses change. Guidewire refers to these running totals as financial calculations. You can use Gosu to manipulate this information and add it anywhere in the user interface. ClaimCenter can also send this information to external accounting systems. ClaimCenter pre-calculates—denormalizes—the calculations for quick retrieval from the database.

See also

- “Configuring ClaimCenter Financials” on page 611 in the *Configuration Guide*\
- “ClaimCenter Financial Calculations” on page 619 in the *Configuration Guide*

Financial Transactions Outside the User Interface

If you create financial transactions in the user interface, ClaimCenter does all the bookkeeping for you. It adjusts aggregate limits, updates all T-accounts, changes all summary financial amounts, and so on. You can also use Gosu to create financial transactions, or you can use the Transaction Presetup rule set.

For more information, see:

- “Transaction Set Presetup Rules” on page 61 in the *Rules Guide*
- “Creating Reserve Transactions Directly” on page 637 in the *Configuration Guide*
- “Creating Checks and Payments by Using CheckCreator” on page 637 in the *Configuration Guide*

Financials Data Model

The following table lists the key financials entities in the data model that you see in the ClaimCenter base configuration. Refer to the *ClaimCenter Data Dictionary* to see other financially related entities.

Entity or field	Description
Check	An entity that groups one or more payments made at the same time to a single payee or group of joint payees. ClaimCenter sends it to an external system to be printed, unless it is a manual check not created by the application.
CheckGroup	An entity that groups together a multipayee check, with a primary check and one or more secondary checks.
CheckSet	The entity that collects all Checks resulting from a single usage of the New Check wizard. It includes <i>all</i> issuances of a recurring Check and checks of a multipayee Check. It is a subtype of TransactionSet. All Checks belong to a CheckSet.
CostCategory	A Transaction field that categorizes a transaction. In the base configuration, the CostCategory typelist includes values that you can use as filters to support the various Lines of Business (LOBs)
CostType	A Transaction field that categorizes a transaction. In the base configuration, the CostType typelist includes the following typecodes: <ul style="list-style-type: none"> • aoexpense – Adjusting and other expense • claimcost – Actual loss payments to claimants or repairers • dcceexpense – Defense and cost containment legal expense • unspecified – Unspecified cost type
Deductible	The entity that tracks the amount, the coverage, and the status of the deductible, such as whether it has been paid or waived. One of the main fields on the Deductible entity is TransactionLineItem, which is a foreign key to TransactionLineItem.
Line Category	A field in a TransactionLineItem that categorizes the amount of that line item.
Payment	A subtype of Transaction representing money paid out. A payment can be eroding or non-eroding, depending on whether it draws down the reserves of its ReserveLine.
Recovery	An entity that records money that reduces a claim's liability, received from such sources as subrogation, salvage, other insurance, co-payments or deductibles. A Recovery object is a subtype of Transaction.
RecoveryReserve	An entity that records the amount of future expected recoveries. It is a subtype of Transaction.
Reserve	An entity that records a potential liability. It is a subtype of Transaction. A Reserve designates money to be set aside for payments. Typically, a reserve is set soon after a claim is made.
ReserveLine	An entity with a unique combination of Claim, Exposure, CostType, and CostCategory fields. Only Exposure can be null. Reserves or recovery reserves are created, or payments are made, or recoveries are applied against one ReserveLine.
Transaction	An entity that represents a financial transaction for a particular claim or exposure. It also contains a non-empty array of TransactionLineItem entities. Transaction is an abstract supertype. The ClaimCenter interface uses its subtypes: <ul style="list-style-type: none"> • Reserve • Payment • RecoveryReserve • Recovery Every transaction is made against a single ReserveLine object.
TransactionLineItem	An entity in every transaction that contains the amount of the transaction. Payment and Recovery transactions can have more than one Transaction Line Item. Use the LineCategory and Comments fields to describe a given Transaction Line Item's contribution to the total transaction amount.
TransactionOnset	This join entity contains a foreign key to the Transaction entity and represents the relationship between a transaction and its onset. It links a Transferred or Recoded transaction (Payment or Recovery) to its new onset transaction.

Entity or field	Description
TransactionOffset	This join entity contains a foreign key to the Transaction entity and represents the relationship between a transaction and its Offset. It links a Voided, Stopped, Recoded, or Transferred transaction (Payment or Recovery) to its new onset transaction.
TransactionSet	A collection of all transactions made at the same time and approved together. This collection can be, for example, a check and all the payments it makes. TransactionSet is an abstract supertype. The ClaimCenter interface uses the following sub-types of TransactionSet: <ul style="list-style-type: none"> • ReserveSet • CheckSet • RecoveryReserveSet • RecoverySet CheckSet is a subtype of TransactionSet. A check is not a Transaction. The checks in the set, while created at the same time, can be issued at different times and to different payees. You can also associate documents with a TransactionSet. All transactions (and checks) in a Transaction Set must be: <ul style="list-style-type: none"> • Approved together • Rejected together • In Pending Approval status together

Transaction Line Items and Their Line Categories

Transactions are always made against a single ReserveLine, which is defined by a unique Exposure, CostCategory, and CostType. These properties classify payments and not checks, which are not transactions. Typically, CostType is the primary division between claim costs and claim expenses, while a CostCategory is a subcategory of a CostType. LineCategory plays no role in defining a ReserveLine, but can be used to provide additional information about the line item amount.

Reversing Transactions: Offsets and Onsets

Sometimes, transactions must be reversed. Examples include a payment that was applied on the wrong reserve line and must be corrected or a check that needs to be voided or stopped. In each case, to maintain a complete trail, at least one of the following new transactions is created that affects the original one:

- **offset** – ClaimCenter creates a new payment with an amount equal to the negative of the original transaction's amount. This payment serves to cancel the original transaction.
- **onset** – In a recode or transfer, a new payment is created as a copy of the original transaction, except that it is associated with the new reserve line. An onset is not created for a payment that is successfully voided or stopped. However, if the void or stop of a check is unsuccessful for any reason, a new onset payment is created on the same reserve line to undo the offset.

Two entities, TransactionOffset and TransactionOnset, link the newly created offset and onset transactions. Each is associated with the original transaction.

TAccount Entities

ClaimCenter uses a subsystem of TAccount entities called *T-accounts* that support efficient calculation of totals for the financial calculations API. They denormalize the amount totals of transactions on each ReserveLine according to the transaction subtype, status, and other criteria. For example, the total of reserve transactions in Pending Approval status on a particular reserve line are stored as the balance on a particular Taccount row.

There is a parallel set of TAccount entities for RITransaction entities as well.

T-accounts are updated when the status of a transaction changes. This process happens internally during the setup phase, which occurs between the execution of the TransactionSetPresetup and TransactionSetPostsetup rule sets. The

process is also triggered when you call the `prepareForCommit` method on a `TransactionSet` or `CheckCreator` object.

IMPORTANT After its `TAccount` objects are updated, you must not modify key properties of a transaction, such as `Amount`, `ScheduledSendDate`, or `ErodesReserves`. These properties determine the `TAccount` object to which the transaction contributes and how much it contributes. For more information on updating these properties, see “Transaction Set Presetup Rules” on page 61 in the *Rules Guide*.

You do not need to access `TAccount` objects or their values directly. The financial calculations use this data to provide their answers.

The following data model entities are related to T-accounts.

<code>TAccount</code>	Represents all financial transactions of a certain category in a certain LifeCycle State, such as eroding payments made against a certain reserve line. T-accounts occur in pairs. For each debit account, such as <code>Submitted Reserves</code> , which holds the amount of a reserve, there is a matching credit account, such as <code>Cash Out</code> . One double-entry bookkeeping event affects one debit and one credit T-account. For example, a payment debits <code>Submitted Reserves</code> and credits <code>Cash Out</code> .
<code>TAccountLineItem</code>	The entry of a specific amount of money, either crediting or debiting one T-account. A <code>TaccountTransaction</code> contains a pair of balancing <code>TAccountLineItems</code> . When a <code>TAccountTransaction</code> is created, it debits one <code>TAccount</code> and correspondingly credits another. Certain state transitions can additionally debit and credit another pair of T-accounts. These credits and debits are represented by <code>TAccountLineItems</code> .
<code>TAccountTransaction</code>	Contains the <code>TAccountLineItems</code> that change a pair of T-accounts to account for a transaction as it moves through its LifeCycle States. For example, when a reserve becomes committed, it is debited or removed from the <code>Pending Approval Reserves</code> T-account and added or credited to the <code>Submitted Reserves</code> T-account.
<code>Tacctxnhistory</code>	Used to track historical transaction data in a T-account.

Transaction Business Rules

ClaimCenter provides sets of rules that affect most of its financial events. You can develop rules that cause ClaimCenter to model your company’s particular financial practices. See “Transaction Set Validation” on page 161 in the *Rules Guide*.

Transaction Business Rule Sets

Rule sets are collections of similar rules. When an event triggers rule execution, the entire rule set executes, rather than individual rules in them. Rules affecting transactions fall into one of these rule sets. For more information, see “Overview of ClaimCenter Rule Sets” on page 16 in the *Rules Guide*.

- **Transaction Approval** – Rule set that checks whether a user has the authority to make the transaction. See “Transaction Authority Approvals” on page 333.
- **Approval Routing** – Rule set that creates an activity to send a transaction to another user for approval. See “Transaction Authority Approvals” on page 333 for an example.
- **Transaction Validation** – Rule set that checks if a transaction exceeds a preset monetary limit. See “Transaction Approvals” on page 333.
- **Initial Reserve** – Rule set that sets a newly created reserve line’s reserve. See “Setting Initial Reserves” on page 333.
- **Transaction Postsetup** – Rule sets that run after a transaction set is approved, after a check is voided, stopped, or escalated, and after other similar events. An example of a Transaction Post-Setup rule is a rule that looks at the sum of initial reserves allocated. It compares it to the policy’s aggregate limit and issues a warning if reserves are already within 10% of that limit.

- **Transaction Preupdate** – Rules that run before any object is updated in the database. They run prior to the Transaction Validation rule set. See “Preupdate and Validation Rules” on page 138.
- **Transaction Presetup** – Rules that run just before any transaction set or check set is committed. See “Financial Transactions Outside the User Interface” on page 329.

See also

- “Initial Reserve Rule Set Category” on page 55 in the *Rules Guide*
- “Transaction Postsetup Rules” on page 58 in the *Rules Guide*
- “Transaction Set Presetup Rules” on page 61 in the *Rules Guide*
- “Transaction Set Preupdate Rules” on page 69 in the *Rules Guide*
- “Transaction Approval Rules” on page 74 in the *Rules Guide*
- “Transaction Set Validation Rule Set” on page 84 in the *Rules Guide*
- “Transaction Set Validation” on page 161 in the *Rules Guide*

Transaction Approvals

One of the most common financial validations concerns evaluating if the limits of liability on a policy’s coverage have been overstepped. The Transaction Validation rule set contains this type of rule.

For example, carriers commonly sell vehicle insurance with the following standard limits:

- 200/500/100 package to limit the maximum payout in one accident to \$200,000 per person for bodily injury
- \$500,000 for all bodily injury in one accident
- \$100,000 for all third party property damage

Using the application’s transaction approval rules and library functions, you can track these limits and raise alerts whenever a transaction exceeds the claim’s exposure limit or the policy’s per-occurrence limit.

ClaimCenter provides the following examples of business rules that pertain to coverage limits:

- Total Payments cannot exceed the exposure’s coverage.
- Reserves cannot exceed the exposure’s coverage.
- Total Payments cannot exceed the coverage’s per-occurrence limit.
- Total Reserves cannot exceed the coverage’s per-occurrence limit.
- A new check cannot increase Total Payments above a chosen limit, such as an aggregate, per-person, or lost wages limit of a Personal Injury Policy coverage.

Transaction Authority Approvals

If you try to approve a transaction, Transaction Approval Rules can ensure that the transactions be marked as Pending Approval. They also create an approval activity by using the Approval Routing rule set. These rules can handle approvals of all kinds, not just those that involve authority limits. The Transaction Approval and Approval Routing rule sets work together to verify if you have the required authority and if not, where to go to obtain approval.

Setting Initial Reserves

The Initial Reserves rule set can create a initial reserve of a predetermined value to a new exposure. For example, rules allocate a reserve for a vehicle damage exposure, and set the amount differently, depending on how the exposure was segmented.

Financial Permissions and Authority Limits

This topic covers the security aspects of financial transactions. For a complete discussion of ClaimCenter security, permissions, roles, ACLs (access control levels), and so on. See “Security: Roles, Permissions, and Access Controls” on page 447.

User Permissions

Separate user permissions pertain to each transaction and to checks:

- View, create, edit, or delete a payment, reserve, recovery, or recovery reserve—16 separate permissions
- Create, edit, or delete a manual payment
- Void, stop, or transfer a check
- Void a check after the check cleared
- Exchange rate manual override
- Edit deductible

By default, the following roles have all these permissions except user admin: adjuster, claims supervisor, manager, clerical, new loss processing supervisor, superuser, and user admin. You can see the complete set of user permissions either in the **Administration** section of the user interface or in the Security Dictionary.

Note: ClaimCenter does not actually use all these permissions. They are all defined for consistency. For example, you cannot edit a recovery, the `recedit` permission. A recovery is a received check, and you cannot change its information. Similarly, you do not edit a reserve or recovery reserve, the `resedit` and `recresedit` permissions. You create a new reserve or recovery reserve by adding to the existing one.

Authority (Transaction Amount) Limits

By using the Authority Limit Profile, an administrator can set the maximum allowed transaction amount for any user for the following:

- A claim’s and any exposure’s Total and Available Reserves
- A claim’s and any exposure’s payments to date
- Any single payment
- A payment that exceeds its reserve
- A change in reserve amount

For more information on authority limits, see “Managing Authority Limit Profiles” on page 476.

The `CheckAuthorityLimits` configuration parameter in the `config.xml` file is set to `true` in the default configuration. This setting causes authority limits to be checked during approval of any transaction set. If you set this parameter to `false`, these authority limit checks are not performed. Additionally, the configuration parameter `AllowPaymentsExceedReservesLimits` is set by default to `true`, enabling users with appropriate permissions to submit payments that exceed available reserves up to the authority limits. If you set this parameter to `false`, it prevents all payments that exceed reserves, regardless of the user’s authority limit permissions.

Access Control Levels

There are no special controls to restrict access to financial objects. To restrict access to sensitive financial information, you must restrict access to the claim or exposure.

Multiple Currencies

ClaimCenter can be set up to use a single, base currency or different currencies for all its financial transactions, based on your business needs. Enabling ClaimCenter to use multiple currencies, known as *multicurrency*, means that you can create reserves and recovery reserves, write checks, and make payments in more than one currency.

This topic describes how multicurrency works, the role of exchange rates, and the various uses of multicurrency in ClaimCenter.

This topic includes:

- “Multicurrency Overview” on page 335
- “Multicurrency Display” on page 339
- “Multicurrency Reserving” on page 340
- “Multicurrency Financial Summaries” on page 340
- “Examples” on page 341
- “Exchange Rates” on page 342
- “Foreign Exchange Adjustments” on page 344

See also

- “Configuring Currencies” on page 85 in the *Globalization Guide*
- “Monetary Amounts in the Data Model and in Gosu” on page 87 in the *Globalization Guide*
- “Exchange Rate Integration” on page 409 in the *Integration Guide*

Multicurrency Overview

You can configure ClaimCenter financials to display as well as use multiple currencies. If you enable multicurrency display, you can write checks, create reserves and recovery reserves, and make payments in more than one currency in a single claim. However, in all calculations, the secondary transaction currency is effectively converted to the claim’s currency. Using multiple currencies, in this case, serves more as a convenience for users who need to use different currencies on a short-term basis.

If you enable multicurrency reserving, you can create and manage reserves and recoveries, write checks, and make payments in multiple currencies. You can track and erode reserves in the currency of choice, thus avoiding exchange rate fluctuations and their potential impact on reserve amounts.

ClaimCenter can be configured in three different modes for currency:

- Single currency mode – All money amounts use one currency. All currency drop-down menus and exchange rate information is hidden, since only one currency is allowed.

Configuration:

`MulticurrencyDisplayMode = SINGLE.`

`DefaultApplicationCurrency` is set to the one currency to use.

- **Multicurrency Display** – Determines if ClaimCenter shows multiple currencies. With multicurrency display enabled, you can:

- Create reserves or recovery reserves in the claim currency. Although these transactions can be created in a non-claim currency, the totals are tracked in the claim currency only.
- Create payments and recoveries in any currency.
- Track these transactions as part of the financial calculations and summary. It must be noted that with this configuration, creating reserves in a different transaction currency is a convenience. Reserves are always converted and tracked in the claim currency. Payments and recoveries erode reserves in the claim currency.

Note: Reserves will be converted and tracked in the claim's currency.

- **Multicurrency Reserving** – Determines if you can track reserves and recovery reserves in multiple currencies on a claim. With multicurrency reserving enabled, you can:
 - Create and track reserves and recovery reserves in any currency.
 - Create Payments and Recoveries in any currency. They erode reserves and recovery reserves respectively in the currency the reserve was created.
 - Track these transactions as part of the financial calculations and summary.

Note: As reserves are tracked in the currency they were created in, exchange rate fluctuations do not impact the remaining amount on a reserve.

IMPORTANT In the base configuration, multicurrency display and reserving are disabled, and ClaimCenter tracks all financial transactions in the default application currency.

Currency Types

ClaimCenter supports a single, main, or default currency, as well as currency types based on the policy, transaction, and reserve line. They are defined as follows:

- **Default currency** – The main or base currency for the system, defined in the `config.xml` file. The terms server currency, reporting currency, and main currency all refer to this default currency. This currency is used application-wide mainly for reporting purposes. For example, a carrier based in London would have its reports printed in their default currency, GBP. The `ReportingAmount` field is on the `TransactionLineItem` entity. It returns the reporting amount of a transaction, which is the equivalent of the transaction amount in the reporting currency.
- **Claim currency** – The currency associated with the claim. The claim inherits the currency from its policy, so it is also known as the policy currency. The `ClaimAmount` field on the `TransactionLineItem` entity stores the claim amount of a transaction, which is the equivalent of the transaction amount in the claim currency. See “Claim Currency and Policy Currency” on page 337 for more information.
- **Reserving currency** – The designated currency of a reserve line. This currency type can be defined only when multicurrency reserving is enabled, otherwise, it defaults to the claim currency. You can specify a reserving

currency if you need to create and track reserves in a non-claim currency. Payments erode reserves in this currency. The `ReservingAmount` field is on the `TransactionLineItem` entity.

- **Transaction currency** – The currency of the transaction amount, which is the primary amount for a transaction, from which other amounts are calculated. For payments, this is the currency in which the actual payment was made. The `TransactionAmount` field is on the `TransactionLineItem` entity.

Each multicurrency transaction can have up to four amounts in each of these currencies associated with it. In the base configuration, for a single transaction, all four of these amounts will always be the same. If multicurrency display is enabled, the transaction, claim, and reporting currency amounts can be different for a transaction. The reserving currency, however, is the same as the claim currency. If multicurrency reserving is enabled, all four currency amounts can be different for a transaction. See “Multicurrency Data Model” on page 602 in the *Configuration Guide* to understand the relationships.

Note: ClaimCenter has a list of all of the currencies in the system in the `Currency` typelist, along with their current exchange rates. However, this typelist is configurable and you can specify the currencies you want to use in ClaimCenter. For more information, see “Exchange Rates” on page 342.

Claim Currency and Policy Currency

When multicurrency display is enabled, ClaimCenter supports policies and claims that do not use the default application currency. The `Policy` and `Claim` entities have a `Currency` field. The policy’s currency determines the initial value for the `Currency` field in the `Policy` entity and is set up in the policy search adapter for verified policies. For unverified policies, the currency is defined when the policy details are added in the New Claim wizard.

The claim currency is equal to the policy’s currency and is determined when the policy is retrieved to create the claim. The `Claim` entity’s `Currency` field is equal to the same field in the `Policy` entity. Changes to the policy’s currency field are always copied to the `Claim.Currency` field.

If there are transactions on a claim, you cannot change the claim currency, as this would impact the transactions and financials calculations.

Configuring Multiple Currencies

Use the following parameters in the `config.xml` file to configure the multicurrency feature in ClaimCenter:

- `DefaultApplicationCurrency` – Specify the default currency to be used across the application. You are required to set this value, regardless of the values of the other two parameters.
- `MulticurrencyDisplayMode` – Specify if you want ClaimCenter to support multiple currencies. Valid values are `SINGLE` and `MULTIPLE`.
- `EnableMultiCurrencyReserving` – Specify if you want ClaimCenter to support multicurrency reserving. If you enable this parameter, `MulticurrencyDisplayMode` must be set to `MULTIPLE`.

In the base configuration, ClaimCenter sets `MulticurrencyDisplayMode` to `SINGLE` and `EnableMultiCurrencyReserving` to `false`.

IMPORTANT The `MulticurrencyDisplayMode` parameter setting is permanent. After you change the value of `MultiCurrencyDisplayMode` to `MULTIPLE` and then start the server, you cannot change the value back to `SINGLE` again. The `MultiCurrencyDisplayMode` parameter is in `config.xml`.

ClaimCenter financial transactions are handled differently, based on whether multicurrency reserving is enabled or disabled.

The following table illustrates the differences:

ClaimCenter Operation	Multicurrency Reserving Disabled	Multicurrency Reserving Enabled
Create checks and payments	Use any currency. Payments are converted to the claim currency and erode reserves in the claim currency.	Use any currency, preferably matching the ReservingCurrency on the ReserveLine. Payments erode reserves in the reserving currency.
Create reserves and recover reserves	Use the currency calculator to create and view reserves in an alternate currency. Amounts are converted to the claim currency when reserves are updated and managed.	Use any currency. Reserves are created and managed in this reserving currency.
Create bulk invoice payments and write associated checks	Use any currency. Payments are converted to the claim currency and erode reserves in the claim currency.	Use any currency. Payments are made in this currency and erode reserves in the reserving currency.
Integrate transactions into financial totals	Transactions are converted to the claim currency and incorporated into financial totals.	Transactions are tracked in reserving currencies.
View financial summaries that include all transactions	View all financial summaries in the claim currency.	View summaries by reserving currency, in addition to the usual summary views.

Note: When you use more than one currency, ClaimCenter performs necessary conversions using automatic or manual exchange rates. See “Exchange Rates” on page 342.

Preferred Currency on Contacts

The Contact entity has a Preferred Currency field that indicates the currency in which that contact would prefer to receive checks. You can assign a Preferred Currency to a contact when you create or edit it. After you specify the payee while writing a check, ClaimCenter defaults the check’s currency to the preferred currency of the payee, if one is specified.

The following points are all configurable.

- **Single payee checks** – ClaimCenter changes the check currency from the default to the Preferred Currency.
- **Joint payee checks** – ClaimCenter makes the same change based on the first joint payee.
- **Multi-payee checks** – ClaimCenter considers only the preferred currency of the primary payee, not secondary payees. All the checks in a check group use the same currency.

Checks, Payments, and Recoveries

If you enable multicurrency display in ClaimCenter, you can create checks and recoveries in any currency. The system defines a default currency for the check or recovery according to the following conditions:

- If the payee for a check or a payer for a recovery has a preferred currency, the check or recovery defaults to this currency.
- If there is no preferred currency specified, the check or recovery currency defaults to the currency of the reserve.

You have the option of overriding the default system currency. Payments and recoveries erode reserves in the currency of the reserve.

Reserves and Recovery Reserves

If multicurrency reserving is enabled, you can create and track reserves in multiple currencies. If multicurrency reserving is disabled, you can still create reserves in different currencies, but only as a convenience. They are essentially converted to and tracked in the claim currency.

Multicurrency Display

If you enable multicurrency display in ClaimCenter configuration, then fields, buttons, and features that show currencies and exchange rates are made visible.

If **MulticurrencyDisplayMode** is set to **MULTIPLE** in the `config.xml` file, you see the following in ClaimCenter:

- If a transaction uses any currency besides the reserving currency, the screen shows both currency amounts. The amount in the reserving currency appears in smaller type below the amount in the transaction currency. Both amounts are formatted according to their currency.
- In the **Policy** screen, you can select the policy currency by using a drop-down list of all of values defined in the **Currency** typelist. As with any policy attribute, if you edit the currency of a verified policy, the policy becomes unverified.
- If you are creating a reserve or a recovery reserve, you can use the multicurrency calculator icon to view the **Set Reserve Amount in Another Currency** page. In this page, you can view and select an alternate transaction currency for the reserve and set its **TransactionAmount** in that currency. You can view and change the amount and exchange rate from the transaction to the claim currency.
See “Market and Custom Exchange Rates” on page 343.
- If writing a check, bulk invoice check, or recovery, you can select an alternate currency. You can view the market exchange rate or set a custom exchange rate for the conversion from the check or recovery currency to the claim currency.
- If you are searching for checks or recoveries in a monetary range, ClaimCenter presents **From** and **To** text fields formatted in the currency chosen for the search. See “Multicurrency Searches” on page 339.

Note: Using multiple currencies requires you to also correctly set the data types for those currencies. See “Monetary Amounts in the Data Model and in Gosu” on page 87 in the *Globalization Guide*.

The New Check Wizard and Multicurrency

You can create all types of checks in any currency. The following steps of the **New Check** wizard use some parts of the multicurrency feature:

- **Step 1** – Shows the **Preferred Currency** of each primary and joint payee entered. Step 1 does not show the **Preferred Currency** of secondary payees.
- **Step 2** – Sets the check’s currency to a payee’s **Preferred Currency**, if specified. See “Preferred Currency on Contacts” on page 338. Use the **Currency** drop-down menu to change the currency. You can also adjust the exchange rate.
- **Step 3** – Displays the **Gross**, **Net**, and **Deduction** amounts in both the check and claim currencies.

The Auto First and Final wizard also uses multicurrency display.

Multicurrency Searches

You can create checks and recoveries in any currency, and you can search for them regardless of currency, or in any one currency. Enter currency parameters in the following screens to control these searches:

- **Search → Recoveries** in the **Optional Parameters** section
- **Search → Checks** in the **Optional Parameters** section

Single Currency Searches

Use the currency selector in the **Optional Parameters** sections to specify a currency for searches. This drop-down list shows all the typecodes in the **Currency** typelist.

If you specify a currency, your search is restricted to items in that currency, and the **From** and **To** fields are used to specify amounts in that currency. Single-currency searches return the sum of all items found. ClaimCenter shows the following messages with the search results:

- **Recovery Search** – The results of this recovery search may be incomplete because a specific currency is being used to limit the search.
- **Check Search** – The results of this search are limited to those checks in the specified check Total range and currency.

Using Multiple Currencies in Bulk Invoices

Bulk Invoices can be written in any currency. The Bulk Invoice, the physical check, and the invoice item checks use this currency. See “Bulk Invoices and Multicurrency” on page 369 for details.

Multicurrency Reserving

You can configure ClaimCenter to use multicurrency reserving by setting the `EnableMultiCurrencyReserving` parameter in `config.xml`.

You can now create reserves, checks, and make payments in varying currencies. Apart from the claim currency, each reserve line, then, has a designated *Reserving Currency*, which defaults to the claim currency. You can specify the currency, along with the cost type and cost category. Payments erode reserves in the corresponding reserving currency. As a result, in subsequent transactions and adjustments, you can use the accurate reserve amount, without being impacted by moving exchange rates and currency fluctuations.

Once you specify the reserving currency, ClaimCenter shows all amounts and calculations for the reserve line in this currency. In the **Financials Summary** screen, you can view reserve line totals in the reserving currency, in addition to the claim currency.

When you create reserve lines in multiple currencies, the following conditions apply:

- Reserves for any one reserve line must be in the same reserving currency.
- All payments on a check must be from reserve lines with the same reserving currency.
- When you recode a payment or transfer a check, you can only select a target reserve line from reserve lines with a reserving currency that matches the existing one.

IMPORTANT If you want to enable multicurrency reserving, multicurrency display must also be enabled. Also, you must have exchange rate information loaded into ClaimCenter before you enable multicurrency reserving. See “Exchange Rates” on page 342.

See also:

- “Setting Reserves in Multiple Currencies” on page 293.
- “Working with Checks” on page 303.

Multicurrency Financial Summaries

In the base configuration, most ClaimCenter features, such as the **Summary** pages, financial calculations, and aggregate limits, operate in the claim currency. The **Financials Summary** screen of each claim uses this currency. ClaimCenter calculates these aggregate amounts in the claim currency.

When multicurrency reserving is enabled, the **Financials Summary** screen of each claim has the capability to show reserve lines in the reserving currency as well as the claim currency. The summary screen also shows aggregates in the reserving currency. Additionally, you can view amounts using fixed or market exchange rates.

See “Foreign Exchange Adjustments and Financials Calculations” on page 345.

Note: Exchange rate adjustments are always non-eroding, even if they adjust an eroding payment. They cannot be made on recoveries, reserves, and recovery reserves and therefore can create small errors in financial summaries. With foreign exchange adjustments, you can change claim and reporting amounts. For example, you might increase the claim amount of a check, which would increase the amount of Total Paid, but Total Reserves and Remaining Reserves would not be affected. They do not take foreign exchange adjustments into account, so Remaining Reserves would no longer equal the difference between Total Reserves and Total Payments.

Examples

The following examples illustrate how you can use the multicurrency features in ClaimCenter to handle transactions across geographical regions with potentially varying currencies.

Example One

A Canadian policyholder spends the weekend in the United States in the state of Florida. Separate currencies are used by carriers who have snowbird policyholders, insured parties who spend a certain season of the year in a different country. In this case, the insurance carrier writes all or most of its policies in Canada, but covers losses in a few other countries on occasion.

ClaimCenter configuration:

- Multicurrency display is enabled.
- Multicurrency reserving is disabled.

Currencies:

- Default currency: Canadian Dollars (CAD)
- Claim currency: Canadian Dollars (CAD)
- Reserving currency: CAD
- Transaction currency: United States Dollars (USD)

Create reserves and recoveries, create checks, and make payments in US dollars for claims associated with the policyholder’s stay in Florida. Payments erode reserves in the claim currency. ClaimCenter calculates the amount of a financial transaction in the claim currency by using the appropriate exchange rate. It then stores the amount both in the transaction currency and the claim currency. Financial summaries are shown in the claim currency.

Example Two

A London-based carrier has a satellite office in Paris. Because the carrier is located in England, ClaimCenter is configured with a default currency of British Pound Sterling (GBP). Policies that are written in England are in GBP. However, the Paris office writes and handles policies and claims in Euros (EUR). Therefore, ClaimCenter must handle claims in both GBP and EUR.

Additionally, carriers using ClaimCenter can create certain transactions in a third, different currency. For example, a Parisian policyholder drives to the Czech Republic and has a car accident. The financial transactions on the claim are paid in the Czech currency, Korunas (CZK).

ClaimCenter configuration:

- Multicurrency display is enabled.
- Multicurrency reserving is disabled.

Currencies:

- Default currency: GBP
- Claim currency: EUR

- Reserving currency: EUR
- Transaction currency: CZK

Although the policy was created in Paris, you can create reserves in Korunas for claims associated with the policyholder's trip to the Czech Republic. Payments erode reserves in the claim currency. ClaimCenter calculates the amount of a financial transaction in the claim currency by using the appropriate exchange rate. Financial summaries are shown in the claim currency.

See also

- See "Setting the Default Application Currency" on page 91 in the *Globalization Guide*
- "Financial Parameters" on page 58 in the *Configuration Guide*

Example Three

Carriers operating in a marine line of business often need to insure fleets in multiple currencies. This is because the insured parties typically insure a single vessel in various currencies to hedge themselves against the risk of exchange rates fluctuations. It is also common for a carrier to create reserves and make payments in a currency other than the policy currency, when the expenses are in a different country.

For example, if a Japanese ship collides with an American ship, adjusters for the American ship may have to create separate reserves in USD and JPY to cover the claim. Hull damage reserves are created for each ship in the respective currencies. They may need to appoint lawyers in both the US and Japan and order parts from China.

ClaimCenter configuration:

- Multicurrency display is enabled.
- Multicurrency reserving is enabled.

Currencies:

- Default currency: USD
- Claim currency: USD
- Reserving currency: JPY and USD
- Transaction currency: CNY

In this case, although the policy was created in the US, you can create reserves in Yen for claims associated with the policyholder's incident with the Japanese ship. Payments erode reserves in the reserving currency. A financial transaction can be made in another currency, such as Yuan, and ClaimCenter calculates the amount of the transaction in the reserving currency by using the appropriate exchange rate. Financial summaries are shown in the claim currency and reserving currency.

Exchange Rates

You can make financial transactions in more than one currency in ClaimCenter. For any two currencies, there exists a conversion factor, called an *exchange rate*, that converts one currency amount to the other.

How Exchange Rates Work

ClaimCenter uses a table of exchange rates to calculate the claim amount from the transaction amount and perform similar currency conversions. It uses the table in conjunction with a class that implements the `IExchangeRateSetPlugin` plugin interface.

For details on the plugin interface, see "Obtaining Market Exchange Rates" on page 343.

Market and Custom Exchange Rates

When you create transactions, you can determine the exchange rate in one of two *modes*, automatic or manual. These modes are described below.

- **Automatic mode** – The system gets the rate based on data in the tables. It uses the exchange rate from the application's table of most current market rates.
- **Manual mode** – When multicurrency display is enabled, if you select a currency other than the claim currency, ClaimCenter displays the **Exchange Rate Mode** field. Select **Manual** and enter a custom rate in the text field. The default value in this field is the market rate. A carrier might try to avoid problems of currency fluctuations by holding or hedging a currency. Therefore, it can be appropriate to manually enter exchange rates instead of accepting the automatically selected market rate.

Obtaining Market Exchange Rates

ClaimCenter obtains current, market-based exchange rates from a web service of an external, third-party system through a class that implements the plugin interface, **IExchangeRateSetPlugin**. These exchange rates are stored in ClaimCenter with effective dates.

The implementation of the plugin interface and how often it runs to import an exchange rate set is based on your business needs.

For example, the plugin implementation could do the following:

- Communicate with a web service.
- Process and import a document with a list of rates. This list could be provided by an internal currency management department.

The Exchange Rate Batch Process

The Exchange Rate batch process invokes the class that implements the **IExchangeRateSetPlugin** interface. In the base configuration, the plugin implementation `gw.plugin.exchangerate.impl.SampleExchangeRateSetPlugin` adds a new set of market exchange rates in ClaimCenter. Running the batch process loads the updated market rates.

In the base configuration, this batch process is commented out in the `scheduler-config.xml` file, as follows:

```
<ProcessSchedule process="ExchangeRate">
    <CronSchedule hours="2"/>
</ProcessSchedule>
```

The batch process might invoke the plugin in the following ways:

- Every day, for the latest market rates.
- Periodically, based on your business requirements.

An implementation of **IExchangeRateSetPlugin** is required to provide an **ExchangeRateSet** object containing at least one **ExchangeRate** object from each currency in the **Currency** typelist to the system default currency. The **ExchangeRate** object must have a **BaseCurrency** element in the chosen currency and a **PriceCurrency** element that is the system default. If *N* represents a currency, then the minimum is *N* times one with a maximum of *N* times *N*. You can also set up these exchange rate entities yourself for every currency X to every Y combination.

ClaimCenter uses the set of **ExchangeRate** objects to construct an exchange rate between every currency pair, which becomes the active market **ExchangeRateSet**.

The two main exchange rate objects are as follows:

- The **ExchangeRate** object represents an exchange rate between a pair of currencies. This rate can be a market rate, in which case it will exist in an **ExchangeRateSet** with rates between every currency pair. It can also be a manually entered custom rate, in which case it typically contains the amount entered by the user and resides alone in an **ExchangeRateSet**.

- The ExchangeRateSet object represents a set of exchange rates, along with supplemental information about those rates, including the effective and expiry dates for the set. The MarketRates field, when true, indicates that the exchange rates are market rates. When this field is false, the set contains only one user-defined custom rate.

In the following illustration, the ExchangeRateSet entity contains two currencies: US dollars and Euros. The entity also has effective date, EffectiveDate, and expiration date, ExpireDate, fields.

Multicurrency and Active Market Rate Sets

If ClaimCenter has been configured for multicurrency display, ClaimCenter must always have an Active Market Rate Set. ClaimCenter defines an Active Market Rate Set if the MarketRates field is set to true on the ExchangeRateSet entity and the ExchangeRateSet has the current date. The current date must be between the effective date, EffectiveDate, and the expired date, ExpireDate.

To determine which ExchangeRateSet entity is the active market set, the system first searches for ExchangeRateSet entities with MarketRates set to true. It then sorts on the most recent, unexpired effective date.

If the MarketRates field is set to false, the ExchangeRateSet entity indicates a custom rate.

IMPORTANT You must run the Exchange Rate batch process at least once to load the market rates. If you do not run it, ClaimCenter displays an error if you try to create a multicurrency check. This error also occurs if the current market rate set expires and no new set has been loaded. To avoid this issue, Guidewire recommends that you not set the expiration date, enabling the system to always get the last known market rate set.

See also

- “Foreign Exchange Adjustments” on page 344
- “Multicurrency Data Model” on page 602 in the *Configuration Guide*
- “Exchange Rate Integration” on page 409 in the *Integration Guide*
- “List of Batch Processes and Distributable Work Queues” on page 129 in the *System Administration Guide*

Importing Multiple Currency Transactions

Use the `IClaimFinancialsAPI.addClaimFinancials` method and the `IClaimFinancialsAPI.addClaimFinancialsWithValidation` method to import financial transactions into ClaimCenter. A call to either of these methods results in a new `TransactionSet` object containing transactions that have the same currency and exchange rates. For details, see “Claim Financials Web Services (ClaimFinancialsAPI)” on page 369 in the *Integration Guide*.

Foreign Exchange Adjustments

When multicurrency display is enabled, sometimes a check is written in a currency other than the claim currency and no custom rate is entered. ClaimCenter typically uses that day’s exchange rates to convert the payment amount to the claim and default currency. If a check clears, this exchange rate usually has changed, and the actual cleared amounts in the claim and reporting currencies will differ from the previously-calculated amounts.

For example, the default, reporting, and claim currencies are US dollars, and you write a check for 100 Euros when the Dollar–Euro exchange rate is 1.3. ClaimCenter calculates \$130 as the claim and reporting amount for

the payment. If the recipient cashes the check one week later and the exchange rate has become 1.4, the carrier's US bank account balance will actually be reduced by \$140.

Note: Reserves are still only eroded by \$130, because foreign exchange adjustments do not erode reserves.

ClaimCenter provides a way to adjust the payment's claim and reporting amounts. In the example, the adjustment would be to \$140. This adjustment changes some, but not all, summary calculations. It does not affect recoveries, for example. See "Foreign Exchange Adjustments and Financials Calculations" on page 345 for details.

Note: You cannot make these adjustments on reserves, recoveries, or recovery reserves.

Making Foreign Exchange Adjustments

You can make exchange rate adjustments on a single payment or on an entire check. If the latter, then the adjustment is distributed proportionally to all the check's payments except offsets, recoded, and canceled payments.

You can make adjustments only after the entity has certain transaction statuses. A check must have a status of Notifying, Requesting, Requested, Issued, or Cleared. A payment must be Submitting or Submitted.

In the previous example, \$140 minus \$130 results in a \$10 adjustment. If the payments of the check had claim amounts of \$39, or 30% of the total, and \$91, or 70% of the total, the adjustment would be distributed between them. \$3 would be applied to the first payment and \$7 to the second.

Methods That Make Foreign Exchange Adjustments

You can apply foreign exchange adjustments to checks and payments in the following ways:

Use the following methods in `IClaimFinancialsAPI`, making explicit calls to the SOAP API.

- `applyForeignExchangeAdjustmentToPayment (paymentId, newClaimAmount)`
- `applyForeignExchangeAdjustmentToPayment (paymentId, newClaimAmount, newReportingAmount)`
- `applyForeignExchangeAdjustmentToCheck (checkId, newClaimAmount)`
- `applyForeignExchangeAdjustmentToCheck (checkId, newClaimAmount, newReportingAmount)`

Use an equivalent scriptable method on a check or payment in Gosu code:

- `applyForeignExchangeAdjustment (newClaimAmount)`
- `applyForeignExchangeAdjustment (newClaimAmount, newReportingAmount)`

Generally, all the methods adjust a payment's claim or reporting amounts to specified values. These adjustments are intended to be used when better values for the amounts are determined later, after a check is created and escalated. To use these methods, ClaimCenter must be configured in multicurrency mode and the payment must meet the following criteria:

- Be on an escalated check that has not been canceled or transferred.
- Not have been recoded.
- Not be an offset payment.
- Not be part of a multi-payee (grouped) check.

Note: You can apply Foreign Exchange adjustments to a payment or check multiple times. Any previous foreign exchange adjustment is rolled back before the new one is applied.

For additional details and examples of these methods, you can access the Gosu API documentation as described at "Gosu Generated Documentation ('gosudoc')" on page 37 in the *Gosu Reference Guide*.

Foreign Exchange Adjustments and Financials Calculations

ClaimCenter treats all foreign exchange adjustments as non-eroding. Therefore, most calculated values do not change if you apply an adjustment, most importantly Open, Available, and Remaining Reserves. However, Net

Total Incurred, Gross Total Incurred, and Total Paid do change. To continue the example at the beginning of this topic, total incurred and total paid values increase by \$10, and the previously mentioned reserve calculations remain unchanged.

See “ClaimCenter Financial Calculations” on page 329 for definitions of all calculated financial values.

Foreign Exchange Adjustments in Custom Financials Calculations

You can create your own custom financial calculations that include foreign exchange adjustments. For example, you could define a calculation similar to Open Reserves that includes foreign exchange adjustments by subtracting the sum of all exchange rate adjustments made on eroding payments.

Note: Exchange rate adjustments are always non-eroding, even if they adjust an eroding payment. Because of their effect on financial calculations, applying foreign exchange adjustments can cause the values shown on the **Financials Summary** screen to not add up.

Methods That Use Foreign Exchange Adjustments

The following methods in `gw.api.financials.FinancialsCalculationUtil` provide expressions that can be used to define new calculations:

Method	Description
<code>getForeignExchangeAdjustmentsExpression</code>	Total foreign exchange adjustments for both eroding and non-eroding payments.
<code>getErodingPaymentsForeignExchangeAdjustmentsExpression</code>	Total foreign exchange adjustments only for payments that erode reserves.
<code>getNonErodingPaymentsForeignExchangeAdjustmentsExpression</code>	Total foreign exchange adjustments only for payments that do not erode reserves.

Example-Based Configuration

An American motorist hits another car in Europe and injures a passenger in the car. The following events take place after this occurrence:

1. A claim is created with the American's insurer to pay the injured passenger. Anticipating that the claim will be paid in euros, the adjuster creates an initial reserve of 80 euros. However, the claim currency is US dollars, as the American's policy is in the US. The claim amount for the reserve transaction is set to \$100 based on the current market exchange rate of 1.25.
2. The adjuster receives a bill for 1200 euros for medical treatment and increases reserves to 1280 euros, a claim amount of \$1600, based on the market exchange rate.
3. The adjuster writes a check for 1200 euros. The exchange rate has increased to 1.26, so the claim amount for the payment is set to \$1512.
4. By the time the check in step 3 clears the European bank, the Euro exchange rate has risen to 1.3, and the insurance company's US bank account is charged \$1560. The amount of the check, 1200 euros, did not change, so the transaction amount for the payment need not be changed. However, the claim amount of the payment, originally \$1512, can be adjusted to reflect the amount for which the check actually cleared, \$1560. The integration makes this adjustment by calling ClaimCenter through one of the methods on the `IClaimFinancialsAPI` SOAP API.
5. The claim adjuster finds that the other driver is partly at fault and opens a recovery reserve for 750 euros. Based on the current Euro to US Dollar exchange rate of 2.0, the claim amount for the recovery reserve is \$1500. The adjuster sends a subrogation request for this amount to the British driver's insurance company.
6. The American insurance company receives and deposits a subrogation check for 750 euros. They enter this recovery by using the current exchange rate of 2.02, so the claim amount is set to \$1515.

7. The recovery check clears the bank for \$1530 at an exchange rate of 2.04. However, the claim amount of the recovery transaction is not adjusted.

The following table shows the first six steps. In this table, entries in bold are changed by the action in the line above them.

Exchange Rate Used	Open Reserves	Total Payments	Total Eroding Payments*	Open Recovery Reserves	Recovery	Gross Total Incurred	Net Total Incurred	Foreign Exchange Adjustment
1) Claim opened. Initial reserve created for 80 Euros.								
--	\$100					\$100	\$100	
2) 1200 Euro bill received for medical treatment. Reserves set to 1280 Euros.								
1.25 \$/Euro	\$1600					\$1600	\$1600	
3) 1200 Euro check sent for insured's medical bills in Europe.								
1.26 \$/Euro	\$88	\$1512	\$1512			\$1600	\$1600	
4) 1200 Euro check clears bank for \$1560. Adjustment made.								
5) Recovery attempt for 750 euros started. Recovery reserve opened for this amount.								
2.0 \$/Euro	\$88	\$1512	\$1512	\$1500		\$1600	\$1600	
6) 750 euro Subrogation check received and recovery of \$1515 entered.								
2.02 \$/Euro	\$88	\$1560	\$1512	\$10	\$1515	\$1600	\$85	

Notes

- * Total Eroding Payments is not a real calculation and is used in the table only for illustration.
- This example shows that foreign exchange adjustments are made on payments only, not on recoveries.
- Step 4, where the foreign exchange adjustment was applied, did not affect Open Reserves or Total Eroding Payments.

Deductible Handling

A *deductible* is the amount the insured is required and obligated to pay by the insurance policy. The insured chooses the deductible amount and it is usually applied to coverages such as comprehensive and collision. Generally, the lower the deductible, the higher the insurance premium. A typical scenario for using a deductible is an auto accident about which you notify your insurance company. Your agent says that they will cover the entire cost of replacing the hood of your car after you contribute your insurance deductible of \$500.

In ClaimCenter, you can apply an insured's deductible to a claim in the Personal Auto line of business. Other lines of business can use deductible handling if you configure them to do so.

This topic introduces you to how ClaimCenter uses deductibles.

This topic includes:

- “Deductible Handling Overview” on page 349
- “Working with Deductibles” on page 350

Deductible Handling Overview

Deductibles are usually applied to the first `claimcost` payment on the check. The deductible amount is specified on a coverage entity in the policy. After you select a policy in the New Claim wizard or in the Auto First and Final wizard, ClaimCenter pulls that policy data from the policy administration system (PAS). For example, a typical auto deductible for a collision coverage on an auto policy is \$500 in the United States. An insured is in an auto accident. There is \$1000 of damage that is to be paid to the auto body shop. \$1000 total damage minus the \$500 deductible equals \$500, which is the amount the insured receives.

However, there are exceptions, and ClaimCenter is flexible in the handling of deductibles. Exceptions can include the following:

- Some policies have a higher deductible based on the claim incident. For example, drivers in Great Britain can pay a higher deductible if they are under a certain age.
- Deductible calculations are often made based on the fault rating of the insured, but only if the insured can prove that the insured's fault was a certain percentage. For example, if the insured could demonstrate a fault of 30%, and that the other party's fault was 70%, the insured would pay only 30% of the deductible.

- In some cases, the deductible can be negotiated with the claim adjuster where fault is hard to quantify or prove.

For these reasons, deductibles can not only be applied, but they can be waived or the amount can be edited.

Note: In the base configuration, ClaimCenter does not support paying a deductible across multiple payments.

Working with Deductibles

This section describes how to work with deductibles and contains the following sections:

- “Viewing Deductibles” on page 350
- “Applying Deductibles” on page 351
- “Editing Deductibles” on page 351
- “Waiving Deductibles” on page 351
- “Setting Up Deductibles” on page 352

Viewing Deductibles

There are several places in the user interface where you see if a deductible has been applied to a claim.

- On the **Summary** screen, you can see this information in the **Financials** section.
- On the **Subrogation** screen, if there is a subrogation on the claim.
- On the **Exposures** screen, such as in an auto policy.

The following example is taken from the **Exposures** screen of the first vehicle.

Financials	
Remaining Reserves	\$3,000.00
Future Payments	-
Total Paid	-
Total Recoveries	-
Net Total Incurred	\$3,000.00
Deductible	
Waive Deductible?	No
Deductible Amount	\$500.00
Deductible Paid?	No
Modify Deductible?	No

In this example, say that the adjuster later determines that the accident was not the insured’s fault. On the **Subrogation Financials** screen, the \$500 deductible has been applied. The deductible will be returned to the insured as soon as the carrier gets that amount from the party who was at fault. On the **Subrogation** screen, the deductible amount is shown only if the insured incurred it.

Because the deductible is associated with a coverage in ClaimCenter, the deductible amounts apply only to reserve lines created for an exposure. Therefore, claim-level reserve lines show no deductible amount.

Applying Deductibles

You can apply deductibles in the following Personal Auto wizards:

- New Check wizard, in step 2 of 3
- Quick Check wizard
- Auto First and Final wizard

You apply, or pay off, a deductible as payment is made against an exposure linked to a coverage with a deductible amount. On the payments step of the check wizard, after choosing a reserve line with an exposure having an unpaid deductible, you can optionally click **Apply Deductible**. If you decide to apply the deductible, ClaimCenter automatically creates a transaction line item with a value equal to the negative of the deductible amount. The new line item is then linked to the deductible, and the deductible is marked as paid.

In the base configuration, there is no support for paying off a deductible over multiple payments. You must apply the entire deductible amount as a negative transaction line item on a payment. If the deductible amount is greater than the amount of the check, ClaimCenter issues the following warning:

This payment cannot be added because it has a deductible line item whose amount exceeds the sum of the other line items' amounts.

After the deductible on a coverage is paid or waived, the **Apply Deductible** button is not available for any payments made against exposures linked to that coverage.

Editing Deductibles

A deductible can be overridden if it has not been paid or waived. The field indicating an overridden deductible is called **Modified**, and you access it by clicking a radio button. Clicking **Yes** causes the amount field to become editable, and you can edit the original amount to a lower, nonnegative amount. If the **Modify** flag is ever reset to **No**, ClaimCenter recalculates the claim deductible amount through the **DeductibleCalculator**, and it becomes uneditable again.

To change the deductible amount to a different number from that indicated on the policy

1. With a claim open, navigate to the **Exposures** screen and click an exposure name to open its details screen.
2. Click **Edit**.
3. Select a coverage if one has not already been selected.
4. In the **Deductible** section, for **Modify Deductible**, click the **Yes** radio button.
5. Enter a **Deductible Amount** and an **Edit Reason**.
6. Click **Update** to save your work.

Waiving Deductibles

A deductible can be waived if it has not been applied to any payment. You waive a deductible in the Details screen for an exposure, where you can set the deductible's **Waive Deductible** flag to **Yes**. This field is not editable if the deductible has already been paid, unless something has caused it to become unpaid, in which case the **Waived** field is again editable. If you waive a deductible, the **Apply Deductible** button does not appear in the check wizard after selecting related exposures. You must also have the permission of **Edit Deductible**.

Waiving a deductible is usually done by more experienced adjusters. Deductibles are often waived in no-fault states if the insured is not at fault.

To waive a deductible

1. With a claim open, navigate to the **Exposures** screen and click an exposure name to open its details screen.
2. Click **Edit**.
3. Select a coverage if one has not already been selected.
4. In the **Deductibles** section, for **Waive Deductible**, click the **Yes** radio button.
5. Enter an **Edit Reason**.
6. Click **Update** to save your work.

See also

- “Configuring Deductibles” on page 511 in the *Configuration Guide*

Setting Up Deductibles

Deductible data comes from the policy. ClaimCenter creates the **Deductible** entity during exposure creation or after updating to a coverage that has a deductible but does not already have a deductible linked to a claim. It is initially marked as unpaid, unwaived, and unmodified—the **Paid**, **Waived**, and **Overridden** columns in the database are **false**. If a new exposure is created without a coverage, or with a coverage that has no policy deductible, no associated deductible is created. Updating a coverage's existing policy deductible amount updates the deductible's amount if it exists and is unpaid.

In the base configuration, deductible handling is automatically set up. The following configuration parameters are set to **true** in the `config.xml` file:

- `UseDeductibleHandling` – Enables deductibles to be applied in the system.
- `AllowMultipleLineItems` – Since deductibles are applied through `TransactionLineItems`, this parameter must be also set to **true** for deductible handling to be enabled.

Setting the configuration parameter `UseDeductibleHandling` to **false** has the following results:

- The **Deductible** section of new claims does not show on the **Exposures** screen.
- For older claims that had an existing deductible, the **Deductible** section shows on the **Exposures** screen, but it is not editable.
- The **Apply Deductible** button does not display on the check wizard screen for old claims that have a deductible applicable.
- Transfer or Recode of payments does not match the deductible from old payments to new payments.

IMPORTANT If you set the configuration parameter `AllowMultipleLineItems` to **false**, while leaving `UseDeductibleHandling` set to **true**, you will encounter issues. You will not be able to create the first claim cost payment because there is no way to apply the deductible.

Bulk Invoices

Use the ClaimCenter bulk invoice feature to record an invoice containing items for multiple claims and then pay it with a single check.

Note: You must integrate ClaimCenter with ContactManager before you can use this feature. To enable you to set the bulk invoice payee, ClaimCenter must obtain contact data from ContactManager first. For details on how to integrate Guidewire ClaimCenter with Guidewire ContactManager, see “Integrating ContactManager with Guidewire Core Applications” on page 45 in the *Contact Management Guide*. See also “Bulk Invoice Integration” on page 391 in the *Integration Guide*.

This topic includes:

- “Bulk Invoice Overview” on page 354
- “Bulk Invoice Process Flow” on page 355
- “Using the Bulk Invoice Screens” on page 355
- “Working with Bulk Invoice Line Items” on page 359
- “Stopping or Voiding a Bulk Invoice” on page 360
- “Bulk Invoice Validation” on page 360
- “Bulk Invoice Approval” on page 361
- “Invoice Line Item Validation” on page 362
- “Bulk Invoice Checks” on page 363
- “Bulk Invoice Escalation” on page 364
- “Lifecycle of a Bulk Invoice and its Line Items” on page 364
- “Bulk Invoice Events and Acknowledgements” on page 369
- “Bulk Invoices and Multicurrency” on page 369
- “Bulk Invoice Financial Permissions and Authority Limits” on page 370
- “Bulk Invoice Web Service API” on page 371
- “Bulk Invoice Data Model” on page 371

Bulk Invoice Overview

ClaimCenter provides the ability to enter multiple claims into a single record and then pay these claims with a single check. In other words, you create an invoice with multiple, or *bulk* line items. The following examples illustrate this concept.

Process cross-claim invoices electronically

A rental car company sends a single monthly invoice to a carrier. This invoice has hundreds of line items, each for a loaner car rental charged to a different claim. You can use the bulk invoice feature to do the following:

- Electronically record the invoice.
- Assign each invoice line item to the correct claim.
- Create a single payment for all the line items on the invoice.
- Create a single check for the entire bulk invoice.

Enter cross-claim invoices manually

A police reports service provider sends a paper invoice every month with a list of police report bills for different claims. Using the bulk invoice feature, you enter the payments for each claim into one screen to create one bulk invoice and send one check.

See also

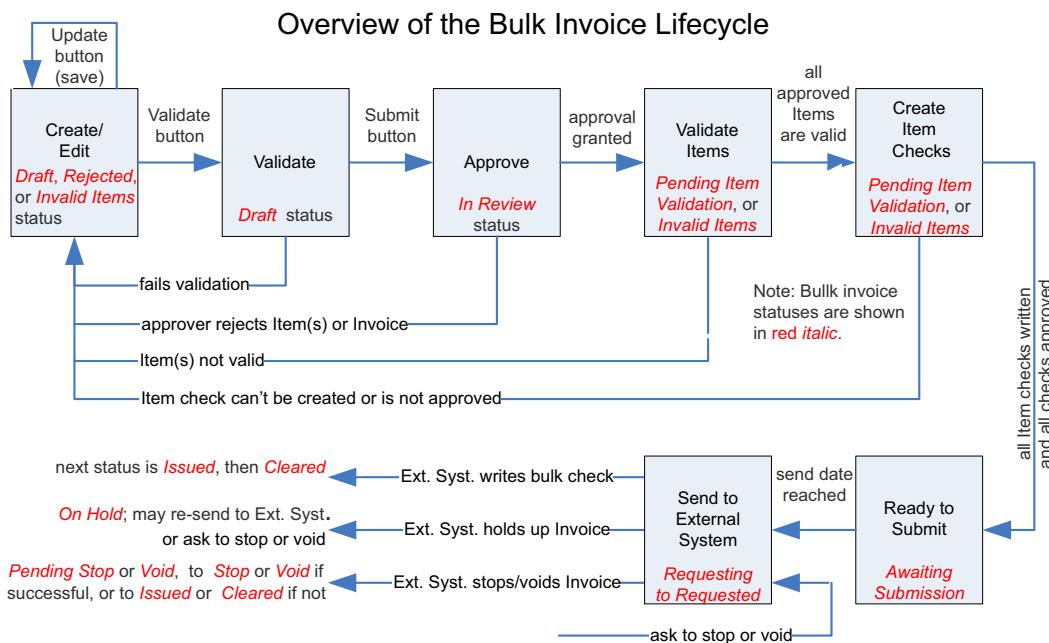
See the following topics for more information on bulk invoices.

Topic	See...
Bulk invoice activity patterns	<ul style="list-style-type: none">• "Miscellaneous Bulk Invoice Activity Pattern Parameters" on page 68 in the <i>Configuration Guide</i>• "Defining Activity Patterns" on page 425 in the <i>Configuration Guide</i>
Bulk invoice approval	<ul style="list-style-type: none">• "Bulk Invoice Approval" on page 361.
Bulk invoice configuration parameters	<ul style="list-style-type: none">• "Miscellaneous Bulk Invoice Activity Pattern Parameters" on page 68 in the <i>Configuration Guide</i>• "Approval Parameters" on page 36 in the <i>Configuration Guide</i>• "Search Parameters" on page 74 in the <i>Configuration Guide</i>
Bulk invoice data model	<ul style="list-style-type: none">• "Bulk Invoice Data Model" on page 371
Bulk Invoice escalation process	<ul style="list-style-type: none">• "Batch Processes Related to Checks and Payments" on page 616 in the <i>Configuration Guide</i>• "List of Batch Processes and Distributable Work Queues" on page 129 in the <i>System Administration Guide</i>
Bulk invoice integration: • <code>IBulkInvoiceValidationPlugin</code> • <code>BulkInvoiceAPI</code> • Validating a bulk invoice • Stopping/voiding a bulk invoice	<ul style="list-style-type: none">• "Bulk Invoice Integration" on page 391 in the <i>Integration Guide</i>• "Bulk Invoice Validation" on page 360
Bulk invoice payment configuration	<ul style="list-style-type: none">• "Configuring Bulk Invoice Payments" on page 658 in the <i>Configuration Guide</i>
Bulk invoice rules for bulk invoice approval and bulk invoice approval assignment	<ul style="list-style-type: none">• "BulkInvoice Approval Rules" on page 45 in the <i>Rules Guide</i>• "BulkInvoice Approval Assignment Rules" on page 40 in the <i>Rules Guide</i>
Bulk invoice screens	<ul style="list-style-type: none">• "Using the Bulk Invoice Screens" on page 355

Bulk Invoice Process Flow

To access the **Bulk Invoices** screen, select **Bulk Invoices** from the **Desktop** drop-down menu. To access the **Bulk Invoice Details** screen, either select an existing bulk invoice, or click **Create New** to open the details screen in edit mode. Enter your information. You cannot save the bulk invoice until you enter information in the required fields. See the “**Bulk Invoice Details Screen**” on page 356 for more information on each field.

The following diagram provides an overview of the bulk invoice process.



Note: ClaimCenter uses a plugin implementation of the `IBulkInvoiceValidationPlugin` plugin interface to perform bulk invoice validation. You can configure the plugin implementation to meet your business needs.

For details of the bulk invoice process flow, see the following topics:

Topic	See...
Bulk invoice creation or editing	<ul style="list-style-type: none"> “Using the Bulk Invoice Screens” on page 355 “Working with Bulk Invoice Line Items” on page 359
Bulk invoice validation	“Bulk Invoice Validation” on page 360
Bulk invoice approval	“Bulk Invoice Approval” on page 361
Line item validation	“Invoice Line Item Validation” on page 362
Line item check creation	<ul style="list-style-type: none"> “Bulk Invoice Checks” on page 363 “Bulk Invoices and Multicurrency” on page 369
Stopping or voiding a bulk invoice	“Stopping or Voiding a Bulk Invoice” on page 360

Using the Bulk Invoice Screens

You access the **Bulk Invoices** screen in ClaimCenter by first navigating to the **Desktop** tab, then selecting **Bulk Invoices** from the menu at the left-hand side of the screen. If there is no **Bulk Invoices** menu item, click the **Desktop** drop-down list and choose **Bulk Invoices**.

In the **Bulk Invoices** screen, you can view and edit existing bulk invoices, create new ones, or further process a bulk invoice. Use the buttons on this screen to do the following:

- **Create New** – Create a new bulk invoice.
- **Delete** – Select the check box of a bulk invoice and then click this button.
- **Submit, Stop, or Void** – Further process a bulk invoice.
- **Refresh** – Refreshes the screen to show the latest invoice status.

The function buttons are available only if you have the correct permissions, and the operation is possible on the selected bulk invoice.

Bulk Invoice Details Screen

To open the **Bulk Invoice Details** screen, do one of the following:

- Click **Create New** on the **Bulk Invoices** screen.
- Click one of the invoice numbers listed on the **Bulk Invoices** screen.

ClaimCenter divides the **Bulk Invoice Details** screen into multiple areas. The upper portion of the screen contains sections pertaining to the bulk invoice as a whole. The middle portion of the screen contains information on the validation status of the bulk invoice. The lower portion of the screen contains a list of line items. See the following for details:

- “Upper Portion of Bulk Invoice Details” on page 356
- “Validation Status Area of Bulk Invoice Details” on page 358
- “Bulk Invoice Line Items Area of Bulk Invoice Details” on page 359

Upper Portion of Bulk Invoice Details

The upper portion of the **Bulk Invoice Details** screen contains information relating to the overall invoice. It also contains a row of buttons that become active depending on the status of the bulk invoice. These buttons include the following:

Field	Description
Edit	Opens a writable version of this screen. This button is only available under specific circumstances. For example, the button is available if the bulk invoice is in Draft or Rejected status.
Submit	Submits the bulk invoice for approval, if required, or for further processing if approval is not required.
Refresh	Updates the bulk invoice status and shows if it has changed.
Update	Save the bulk invoice to the database in its current state, even if incomplete. You see this button if you create a new bulk invoice or edit an existing bulk invoice. After you click Update to save a bulk invoice, ClaimCenter shows the invoice with Draft status in the list of bulk invoices on the Bulk Invoices screen. It is possible to re-edit a bulk invoice after it has left Draft status, but not yet reached Requesting status. To do so, click the bulk invoice number in the list and click Edit . If you edit a bulk invoice and make any of the following changes, ClaimCenter returns the bulk invoice to Draft status: <ul style="list-style-type: none"> • Edit Payee or Total Amount. • Add or delete a line item. • Edit the claim number for a line item. • Edit the reserve line information for a line item, such as exposure, cost category, or cost type. • Edit the payment type if a line item.
Note: During line item validation, you can edit only line items that have failed the validation.	
Cancel	Undo any changes since you last clicked Update . You see this button in Edit mode only.

Invoice Section of Bulk Invoice Details

The **Invoice** section of the **Bulk Invoice Details** screen contains the following fields:

Field	Description
Invoice #	An identifier assigned to the invoice being entered. Typically, this identifier comes directly from the invoice received from the vendor. It is optional.
Date Received	The date that the bulk invoice was received from the vendor. The default value is the current day's date.
Distribution	Select one of the following: <ul style="list-style-type: none"> • Distribute amount evenly – ClaimCenter divides the total amount evenly among all the line items. Distribute amount evenly is useful if your bill contains the same charge for many similar claims, for example. • Enter individual amounts – Enter individual amounts for each line item.
Amount to distribute	If you select Distribute amount evenly , this field must contain a value. This value is the total amount of the invoice ClaimCenter will distribute equally among all the invoice items. If you do not select Distribute amount evenly , ClaimCenter hides this field.
<i>If multicurrency display is enabled, the following field also appears:</i>	
Currency	The currency that this bulk invoice uses. A bulk invoice has a single currency that ClaimCenter applies to all bulk invoice items and their corresponding checks when created or updated. For more information, see "Multiple Currencies" on page 335.
<i>If multicurrency display is enabled, the following fields also appear if the currency you select is not the default currency:</i>	
Exchange Rate Mode	If Automatic , the default, ClaimCenter uses the current market exchange rate. If Manual , you can enter a specific rate in the Exchange Rate field. For more information on this set of fields, see "Exchange Rates" on page 342.
Exchange Rate	The rate that this bulk invoice uses for all its items' associated payments. This rate is from the bulk invoice currency to the reporting currency, if ClaimCenter is in multicurrency mode.
Rate Set Description	Description of the origin of the exchange rates being used for this bulk invoice.
Date of ExchangeRate Entry	Date that the exchange rate being used for this invoice was entered.

Status Section of Bulk Invoice Details

The **Status** section of the **Bulk Invoice Details** screen contains the following fields:

Field	Description
Status	Status of the bulk invoice. See "Bulk Invoice Lifecycle Diagram" on page 366.
Date Approved	If the bulk invoice was approved, the date when the reviewer approved the bulk invoice.
Total Approved Amount	The total of all approved items. ClaimCenter calculates and stores both the total amount for all line items, and the <i>total approved amount</i> , which is the amount of the bulk invoice check. ClaimCenter stores these amounts internally with the following values: <ul style="list-style-type: none"> • Its value in the default application currency • Its value in the currency of the bulk invoice
Issue Date	Date the bulk invoice was issued.

Invoice Item Details Section of Bulk Invoice Details

The **Invoice Item Details** section of the **Bulk Invoice Details** screen contains the following fields:

Field	Description
Default Cost Type	Use to filter the available reserve lines for each item. You can also use these fields as you enter a new reserve line.
Default Cost Category	
Default Payment Type	Assign Supplemental, Final, or Partial to the payment type of each line item.

Check Details Section of Bulk Invoice Details

The Check Details section of the **Bulk Invoice Details** screen contains the following fields:

Field	Description
Payee	Required. You can select the payee from contacts in the Address Book. ContactManager or an external contact management system must be enabled so you can search the Address Book.
Payment Method	Required. Select check or electronic funds transfer (EFT). Depending on your selection, additional fields are shown.
Pay To the Order of	Required. This field is shown only if you opt to pay by check and defaults to Payee. You can select one or more payees from the address book.
Check #	The number of the check that pays the bulk invoice. ClaimCenter propagates this number to the item checks. This field is shown only if you opt to pay by check.
Delivery Method	Select from Send, Hold for adjuster, or No check needed if a manual check was written. This field is shown only if you opt to pay by check.
Recipient	Required. The person to whom the check processing system sends the check. The recipient defaults to Payee. This field is shown only if you opt to pay by check.
Mailing Address	The address where the check is sent. This defaults to the address of the Payee. This field is shown only if you opt to pay by check.
Select EFT Record	Select an existing EFT record attached to the current payee. This field is shown only if you opt to pay by EFT.
Name on the Account	Required. Name of the person holding the account. This field is shown only if you opt to pay by EFT.
Bank Name	Name of the bank receiving the payment. This field is shown only if you opt to pay by EFT.
Account Type	Required. Select Checking, Savings, or Other. This field is shown only if you opt to pay by EFT.
Account Number	Required. Enter the number of the account that is to receive the payment. This field is shown only if you opt to pay by EFT.
Routing Number	Required. Enter the ABA routing number of the receiving bank. This field is shown only if you opt to pay by EFT.
Report As	Whether the check amount is reportable to an income tax agency, such as the IRS.

Payment Instructions Section of Bulk Invoice Details

The **Payment Instructions** section of the **Bulk Invoice Details** screen contains the following fields:

Field	Description
Send Date	Required. The date to send the bulk invoice check to the downstream check-writing system.
Check Instructions	Special instructions, which must be a valid value from the <code>CheckHandlingInstructions</code> type-list.
Memo	Provides the ability to add free-form text to the check as you write it.

Validation Status Area of Bulk Invoice Details

ClaimCenter shows the validation status of the bulk invoice near the middle portion of the **Bulk Invoice Details** screen. You must write your own validation by configuring a plugin implementation of the `IBulkInvoiceValidationPlugin` plugin interface. In the base configuration, ClaimCenter provides the sample plugin implementation `gw.plugin.bulkinvoice.impl.SampleBulkInvoiceValidationPlugin`. This class is sample code only. You must configure the plugin code for your business needs. See “[Bulk Invoice Validation](#)” on page 360 for more information.

Bulk Invoice Line Items Area of Bulk Invoice Details

The lower portion of the **Bulk Invoice Details** screen contains a table of line items. Each line item corresponds to an invoice line item of the original bill. This table is initially empty after you create a new bulk invoice. Use the following buttons in working with line items:

- **Add** – Use to add a new blank row in which you can enter the details of another line item.
- **Remove** – Use to delete all line items whose check boxes have been checked.

Use the following fields to create a line item:

Field	Description
Claim Number	The claim against which to make the payment shown on this line. After entering a number, ClaimCenter checks to see that it is valid before allowing you to fill in the rest of the line item information.
Reserve Line	The reserve line on the claim against which to make the payment. ClaimCenter displays all the reserve lines on the claim in a drop-down list, after filtering them by Default Cost Type and Default Cost Category , if selected. If you select New to create a new reserve line, ClaimCenter prompts you to reselect an exposure.
Exposure	(Optional) If creating a new reserve line, select an exposure on the claim from this drop-down menu. See "Working with Bulk Invoice Line Items" on page 359 for more information. Note: A newly created reserve line uses the Cost Type and Cost Category from the Default Cost Type and Default Cost Category fields.
Payment Type	Choose one of the following: <ul style="list-style-type: none">• Final• Partial This value can be different for each line item.
Amount	Enter this value unless you previously chose to Distribute amount evenly , in which case the split amount appears.
Deductions	Shows any deductions created on the check by a deduction plugin, such as the BackupWithholdingPlugin plugin.
Service Date	See "Service Dates and Periods" on page 303.
Description	Optional field in which you can enter additional information.
Alerts	A list of messages describing errors encountered while creating or editing a bulk invoice, such as Invalid Claim Number or Payment for this line item exceeds reserves . The bulk invoice validation process produces other alerts.
Status	The bulk invoice equivalent of a transaction status. For a list of these statuses, see "Bulk Invoice Lifecycle Diagram" on page 366.

Working with Bulk Invoice Line Items

The lower portion of the **Bulk Invoice Details** screen contains information on the line items associated with the bulk invoice.

To create a new line item

1. If necessary, click **Edit** in the **Bulk Invoice Details** screen to access a writable version of the bulk invoice.
2. Click **Add** to create a new line item.
3. Enter the number of the claim against which ClaimCenter is to charge the invoice items on the bill.
 - If the claim number that you enter is invalid, ClaimCenter colors the **Claim #** field yellow. You cannot continue until you enter a valid claim number.
 - If the claim number is valid, ClaimCenter displays a list of its reserve lines. The reserve lines are filtered by the **Default Cost Category** and **Default Cost Type** values that you set previously for the bulk invoice.

4. Select an existing reserve line on the claim or select **New...** If you assign a line item to a reserve line that does not yet exist on the claim, ClaimCenter creates the reserve line on the claim during line item validation.
5. Select the **Exposure**, unless you want the reserve line to be at the claim level.
6. Select a Cost Type or a Cost Category or both in the **Default Cost Type** or **Default Cost Category** drop-down lists, in the Invoice Details portion of the screen.
7. Enter the remaining required fields:
 - **Payment Type**
 - **Amount**
 - **Deductions**
8. Click **Update** to save your work. The current values define the reserve line.

Notes:

- A bulk invoice line item can only contain one payment. See “Placeholder Checks” on page 362.
- It is possible to create reserve lines with different Cost Types or Cost Categories or both. To do so, use one set of defaults. Click **Update**, and then select a new set of defaults.
- It is important to understand that creating a new reserve line does not create a reserve for it. It is possible that this action can cause the line item to fail its validation if the payment exceeds its reserves.

Stopping or Voiding a Bulk Invoice

The integration with an external check-writing system provides an opportunity to try to stop or void a bulk invoice. Stopping or voiding moves the bulk invoice and its items into, respectively, Pending Stop or Pending Void status. The external check-writing system calls the **BulkInvoiceAPI** web service after it completes the cancellation. At this point, ClaimCenter transitions the bulk invoice into Stopped or Voided status.

Bulk Invoices that Are On Hold

The external system can also stop processing a bulk invoice and notify ClaimCenter through the **BulkInvoiceAPI** web service that the invoice is on hold. In this case, you can void it, stop it, or resubmit it. You must first correct the problem found by the downstream system before attempting to resubmit the bulk invoice.

Bulk Invoice Validation

ClaimCenter performs validation on the bulk invoice as part of the submission process, which occurs after you click **Submit**. The purpose of this validation is to ensure that the bulk invoice conforms to your company’s business practices. You can configure this validation by configuring a plugin implementation of the **IBulkInvoiceValidationPlugin** plugin interface. In the base configuration, ClaimCenter provides the sample plugin implementation **gw.plugin.bulkinvoice.impl.SampleBulkInvoiceValidationPlugin**.

The following sequence outlines the process that ClaimCenter follows in validating a bulk invoice in the base configuration:

1. The user clicks **Submit**.
2. ClaimCenter executes method **validateBulkInvoice**, for example, from the **EditBulkInvoiceDetail** PCF file, passing it the current bulk invoice. This method is defined in the plugin class that implements the **IBulkInvoiceValidationPlugin** plugin interface.
For an example of this method, see the plugin implementation **gw.plugin.bulkinvoice.impl.SampleBulkInvoiceValidationPlugin**.

3. The sample code—and, in general, any bulk invoice validation code—checks for specific conditions and generates error alerts if the bulk invoice meets those conditions. To customize the validation code, you set the following:

- The condition that triggers the validation alert.
- The type of the alert, as defined in the `BIValidationAlertType` typelist.
- The content of the alert message.

ClaimCenter also performs other validation checks internally, including the following:

- The validity of the claim number.
- The validation level of the exposures on the claim. All claim exposures must be at the Ability to Pay validation level to pass validation.

Note: Many edits invalidate the bulk invoice. Thus, ClaimCenter can repeat validation multiple times. See “Using the Bulk Invoice Screens” on page 355.

Bulk Invoice Approval

There are two approval processes that a bulk invoice must pass before ClaimCenter can further process the bulk invoice:

Approval Process	Description
Bulk invoice approval	Bulk invoice approval occurs after bulk invoice validation.
Check approval after line item validation	ClaimCenter requires that every check created by the bulk invoice must pass thorough the same approval process as all other checks. See “Bulk Invoice Checks” on page 363 for more information.

Bulk invoices go through a first approval process similar to transactions in ClaimCenter, except that there are no authority limits for bulk invoices. Clicking **Submit** starts this approval process. If no approval is required, the **Submit** button starts line item validation, which otherwise starts after approval is granted.

After being approved, the bulk invoice’s status becomes Pending Bulk Invoice Item Validation. All its line items not marked In Review or Rejected by the approver receive Item Approved status. All Rejected and In Review line items remain in the bulk invoice with this status. See “Orphan Line Items” on page 363.

If a bulk invoice and a particular item are approved, but ClaimCenter subsequently rejects that item’s check, then the bulk invoice item’s status becomes Not Valid. This status reflects the fact that ClaimCenter performs approval of the bulk invoice item in bulk invoice approval rules and activities. You need to fix the item, remove it, or manually reject it for the same reason the item’s check was rejected.

Bulk Invoice Approval Rules

In the base configuration, ClaimCenter provides a single Bulk Invoice Approval rule. This rule requires an approval for all bulk invoices. ClaimCenter disables this sample rule in the base configuration.

- If you have added additional approval and approval assignment rules, the approver sees an approval activity for the bulk invoice after you click **Submit**. The approver can now reject or approve the entire bulk invoice.
- If you are the approver and you want to review the bulk invoice, first select it from your **Activities** screen. The bulk invoice appears in the workspace at the bottom of the screen. Mark line items that you do not approve as either Rejected or In Review. ClaimCenter ignores all line items so marked—see “Orphan Line Items” on page 363 for more information. You can optionally add a comment to the marked items explaining the reasons for flagging them. You can also add comments to approved items.

After flagging line items, the approver can approve or reject the entire bulk invoice by using buttons of the same name on the same screen. If the approver clicks **Cancel** at any point, ClaimCenter removes all flags from all line items.

See also

- “BulkInvoice Approval Rules” on page 45 in the *Rules Guide*
- “BulkInvoice Approval Assignment Rules” on page 40 in the *Rules Guide*.
- “Bulk Invoice Integration” on page 391 in the *Integration Guide*

Invoice Line Item Validation

ClaimCenter initiates line item validation as soon as the bulk invoice has been approved, or submitted, if approval is not needed. This process proceeds asynchronously. To be validated, each approved line item:

- Must pass the Ability to Pay system validation level for its exposure or claim.
- Must not exceed available reserves, unless the configuration parameter `AllowPaymentsExceedReservesLimits` is set in the `config.xml` file.
- Must have a valid Payment Type.

If any line items fail this validation, its status becomes Not Valid. Additionally, the bulk invoice itself is given the status Invalid Bulk Invoice Items and cannot be processed further. You must first either edit or remove the line items. Editing or removing a line item returns the bulk invoice to Draft status for reapproval and a repeat of this line item validation.

Placeholder Checks

After a line item passes validation, ClaimCenter creates a check against the reserve line of the claim associated with the line item. These checks are never written. They are placeholders for the portion of the large bulk invoice check associated with that claim’s reserve line. The claim financial screen displays this information and provides details of that reserve line. The purpose of these checks is to indicate that a bulk invoice made a payment against that reserve line. Therefore, you cannot edit or delete these checks from the **Check Detail** screens.

As ClaimCenter creates each placeholder check, it also:

- Creates a claim contact for the check from the bulk invoice payee.
- Saves the contact with the claim.
- Marks the contact as linked with ContactManager.

ClaimCenter synchronizes these claim contacts with ContactManager. If the data changes for a contact in ContactManager, ClaimCenter updates the contact data as it runs the contact automatic synchronization batch process.

Note: A check created for a bulk invoice line item can only contain one payment with one line item.

Transfer and Recode

It is possible to transfer a placeholder check from one claim to a different claim. This process creates a new invoice item against the new claim. It is also possible to record the payment on a placeholder check on another reserve line, which updates the invoice item’s reserve line. If you make that change after the bulk invoice has been sent to an external accounting system, ClaimCenter notifies that system.

Repeated Line Item Validations

It is possible for line item validation to occur multiple times. As a consequence, it is possible for ClaimCenter to have validated some line items already. If this is the case, one or more line items can already possess a placeholder check. If a line item possesses a placeholder check already:

- ClaimCenter updates the existing check to reflect any editing changes.
- ClaimCenter retires the existing check if a line item becomes invalid after having been previously validated.

Note: During validation, if the check has already been approved, ClaimCenter does not require that the check be re-approved.

Orphan Line Items

If the bulk invoice approver marks any line items Rejected or In Review, those line items do not participate in line item validation. You can edit these items to remove these statuses until line item validation passes all the rest of the line items and their checks are approved. The bulk invoice now receives Awaiting Submission status, and these line items must now remain in the bulk invoice with their Rejected or In Review status. Their amounts do not become part of the bulk invoice's check.

For ClaimCenter to pay these amounts, you must either copy them to another bulk invoice, or write checks directly from their claims. Alternatively, you can edit the bulk invoice. However, such an edit in most cases invalidates the bulk invoice and moves it back to Draft status.

Bulk Invoice Checks

After ClaimCenter determines that the send date for the check associated with a bulk invoice has been reached, it sends the check to an external check-writing system for issuance. You enter the values to be written on the check in the **Payment Instructions** and **Check Details** sections of the **Bulk Invoices → Bulk Invoice Details** screen.

Note: You must write a message transport plugin implementation to listen for the **BulkInvoiceStatusChange** event for ClaimCenter to be able to pass the check to an external system. See “Bulk Invoice Integration” on page 391 in the *Integration Guide* for more information.

Bulk Invoice Check Approval

Every check created by the bulk invoice must pass thorough the same approval process as all other checks. If it is not possible to either create or approve a check, ClaimCenter cannot send the bulk invoice itself to the external processing system. You must remove or edit the offending line item. If you edit the line item, ClaimCenter then requires that it be re-approved.

Bulk Invoice Escalation

Escalating a bulk invoice is the last step in the creation and approval of a bulk invoice. It involves the following batch processes:

Batch Process	Description
Bulk Invoice Workflow Monitor	The BulkInvoiceWF batch process transitions the bulk invoice to Awaiting Submission status after its checks are approved. It can also transition the bulk invoice to Invalid Bulk Invoice Items status. Which status a bulk invoice transitions to depends on whether all the pending-approval checks were either approved or rejected.
Bulk Invoice Escalation	<p>After the bulk invoice reaches its Send date and is in Awaiting Submission status, the BulkInvoicesEscalation batch process gives the bulk invoice Requesting status. Integration code sends the bulk invoice to the downstream accounting or check-writing system.</p> <p>You can edit the bulk invoice until it receives Requesting status. Most edits that you make, however, invalidate the bulk invoice and return it to Draft status. The only actions possible for the bulk invoice after it has been escalated are:</p> <ul style="list-style-type: none"> • Stopping the bulk invoice • Voiding the bulk invoice • Placing the bulk invoice On Hold <p>The bulkinvoicesescalation batch process escalates the placeholder checks for the items, causing the items to go to Submitting status. You can exclude an individual placeholder check from this process by clearing its PendEScalationForBulk property. This exclusion causes ClaimCenter to escalate the check as a standard check with the financialesc—Financials Escalation—batch process.</p>

See also

- For more information on these batch processes, see “Batch Processes and Work Queues” on page 123 in the *System Administration Guide*.
- For more information on bulk invoice processing, see “Bulk Invoice Process Flow” on page 355.
- For more information on creating or editing a bulk invoice, see “Using the Bulk Invoice Screens” on page 355.

Lifecycle of a Bulk Invoice and its Line Items

Each stage in the lifecycle of a bulk invoice has a specific status. The **Bulk Invoice** screen shows the status of each bulk invoice. To update the ClaimCenter screen to reflect the latest status values, click **Refresh**.

See also

- Individual line items also have their own, similar lifecycles and statuses. See “Lifecycle of Bulk Invoice Line Items” on page 368 for details.
- Status changes cause events that you can use to trigger a custom rule or action. See “Bulk Invoice Events and Acknowledgements” on page 369 for details.

Lifecycle of a Bulk Invoice

The lifecycle of a bulk invoice has the following general course:

- A user creates a bulk invoice. This process can take place over a period of time.
- The user clicks **Update** for the first time. This action saves the current bulk invoice information to the database, complete or not. All bulk invoices at this point have a status of Draft.
- The user clicks **Submit**. ClaimCenter performs validation on the bulk invoice:

- If the bulk invoice passes validation, and it requires approval, ClaimCenter sends the bulk invoice to the selected reviewer and changes the status to In Review. If approved, line item validation and processing starts immediately. The status is Pending Bulk Invoice Item Validation.
- If the bulk invoice passes validation and it does not require approval, clicking **Submit** immediately starts line item validation and processing. The status is Pending Bulk Invoice Item Validation.
- The `BulkInvoiceSubmission` distributed work queue processes each item by creating a placeholder check on the item's associated claim. This check might require approval, like any other check. This approval is separate from bulk invoice approval.

Note: If a bulk invoice gets stuck in Pending Bulk Invoice Item Validation status and all workers have finished, an administrator must run the Bulk Invoice Submission batch process again. For more information, see “Bulk Invoice Submission” on page 131 in the *System Administration Guide*.

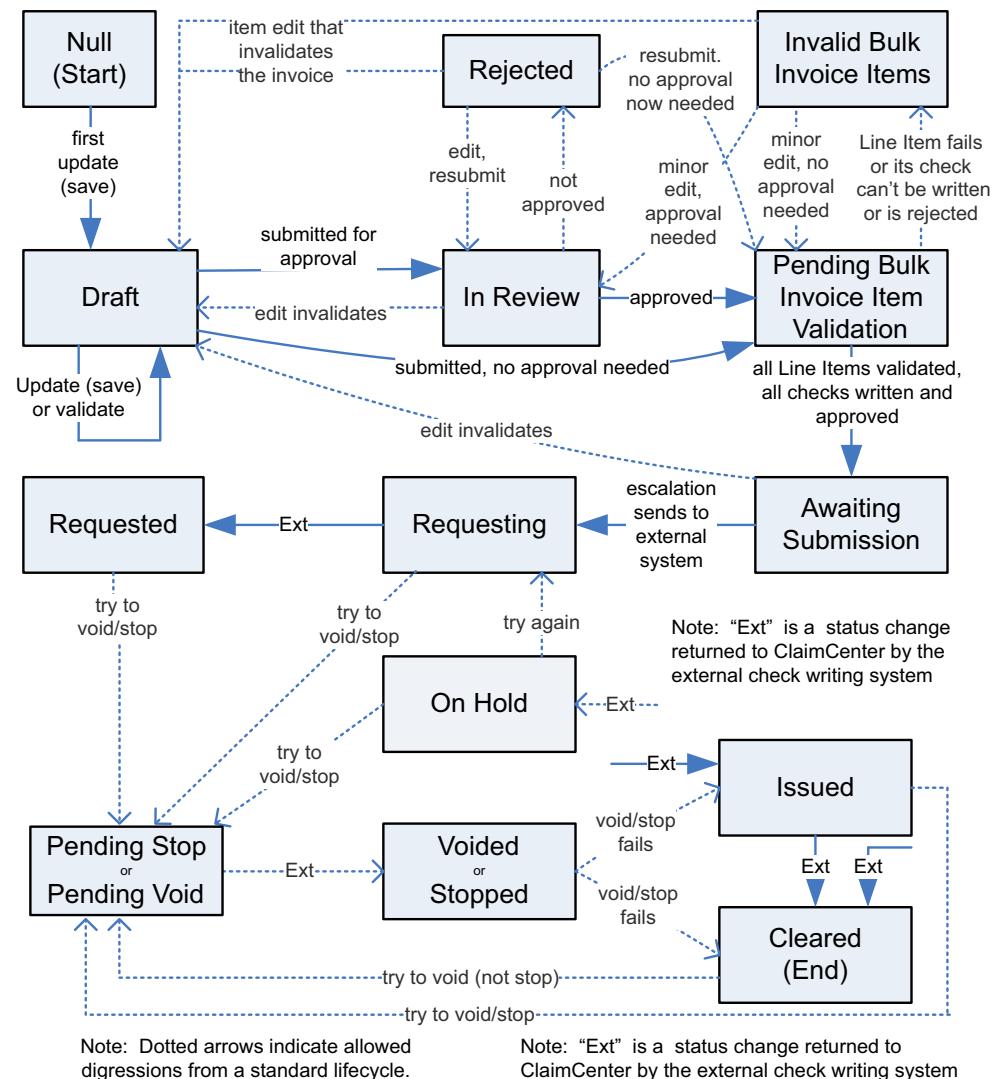
- If a line item fails its line item validation, or its check cannot be written or is rejected, ClaimCenter moves the bulk invoice status to Invalid Bulk Invoice Items. At this point, it is possible to re-edit the line item to remove the validation issue.
- After ClaimCenter validates all line items and the associated placeholder checks are approved, ClaimCenter executes a batch process called Bulk Invoice Workflow Monitor (`BulkInvoiceWF`). This process transitions the bulk invoice from Pending Bulk Invoice Item Validation status to either Awaiting Submission status or Invalid Bulk Invoice Items status.
- If ClaimCenter moves the status to Awaiting Submission, the bulk invoice remains in that status until it reaches its send date. At this point, any editing that you perform on the bulk invoice returns it back to Draft status.
- After the bulk invoice reaches its send date, ClaimCenter escalates the bulk invoice to Requesting status and transmits it to an external check-writing system.
- After the external system acknowledges receipt of the request, ClaimCenter moves the bulk invoice to the Requested status.
- After the external system produces the bulk check, it sends an Issued status, then a Cleared status back to ClaimCenter.
- At any time after sending the bulk invoice to the external system, but before it reaches Cleared status, you can attempt to stop or void its check. This attempt moves the bulk invoice status to either Pending Stop or Pending Void. If the attempt to stop succeeds, the bulk invoice status then moves to Stopped. If the attempt to void succeeds, the bulk invoice status then moves to Void.
- The external system can also attempt to stop a bulk invoice by giving it On Hold status.

Bulk Invoice Lifecycle Diagram

The following diagram illustrates the transitions from one bulk invoice status to another in the base configuration.

Note: Some statuses advance either by web service APIs or through the user interface, which the diagram does not show explicitly. See “Financial Transaction Status and Status Transitions” on page 363 in the *Integration Guide* and “Check Integration” on page 372 in the *Integration Guide*.

Bulk Invoice Statuses



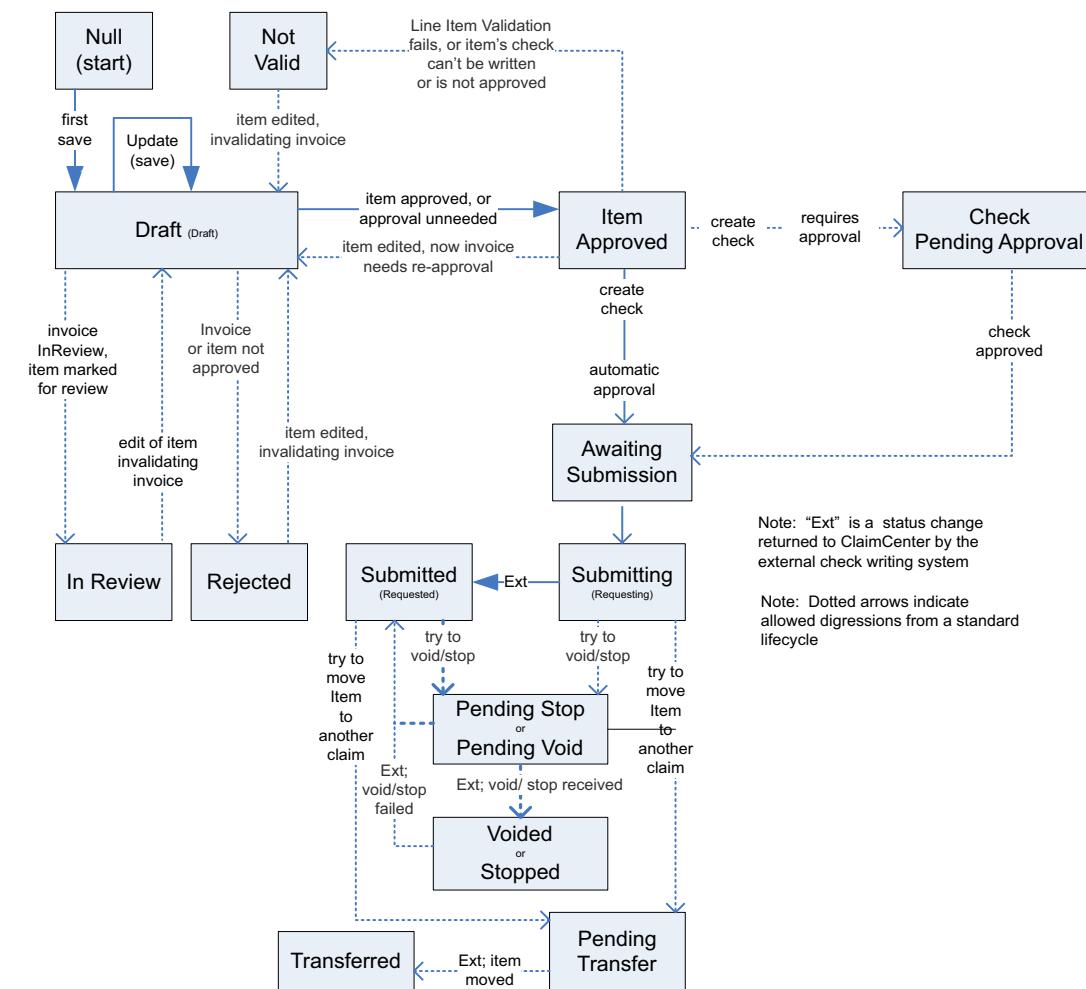
Bulk invoice status	Can delete or edit	Description
Awaiting submission	yes	Awaiting the date to be submitted to the downstream system.
Cleared	no	Downstream system notification that the bulk invoice check cleared.

Bulk invoice status	Can delete or edit	Description
Draft	yes	Bulk invoice is possibly committed to database, but is not yet ready for validation due to one of the following: <ul style="list-style-type: none"> After being initially edited or re-edited after saving, or after being invalidated by edits by the approver. After edits to correct line item validation errors, or after edits while awaiting submission to the downstream system.
In review	yes	Submitted for approval and waiting for approval from the assigned approver.
Invalid bulk invoice items	yes	At least one line item failed processing, or its check could not be written or was rejected.
Issued	no	Downstream system notification that the bulk invoice check was issued.
null	yes	Creation started but never saved, meaning that the creator of the bulk invoice has never used the Update button.
On hold	no	Downstream system found problems and notified ClaimCenter.
Pending bulk invoice item validation	no	Approved, or not needing approval, ClaimCenter is currently processing—validating—all the line items.
Pending stop	no	The messaging plugin sent a message downstream to stop the bulk invoice. ClaimCenter does not configure the message plugin in the base configuration. You must manually set this up.
Pending void	no	The messaging plugin sends a message downstream to void the bulk invoice. ClaimCenter does not configure the message plugin in the base configuration. You must manually set this up.
Rejected	yes	Rejected by the assigned approver.
Requested	no	Downstream acknowledgement that bulk invoice was received.
Requesting	no	Queued for submission to the downstream system.
Stopped	no	Downstream system reported that the stop request succeeded.
Voided	no	Downstream system reported that the void request succeeded.

Lifecycle of Bulk Invoice Line Items

The following diagram illustrates the transitions from one line item status to another in the base configuration.

Statuses of Bulk Invoice Items



The following list describes each status of a bulk invoice line item:

Line item status	Invoice status	Can delete or edit	Comment
Awaiting submission	awaitingsubmission	yes	Bulk invoice item and its check have passed approval and are ready to be escalated, after the bulk invoice is ready to be escalated
Check pending approval	pendingitemvalidation	yes	Bulk invoice item has passed the bulk invoice approval process and is waiting for its check to be approved
Draft	draft	yes	Being initially edited, or reedited after being invalidated by edits after line item validation rejects it or another line item
In review	any	yes	Approver gives Item this status. It will not be processed further unless reedited. See "Orphan Line Items" on page 363.

Line item status	Invoice status	Can delete or edit	Comment
Item approved	any	yes	Passed bulk invoice approval and passed line item validation.
Not valid	any	no	Failed line item validation processing.
Null	null	yes	Bulk invoice created but never saved—Update button not clicked.
Pending stop	pendingstop	no	Message sent downstream to stop the invoice.
Pending transfer	requested or later	no	Notify downstream system to transfer Item to another claim.
Pending void	pendingvoid	no	Message sent downstream to void the invoice.
Rejected	any	yes	Same as in review.
Stopped	stopped	no	Downstream acknowledgement that stop request received.
Submitted	requested	no	Downstream acknowledgement that submission received.
Submitting	requested	no	Submitted (sent) to the downstream system.
Transferred	requested or later	no	Downstream acknowledgement that transfer request received.
Voided	voided	no	Downstream acknowledgement that void request received.

Bulk Invoice Events and Acknowledgements

ClaimCenter generates a specialized `BulkInvoiceStatusChanged` event every time it updates the bulk invoice status, as well as when it first creates the bulk invoice. In addition to the `BulkInvoiceStatusChanged` event, ClaimCenter generates the following events as well:

- `BulkInvoiceAdded`
- `BulkInvoiceUpdated`
- `BulkInvoiceRemoved`

These events are similar to the events that ClaimCenter generates for all financial transactions and checks.

IMPORTANT You must implement a version of the message transport plugin that can listen for the `BulkInvoiceStatusChanged` event. This message transport plugin implementation is necessary for ClaimCenter to be able to pass the check to an external system. See “Bulk Invoice Integration” on page 391 in the *Integration Guide* for more information.

Bulk Invoices and Multicurrency

A bulk invoice uses a single currency. That currency becomes the transaction currency for each of its invoice items’ checks. The transaction currency does not have to be the same as the default application currency. Whatever currency you choose, the entire bulk invoice and its associated checks use this currency, as do all the line items associated with the bulk invoice.

The bulk invoice also has an exchange rate from its transaction currency to the reporting currency. It is possible to attach the items for a bulk invoice to different claims, with different currencies.

It is also possible for the currency that a claim uses to differ from the default application currency and from the currency of the bulk invoice. This means that the bulk invoice transaction-to-reporting exchange rate cannot be used directly as the transaction-to-claim and claim-to-reporting exchange rates on the check.

ClaimCenter selects the two exchange rates for each check according to the following table:

Currencies: Transaction/BI, Claim, and Reporting	Transaction-to-Claim Exchange Rate	Claim-to-Reporting Exchange Rate
All currencies are the same.	Market identity rate. This is defined as a market exchange rate in which the base currency equals the price currency and the numerical value is 1.	null
The reporting currency is different.	Market identity rate.	The bulk invoice's transaction-to-reporting rate
The claim currency is different.	ClaimCenter uses market rates and does not prompt you for an exchange rate.	ClaimCenter uses market rates
The Transaction/BI currency is different	The bulk invoice's transaction-to-reporting exchange rate.	null
All are different, automatic	Market rate.	Market rate
All are different, manual	Custom rate created by dividing the bulk invoice's transaction-to-reporting rate by the claim-to-reporting rate.	Market rate

After you select market rates, including identity rates, the following occurs.

- If the bulk invoice transaction-to-default rate is a market rate, it is possible to select it from that rate's market rate set.
- If the bulk invoice uses a custom rate, it is possible to select it from a market rate set with a date near that of the custom rate's effective date.

After ClaimCenter updates the checks, it repeats this process and recalculates the exchange rates and amounts.

Exchange Rate Adjustment of a Bulk Invoice

You can apply foreign exchange adjustment to the placeholder checks of a bulk invoice (the checks created for each item), but not to the bulk invoice itself.

Bulk Invoice Financial Permissions and Authority Limits

This section lists all the security aspects of bulk invoice transactions.

User Permissions

The following user permissions pertain to bulk invoices:

- `bulkinvview` – View bulk invoice
- `bulkinvcreate` – Create bulk invoice
- `bulkinvedit` – Edit bulk invoice
- `bulkinvdelete` – Delete bulk invoice

In the base configuration, the following roles have all the previously listed user permissions:

- Adjuster
- Claims Supervisor
- Clerical
- Customer Service Representative
- Manager
- New Loss Processing Supervisor

- Superuser

Authority Limits

Bulk invoices have no special authority limits, but all transaction authority limits apply. These limits set the following:

- The maximum for the claim and exposure total and available reserves
- The maximum for any single payment
- The maximum for a change in reserves amount
- The maximum for a payment that exceeds reserves

The `CheckAuthorityLimits` configuration parameter in the `config.xml` file controls whether ClaimCenter checks authority limits for individual checks. The default value is `true`.

For more information on authority limits, see “Managing Authority Limit Profiles” on page 476.

Bulk invoice checks are subject to the same rules that apply to standard ClaimCenter checks. If you configure ClaimCenter to not allow payments to exceed reserves, this setting also affects bulk invoices. In this case, be sure that reserves are set high enough before creating the checks of a bulk invoice, or set configuration parameter `AllowPaymentsExceedReservesLimits` in the `config.xml` file to `true`.

Bulk Invoice Web Service API

ClaimCenter includes a web service called `BulkInvoiceAPI` that enables an integrated system to submit and manipulate bulk invoices directly from the external system. For example, it is possible for an associated rental car company to directly submit bulk invoices to ClaimCenter from its systems by using this web service. In addition, `BulkInvoiceAPI` methods can create and submit bulk invoices, as well as add, update, and delete bulk invoice items.

See also

- See “Bulk Invoice Integration” on page 391 in the *Integration Guide* for more information on the `BulkInvoiceAPI` web service methods.

Bulk Invoice Data Model

The data model uses the following entities to support bulk invoices.

Entity	Description
<code>BulkInvoice</code>	The top level <code>BulkInvoice</code> entity. It corresponds to the incoming invoice or bill to be paid. It has a unique ID that can correspond to the invoice, some data fields, such as payee and a scheduled send date, and a non-null array of <code>BulkInvoiceItem</code> objects.
<code>BulkInvoiceItem</code>	Describes one line of the <code>BulkInvoice</code> . It corresponds to one line item of the original invoice. It contains data fields describing the reserve line of the claim to which the item is to be charged, the amount, and the payment type. It is associated with a single claim.

Entity	Description
BIVValidationAlert	Encapsulates one alert generated by a bulk invoice validation. Your implementation of the <code>IBulkInvoiceValidationPlugin</code> plugin interface must return an array of these objects, or <code>null</code> if the validation is successful. Each alert consists of a message and an alert type taken from the <code>BIVValidationAlertType</code> typelist.
	See “Bulk Invoice Validation” on page 360 for more information on generating validation alerts.
ReserveLineWrapper	Provides a level of indirection between a <code>BulkInvoiceItem</code> and its <code>ReserveLine</code> . This extra level is necessary if you create a <code>BulkInvoiceItem</code> for a non-existent reserve line, which prevents ClaimCenter from committing the <code>BulkInvoiceItem</code> to the database. The <code>BulkInvoiceItem</code> has a non-null foreign key to <code>ReserveLineWrapper</code> . There is a second foreign key from the wrapper to the actual reserve line that is <code>null</code> if the reserve line does not yet exist. ClaimCenter displays the wrapper’s reserve line, so you never see this.

The bulk invoice feature uses the following typelists.

Typelist	Description
<code>BulkInvoiceStatus</code>	The status of the bulk invoice. Its typecodes control which actions are possible for the invoice, such as edit, submit, void, and so on.
<code>BulkInvoiceItemStatus</code>	The status of a single <code>BulkInvoiceItem</code> . As with the <code>BulkInvoiceStatus</code> , this status controls which actions are possible for a given invoice item.
<code>BIVValidationAlertType</code>	The alert type for an alert returned from the <code>IBulkInvoiceValidationPlugin</code> . In the base configuration, this typelist has only the following typecodes: <ul style="list-style-type: none">• <code>itemwitharchivedclaim</code>• <code>unspecified</code> You can extend this list with alert types specific to the tests that you execute in your validation plugin implementation.

The bulk invoice feature uses the following configuration parameters. See “Application Configuration Parameters” on page 33 in the *Configuration Guide* for details.

Configuration parameter	Description
<code>AllowPaymentsExceedReservesLimits</code>	If true, a user can submit payments that exceed available reserves up to the amount limited by the <code>paymentsexceedreserves</code> authority limits. See “ <code>AllowPaymentsExceedReservesLimits</code> ” on page 58 in the <i>Configuration Guide</i> .
<code>BulkInvoiceApprovalPattern</code>	Name of the activity pattern to use if creating bulk invoice approval activities. See “ <code>BulkInvoiceApprovalPattern</code> ” on page 36 in the <i>Configuration Guide</i> .
<code>BulkInvoiceItemValidationFailedPattern</code>	Name of the activity pattern to use in creating an activity to alert of a failure during processing of a bulk invoice item. See “ <code>BulkInvoiceApprovalPattern</code> ” on page 36 in the <i>Configuration Guide</i> .
<code>BulkInvoiceUnableToStopPattern</code>	Name of the activity pattern to use if creating an activity to alert that ClaimCenter was unable to stop a bulk invoice. See “ <code>BulkInvoiceUnableToStopPattern</code> ” on page 68 in the <i>Configuration Guide</i> .
<code>BulkInvoiceUnableToVoidPattern</code>	Name of the activity pattern to use in creating an activity to alert that ClaimCenter was unable to void a bulk invoice. See “ <code>BulkInvoiceUnableToVoidPattern</code> ” on page 68 in the <i>Configuration Guide</i> .
<code>MaxBulkInvoiceSearchResults</code>	Maximum number of bulk invoices that ClaimCenter returns in a search. See “ <code>MaxBulkInvoiceSearchResults</code> ” on page 74 in the <i>Configuration Guide</i> .

part VII

ClaimCenter Services



chapter 36

Services

The Services feature in ClaimCenter provides the adjuster with tools to create, track, and manage requests for services to be provided by vendors. ClaimCenter works in conjunction with a contact management system such as Guidewire ContactManager and optionally, a vendor portal, to streamline the communication between adjusters and specialists offering services. Using this feature, you can identify the right vendors, create service requests, follow up on the progress of the work, make payments, and track vendor performance.

This topic includes:

- “Services Overview” on page 375
- “Creating a Service Request” on page 377
- “Viewing Service Requests” on page 378
- “Promoting Service Requests” on page 381
- “Canceling or Declining Service Requests” on page 381
- “Assigning Service Requests” on page 382
- “Service Request Documents” on page 383
- “Making Payments” on page 384
- “Lifecycle of a Service Request” on page 385
- “Service Request Metrics” on page 386
- “Configuring Service Requests” on page 388

See also

- “Vendor Services” on page 181 in the *Contact Management Guide*
- “Configuring Services” on page 495 in the *Configuration Guide*

Services Overview

A *service* can be defined as any action that can be requested from a third-party vendor or internal provider. Some examples are requesting a rental or courtesy vehicle, inspection and repair of damaged equipment, or commissioning construction services. The services feature provides adjusters with the ability to send service requests to vendors outside ClaimCenter and follow up on their progress. ClaimCenter uses a contact management system,

such as ContactManager, to access and select vendors capable of providing specific services and a vendor portal to facilitate communication with vendors.

Note: In this topic and included examples, Guidewire ContactManager is used as the default contact management system, and the Guidewire Vendor Portal is used as the default vendor communication portal. If you use non-standard components to manage contacts and vendors, please ensure they are integrated appropriately with Guidewire ClaimCenter before proceeding with adding and managing services.

You can create a service request in ClaimCenter in two ways – during claim creation in the New Claim wizard or at any time using the **Actions** menu. This topic covers the creation of service requests in the **Actions** menu. See “New Claim Wizard Steps” on page 80 for more on adding services in the New Claim wizard.

Once a service request is created, its status can be monitored and updated in both ClaimCenter and the integrated Vendor Portal. You can add one or more quote and invoice documents to the service request and send messages to the vendor. When work is complete, you can proceed from the service request to the payment process using the built-in payment wizard.

You can also associate notes and activities to the service request, and ClaimCenter can be configured to notify adjusters with a generated activity when a service request fulfills a condition. For example, the adjuster is notified when a service request is declined.

The following sections describe the process of setting up and using the services feature in more detail.

Setting Up Services

A basic set of services is provided in XML file format with sample data. This information can be customized per business requirements and imported into ClaimCenter and ContactManager. This is the recommended approach.

Note: Once service data is imported, you cannot edit it or manage its synchronization with ContactManager in the application user interface. You can only make changes by editing the corresponding XML file and importing it back into the applications. Review your XML data files carefully before finalizing them for import into ClaimCenter and ContactManager.

The services directory is structured in a tree format and shown when you attempt to add a service to a claim. At the topmost level of the tree, the folder nodes represent service categories. Under these, you can define service subcategories or service types. The leaf nodes of the tree represent the specialized services grouped under each category.

In the services XML files, you can configure associated service request types—incident types—as well as the categories, subcategories, and service types of the vendor service tree.

See also

- “Importing Services” on page 495 in the *Configuration Guide*
- “Installing Sample Data” on page 53 in the *Installation Guide*

Service Request Types

A service request can have a different lifecycle, based on its request type. Once you select the request type, the service request goes through various predefined stages, which are indicated in the ClaimCenter user interface by status and action update messages.

Service requests in ClaimCenter are classified into four types:

- Quote
- Quote and Perform Service
- Perform Service
- Unmanaged

Quote

Use the **Quote** request type if you require only a quote from vendors. You would use this option, for example, to compare vendor quotes before making a final selection.

You can *promote* a quote-only service request to a quote-and-perform-service request using the **Request Service from Quote** menu option. See “Promoting Service Requests” on page 381.

Quote and Perform Service

Use the **Quote and Perform Service** request type if you require the complete service request lifecycle – obtain quotes, request service, and make payments.

Perform Service

Use the **Perform Service** request type if you only require a service, such as requesting a courtesy or rental car. You can then proceed to make a payment, if necessary, once the service is complete.

Unmanaged

The **Unmanaged** request type is a specialized type used only for services created from the Auto First and Final wizard. This request type is not available for other claims.

Creating a Service Request

In ClaimCenter, you can create a new service request by using the **Actions** menu.

To create a new service request

1. Click **Actions** → **New...Service**.
2. ClaimCenter displays the **Create Service Request** screen, where you enter relevant information to be communicated to the vendor on the specified services.

Enter the following information:

- **Relates To** – Specify if the service is requested for the entire claim or for a specific incident.
- **Services to Perform** – Add the services you would like the vendor to perform.

Click **Add** to view the services directory in the **Select Services to Add** screen. The selected services are shown by category, subcategory, and service type. In the **Select Services to Add** screen, you can search for specific services in the directory by entering text in the text field and selecting **Filter**. You can also **Reset** your selections to start over.

Select one or more related services, and click **Add** again.

Note: The **Filter** option can perform partial name searches as well.

You can add one or more related services to one service request, and you can specify this in the Services data files. If you attempt to add services that cannot be combined in the same service request, ClaimCenter displays an error message. Request these services in separate service requests. For example, in the base configuration, you cannot add a request for a car rental along with a request to repair furniture.

- **Request Type** – Select the type of the service request. You can choose from **Perform Service**, **Quote**, and **Quote and Perform Service**, depending on whether you are requesting only a quote, only a service, or both. ClaimCenter only displays the request types associated with the services selected in the previous step. This is configurable as well.
- **Name** – Select a vendor. You can create a new vendor contact, select an existing vendor on the claim, or you can search and retrieve information for a vendor from ContactManager. If you choose the latter, the

Search Address Book For Vendors screen now displays with the selected services and an option of finding only vendors offering these services.

- **Additional Instructions** – Enter any additional instructions you have for the vendor regarding this service. This field is optional.
- **Requested Quote/Service Completion Date** – Enter the desired date of quote or service completion for the vendor. The initial value is set to a week from the current date.
- **Customer Contact** – Add a customer contact for the service request. You can create a new contact, select an existing contact on the claim, or you can search and retrieve information for an existing contact from ContactManager.
- **Service Address** – Enter the address at which the service is to take place.

3. If your service request is complete, click **Submit**. Alternately, you can choose to simply **Save** it in draft form and return to complete it later.

The service request is now shown in the **Services** screen, associated with the claim, assigned a service number, and sent to the selected vendor for processing. The vendor is notified through the Vendor Portal, and as the vendor responds, you can manage and monitor the status and progress of the service request in ClaimCenter.

Creating Services Requests in the New Claim Wizard

You can also create a service request during claim creation in the **New Claim Wizard**. The **Services** menu is included in **Step 4** of the wizard for configured policy types. See “**New Claim Wizard Steps**” on page 80 for more information.

Viewing Service Requests

After a service request is added to a claim or incident, it is assigned a service number, and you can view details and associated components in the main **Services** screen.

The **Services** screen provides a list of services and a detail view showing details on the currently selected service.

Services List

The **Services** screen displays all service requests associated with a claim, organized by **Request Type**, **Status**, and service number (**Service #**).

The following icons indicate the service request type:

Icon	Service Request Type
	Perform Service
	Quote
	Quote and Perform Service

The following icons indicate the status of a service request:

Icon	Service Request Status
	Draft, Declined, Canceled, or Expired These are Progress status messages.
	Requested
	Quoted
	Completed
	Alert. The service request needs your attention. This icon can be used in conjunction with the other icons.

Each service request also displays the **Next Action** to be taken, the responsible **Action Owner**, and whether the service request relates to a claim or an incident. Vendor and service request details and quote amounts, if any, are also shown. The **Target** column displays the estimated date for the Next Action to be completed.

Select a service to view details and associated components of the service request, which are described next.

Detail View of a Service

In ClaimCenter, a service request goes through a sequence of stages in its path to completion. You can view and edit the status of a service request in the **Details** card, which includes the following:

- **Service Number** – Unique number generated by ClaimCenter and assigned to the service request. Like the claim number, you can configure how this is generated, but it needs to be a globally-unique string. Refer to the ClaimCenter Configuration Guide for more information.
- **Reference Number** – Number assigned by the vendor in the Vendor Portal.
- **Progress** – The status of the service request. See “Lifecycle of a Service Request” on page 385 for more information on the possible values of the **Progress** status.
- **Quote Status** – The status of any attached quotes. See “Lifecycle of a Service Request” on page 385 for more information on the possible values of the **Quote Status**.
- **Next Action** – The next step to be taken to complete the service request. This step is dependent on the **Progress** and **Quote Status** fields.
- **Action Owner** – The party responsible for taking the next step, usually the adjuster or the vendor.
- **Relates To** – Specifies if the service request is associated with the entire claim or with a specific incident.
- **Requested Quote/Service Completion Date** – Requested date of completion.
- **Expected Quote/Service Completion Date** – Expected date of completion. The initial value of this date is the requested date. It is updated, if necessary, by the vendor.
- **Currency** – Currency for the service request and associated invoices.

The **Vendor** section lists the contact information for the vendor performing the service and the communication method used by ClaimCenter to connect to vendors. In the **Services to Perform** section, the category, subcategory, and type of service are shown, along with the request type.

Customer and service contact information is also shown in this card.

Quotes

The **Latest Quote/Prior Quote** section displays details of the most recent quote attached to the service request. You can view or edit the quote. You can also request a requote, revise the quote amount, or approve the quote in this section.

The **Quote Documents** table enables you to view and edit the quote document. See “Editing Quotes” on page 383 for more information.

Invoices

The **Invoices** section displays the invoices attached to the service request. You can add another invoice or view the existing invoices in the **Invoices** card.

See “Approving Invoices” on page 384 for more information on adding and approving invoices.

Metrics

The **Metrics** section provides information on various metrics measured during the progress of this service request, such as **Quote Timeliness** and **Number of Delays**.

See “Service Request Metrics” on page 386 for more information on service request metrics.

History

The **History** card displays a record of all changes made to the service request, including actions originating from the vendor portal. Links to attached documents, if any, are shown.

Activities

The **Activities** card lists activities, if any, generated by the service request. For example, when a vendor adds a quote, ClaimCenter creates an activity to notify you that it needs to be reviewed.

Like the **Workplan** menu link, you can view, assign, skip, complete, approve, or reject activities. See “Activities Overview” on page 217 for more details on managing activities.

Documents

In the **Documents** card, you can add and view documents, including quotes and invoices, associated with the service request. Documents can be attachments to files in your system or links to other documents in ClaimCenter.

Note: You need appropriate permissions to access documents with special confidentiality and security levels. See “Document Security” on page 526 for more information.

Notes

In the **Notes** card, you can create, edit, and view notes associated with a selected service request.

Note: You need appropriate permissions to access notes with special confidentiality and security levels. See “Notes Security” on page 255 for more information.

Invoices

In the **Invoices** card, you can create, edit, and view invoices for the selected service request.

Messages

In the **Messages** card, you can create and send messages to vendors using the Vendor Portal. Messages can be in the form of questions or requests for information.

When questions are received, ClaimCenter generates an activity to notify the adjuster that a response is required.

The following icons are used to indicate the type of service request messages:

Icon	Service Request Message Type
	Inbound Message
	Outbound Message

Promoting Service Requests

You can promote a Quote request type to a Quote and Perform Service request type once it is complete and a quote has been enclosed.

To promote a Quote request type

1. Open the claim and click **Services** in the sidebar.
2. Select a service request in the list of service requests.
3. Click **Request Service from Quote**.
4. In the **Request Services from Quote** screen, enter the required information, including the service completion date. Add additional services, if necessary. Click **Update**.
The **Request Type** is now updated to **Quote and Perform Service**, and you can proceed to edit and complete the service request type accordingly.

Canceling or Declining Service Requests

A service request can be canceled or declined both in ClaimCenter and in the Vendor Portal.

To cancel a service request in ClaimCenter

1. Open the claim and click **Services** in the sidebar.
2. Select a service request in the list of service requests.
3. Click **Cancel Service**.
4. Enter the reason for canceling the service request, and click **Cancel Service**.

The **Progress** status of the service request is now **Canceled**. If the request for cancellation comes from the Vendor Portal, the status is updated to **Canceled** automatically.

Note: Once a service request is canceled, its status cannot be reverted.

To record a service request as declined in ClaimCenter

1. Open the claim and click **Services** in the sidebar.
2. Select a service request in the list of service requests.

3. Click **Record Vendor Progress** and then, click **Vendor Declined**.
4. In the **Vendor Declined Work** screen, enter the reason for canceling the service request, and click **Update**.

The **Progress** status of the service request is now **Declined**. If the request for declining the service request comes from the Vendor Portal, the status is updated to **Declined** automatically.

Note: Once a service request is declined, its status cannot be reverted.

Assigning Service Requests

In ClaimCenter, assignable entities such as claims, exposures, and service requests can be assigned to a user. In the base configuration, global and default assignment rules assign service requests to the claim owner. You can configure these as needed. See “How Work is Assigned” on page 199.

To assign a service request

1. Open the claim and click **Services** in the sidebar.
2. Select the service request in the list of service requests.
3. Click **Assign**.
4. Assign the service request using one of the following options:
 - a. Assign the service request to the claim or exposure owner, or to another user, or by using automatic assignment.
 - b. Assign the service request by using a picker. The picker helps you find a user by name, group name, or proximity to a location.

The screenshot shows the Guidewire ClaimCenter interface with the following details:

- Header:** Guidewire ClaimCenter*, Desktop | ▾, Claim (426-24-366070) | ▾, Search | ▾, Go to (Alt+/), Settings icon.
- Toolbar:** Pol: 23-502011, Ins: Western Farmer's Supply, DoL: 10/20/2013, St: Open.
- Sidebar:** Summary, Workplan, Loss Details, Exposures, Parties Involved, Policy, Financials, Notes, Documents, Plan of Action, **Services** (selected), Litigation, History, Calendar.
- Dialog Box:** **Assign** (Return to Services)
 - Select how you would like to do the assignment:**
 - Select from list: **Claim/Exposure Owner** (dropdown menu)
 - Find a user or group:
 - Search For:** User, First name, Last name, User Name, Group Name, Role, Attribute Name.
 - Location:** Country, City, State, ZIP Code.
 - Buttons:** Search, Reset.

Service Request Documents

Documents can be attached to a service request by the vendor or adjuster. A service request can be associated with the following types of documents:

- **Quote** – A document from one or more vendors with an estimated payment amount for the service to be performed.
- **Invoice** – A document from the selected vendor with the actual payment amount requested for the service performed.
- **Document (other)** – Other documents, such as photographs, that the adjuster or vendor needs to share.

Adding Quotes

Quote documents can be added to the service request in two ways:

- **By the vendor in the Vendor Portal** – In this case, the quote documentation is attached to the response from the Vendor Portal, and ClaimCenter automatically associates it with the service request. In the process, the quote document is assigned a file name, and ClaimCenter also generates an activity to review the quote.
- **By the claims adjuster in ClaimCenter**

When you receive a quote from a vendor, you can add it, along with accompanying documents, to a service request.

To add a quote

1. In the Services screen, click the **Details** card and click **Add Quote**.
2. Enter a **Reference Number**, if necessary.
3. Enter the **Total Amount** included in the quote. The currency for this field defaults to the claim currency.
4. Enter the number of days estimated in the quote to complete the service.
5. Enter a description.
6. Click **Attach**. In the **Attach Document** screen, browse for and select a document. Enter document status and type, and click **OK**.
7. Click **Update**.

The document is now attached to your service request. You can attach multiple documents using the **Attach Document** screen.

See “Working with Documents” on page 527 for more information on using documents in ClaimCenter.

Note: You can only add quotes to service requests that have none.

Editing Quotes

You can edit a quote document in two ways—request a requote from the vendor, or revise the quote yourself.

Request Requote

To request another quote

1. In the Services screen, click the **Details** card, and then click **Request Requote**.
2. In the **Request Requote** screen, enter a reason for the request.
3. Enter a requested quote completion date, if different from the current one.

4. Click Update.

The vendor is now notified through the vendor portal that this quote needs revision.

Revise Quote

To revise a quote

1. In the Services screen, click the **Details** card and click **Revise Quote**.
2. In the **Revise Quote** screen, enter the following information.
 - A reference number, if necessary.
 - A new quote amount.
 - Requested number of days to complete the service.
 - An updated description, if necessary.
3. Click **Link** or **Attach** to add a new quote document, if there is one.
4. Click **Update**.

The quote is now updated in ClaimCenter.

Adding Invoices

When you receive a quote from a vendor, you can add it, along with accompanying documents, to a service request.

To add an invoice

1. In the Services screen, click **Add Invoice**.
2. Enter a Reference Number.
3. Enter the Total Amount included in the quote. The currency for this field defaults to the claim currency.
4. Enter the number of days estimated in the quote to complete the service.
5. Enter a description.

Approving Invoices

Once an invoice has been added to a service request, you can approve it.

To approve an invoice

1. Select the service request in the list of service requests, and then click **Approve Invoice** in the same row.
2. The **Invoices** card is shown. Click **Approve**.

The invoice is now approved, and you can click **Pay** to proceed to the services payment wizard.

Making Payments

When an invoice is approved, you can proceed directly from the service request to a customized payment wizard, where relevant information from the service request is already recorded for you.

To make a payment

1. Select the service request.

2. In the detail view, click the **Invoices** card.
3. Click **Pay**.
4. Step 1, **Enter payee information**, of the payment wizard is now shown with the following information preselected from the service request:
 - Payee name and type
 - Recipient name and mailing address
 - Service number
 - Invoice reference number, if any.
 - Invoice amount

Edit the payee and recipient details, if needed, and click **Next**.

Note: The currency of the check must match the currency of the service request associated with the invoice.
5. Step 2, **Enter payment information**, is now shown. Enter payment details and click **Next**.
6. Step 3, **Set check instructions**, is shown. Edit instruction details and add or remove documents, if necessary. Click **Finish** to create your check.

IMPORTANT Service request invoices do not support recurring or grouped (multi-payee) checks. Configuration to enable this behavior is not recommended.

See also:

- “Checks” on page 301.
- “Payments” on page 296.

Lifecycle of a Service Request

A service request is defined by its **Progress** status and **Quote Status**. The Progress status indicates the state of the work done by the vendor for the service request. The Quote status describes the state of quotes, if any, linked to the service request.

An adjuster can manage the status of a service request entirely in ClaimCenter, or in ClaimCenter and a third-party vendor portal, such as the Guidewire Vendor Portal. When a portal is used, the state of a service request is controlled by the adjuster in ClaimCenter and by the vendor in the Vendor Portal. ClaimCenter manages the flow of information between the two efficiently so that adjusters and vendors can monitor and update service requests seamlessly.

You can configure the way in which ClaimCenter transitions through the states of the three service request types. See the ClaimCenter Configuration Guide for more information.

Quote Request Types

You can request a vendor to provide only a quote for a selected service. The example in this topic illustrates the stages of a quote-only service request.

Example 1. Requesting Quotes for a Carpentry Service (Quote)

Create a **Quote** service request using the following steps:

1. Click **Actions** → **New...Service**.
2. In the **Create Service Requests** screen, enter the following information. See “Creating a Service Request” on page 377 for more information on these fields.

- Relates To – Select Claim.
- Services to Perform – Click **Add** and select one or more services. For this example, select **Property → Construction services → Carpentry** from the services directory. Click **Add** again.

Note: In this example, service information loaded into ClaimCenter as part of sample data is used.

- Request Type – Select **Quote**.
- Vendor Name – Select a vendor specializing in the requested service.
- Additional Instructions – Enter special instructions, if any, for the vendor.
- Requested Quote Completion Date – Select a date.
- Customer Contact – Select the primary customer contact.
- Service Address – Select the address for the service.

3. Click Save.

The service request is assigned a Service Number and saved in ClaimCenter, but it is not sent to the vendor yet. The Progress Status is set to **Draft**, and the Quote Status is set to **No Quote**.

The Next Action is set to **Submit request**.

4. In the Services screen, where the service request is now shown, click **Submit.**

ClaimCenter now sends the service request to the vendor through the Guidewire Vendor Portal. The Next Action is set to **Agree to provide quote**.

5. The selected vendor can now view the service request in the vendor portal with instructions on how to proceed with the next step. Once the vendor responds, ClaimCenter automatically updates the status of the service request accordingly.

For example, if the vendor responds by adding a quote, you are notified that a quote document is now available for perusal and approval.

The following updates are made in ClaimCenter:

- Progress – **Work Complete**
- Quote Status – **Quoted**
- Next Action – **None - quote submitted**

You can now view the quote and associated documents, if any.

See “Lifecycle of a Service Request” on page 503 in the *Configuration Guide* for more information on the lifecycle of a quote-only service request.

Service Request Metrics

Adjusters can manage multiple service requests at any given time, and it might be useful to monitor these service requests and focus on those that are delayed or problematic. ClaimCenter provides *metrics* – data embedded in the Services feature, which can provide a quick snapshot of the performance of service requests and vendors, especially in comparison with company benchmarks.

Service request metrics automatically track the status and timeliness of each service request and show how a service request performs against predefined target values. Using this information, you can identify crucial pieces of information such as high-performing vendors and service requests that have been delayed past the target number of days.

The benefits of these configurable metrics include:

- Providing information, in a single consolidated view
- Setting targets
- Identifying vendors who are high or low performers

- Adjusting metrics over time to improve the service experience

Services Metrics Fields

Open a claim and click **Services**. View the **Metrics** section in the lower, right portion of the main **Services** screen.

In the base configuration, the following metrics are included:

- **Response Time**
- **Quote Timeliness**
- **Service Timeliness**
- **Invoice Variance vs. Quote**
- **Number of Delays**
- **Cycle Time**

These metrics are tracked at the service request level, that is, each service request is tracked individually. You can compare a service request's metrics to company-specific targets and gauge how well or poorly a vendor is performing.

All the metrics, except **Invoice Variance vs. Quote**, are time-based. Over a period of time, you can review this data and take appropriate action to improve customer satisfaction and reduce service request-related delays and expenses.

As with Claim Health Metrics, you can change the values that are measured and set new targets for them as well.

Services Metrics Calculations

In the **Metrics** table, the following columns are used for calculations:

- **Value** – The calculated value of this metric for the service request.
- **Target/Service Level** – The defined target value set for this metric, which is configurable.
- **Status** – The visual representation of how the service request performs against the target value.
Statuses include:
 - Green circle with check mark, meaning *on target*
 - Yellow circle with exclamation point, meaning *at risk*
 - Red circle with X, meaning *requires attention*
 - Gray circle, meaning *not applicable* or *not set by the administrator*

The following table describes how ClaimCenter calculates metrics for Services.

Metric	Calculation	Target
Response Time	Time elapsed between submitting a service request to a vendor and receiving a response.	Defined in SampleMetricLimits.gs
Quote Timeliness	Time elapsed between the Requested Quote Completion Date and the actual quote Completion Date.	Defined in SampleMetricLimits.gs
Service Timeliness	Time elapsed between Requested Service Completion Date and the actual Completion Date.	Defined in SampleMetricLimits.gs
Invoice Variance vs. Quote	Value calculated as Total invoice-Latest quote/Latest quote.	Defined in SampleMetricLimits.gs
Number of Delays	Number of Expected Quote/Service Completion Date values that needed to be updated.	Defined in SampleMetricLimits.gs
Cycle Time	Time elapsed between submitting a service request and completing work (Completion Date).	Defined in SampleMetricLimits.gs

See also

- For information on using Guidewire Studio to configure service request metrics, see “Configuring Services” on page 495 in the *Configuration Guide*.

Configuring Service Requests

ClaimCenter includes a configurable state handler for each of the service request types that defines the stages in their progress to completion. See “Configuring Services” on page 495 in the *Configuration Guide*.

part VIII

ClaimCenter Management

Claim Performance Monitoring

Adjusters can have several hundred open claims at any given time, and their supervisors might manage an average of twelve adjusters. Supervisors are therefore responsible for a book of claims that can number in the thousands, and monitoring this many claims can be a problem. ClaimCenter provides Claim Performance Monitoring tools to help supervisors and adjusters focus on claims that might be problematic and diagnose a claim's status.

The Claim Performance Monitoring tools monitor the health of each claim and automatically track the status and health metrics for each claim. Using this information, adjusters and supervisors can diagnose the health of the claim file and can identify claims that need immediate or additional attention. This attention to the claim process enables you to measure, track, and understand the metrics that strongly influence the customer experience, such as time to first contact or first payment.

Claim Performance Monitoring tools include:

- **Claim Health Metrics** – Embedded in every claim to provide data, or *metrics*. You can see the overall health of a claim and to compare it to your company's specific benchmarks.
- **Claim Reports** – Aggregate important claim information and show the status of claims for groups and organizations. Managers and supervisors can take appropriate action based on the information contained in the reports.
- **Claim Headline** – The top section of the claim **Summary** screen, the claim headline presents a view of the most important aspects of a claim.
- **High Risk Indicators** – Visible in the claim **Summary** screen and persistent on the claim Info bar, high risk indicators provide a risk assessment of the claim. They are also available on the claim startup page.

You can use the metrics, coupled with high-risk indicators, icons, and flags, to understand certain aspects of a claim quickly and possibly take immediate action.

The benefits of these configurable metrics include:

- Providing information, in a single consolidated view
- Setting thresholds
- Adjusting metrics over time to improve the customer service experience

This topic includes:

- “Claim Health Metrics” on page 392
- “Aggregated Metric Data” on page 395
- “Claim Summary” on page 396
- “Claim Status Screen” on page 397
- “Administering Metrics and Thresholds” on page 399

See also

- For examples of how to configure metrics, “Configuring Claim Health Metrics” on page 553 in the *Configuration Guide*.
- For information on ClaimCenter reports that use metric data, see the *InfoCenter Reports Guide* in the Guidewire InfoCenter distribution.

Claim Health Metrics

The **Claim Health Metrics** screen shows how a claim and its exposures perform against target values for the carrier defined metrics. It provides a fast way for you to quickly understand the claim’s health. You can then compare the claim’s health to a defined target. By using this screen, you can determine information like:

- Why it has been so long since an adjuster reviewed this claim.
- Why the current reserve is so much higher than the initial reserve.
- Why the expense to loss cost ratio is so high.

In the base configuration, ClaimCenter provides a set of claim health metrics. These metrics include Days Open, Initial Contact with Insured (Days), Number of Reserve Changes, and Incurred Loss Costs as % of Net Total Incurred. These metrics can be tracked at the claim level, at the exposure level, or both. By comparing a claim’s health metrics against company-specific targets and service levels, you can understand the status of a claim, and, if necessary, you can take the appropriate action. These metrics can be further defined with *tiers*, which introduce a finer level of granularity.

The metrics can differ depending on the line of business. For example, the Compensability Decision metric applies only to workers’ compensation claims.

This topic includes:

- “Uses of Claim Health Metrics” on page 392
- “Claim Health Metrics Fields” on page 393
- “Claim Health Metrics Calculations” on page 393
- “Claim and Exposure Tiers” on page 395

Uses of Claim Health Metrics

With claim health metrics, real-time information is delivered in the context of the claim that is immediately visible to all claims handling personnel. This consistent guidance helps you to understand and improve claim management.

Because ClaimCenter tracks both open and closed claims for claim health metrics, the information is forward-looking and actionable. Over time, adjusters can actively work to reduce their cycle times, lower claim related expenses, and improve customer experience. You can change metrics and set new targets for these metrics.

Claim Health Metrics Fields

With a claim open, if you navigate to **Summary** → **Health Metrics**, you see the **Claim Health Metrics** screen. This screen lists the metrics for this claim, each of which has the following information:

- **Value** – The calculated value of this metric for the claim.
- **Target/Service Level** – The defined target value set for this particular metric, which is configurable in the **Administration** tab. See “Administering Metrics and Thresholds” on page 399.
- **Status** – The visual representation of how the claim performs against the target values set by the administrator. Statuses include:
 - Green circle with check mark, meaning *on target*
 - Yellow circle with exclamation point, meaning *at risk*
 - Red circle with X, meaning *requires attention*
 - Gray circle, meaning *not applicable* or *not set by the administrator*

ClaimCenter re-evaluates the Claim Health Metric statuses at the end of the preupdate rules. As you view the **Claim Health Metrics** screen, ClaimCenter also evaluates the time-based metrics. At the time ClaimCenter creates the claim or exposure, it stores the metric target values as a temporal snapshot on the claim or exposure itself. Storing these values as a snapshot means that later changes to the administrative data do not affect the metric targets for that claim or exposure.

For efficiency of reporting, ClaimCenter also stores the current metric statuses of the claim or exposure, not the calculated value of the metric, on the claim or exposure. ClaimCenter stores these values whenever metrics are re-evaluated. For information on reports that use these values, see the *InfoCenter Reports Guide* in the Guidewire InfoCenter distribution.

If a claim or exposure changes tiers, ClaimCenter uses the metric limit values defined in the **Business Settings** → **Metrics and Thresholds** screen of the **Administration** tab. If the change in tiers is due to a change in information, such as the addition of an injury incident, the metric targets and status are updated. This behavior is based on the current administrative settings for the respective tier. See “Claim and Exposure Tiers” on page 395.

Claim Health Metrics Calculations

The following table describes how ClaimCenter calculates metrics that vary based on calculations.

Metric	Closing Event	Skipped Event	Open Calculation	Closed Calculation
Days Open	Claim.Status is "Closed"	Not applicable	Days between Claim.ReportDate and today	Days between Claim.ReportDate and closing event
Initial contact with Insured in Days	Activity with ActivityPattern equal to Initial Contact with the Insured activity with an activity status of "Closed"	Activity with ActivityPattern having an Activity Status of "Skipped"	Days between Claim.ReportDate and today	Days between Claim.ReportDate and closing event
Time to First Loss Payment in Days	First escalated payment with a Cost Type equal to Claim Cost	Not applicable	No payment made.	Days between Claim.ReportDate and either the scheduled send date of the claim cost payment that is escalated or time of the claim's closing if no such payment was made

Metric	Closing Event	Skipped Event	Open Calculation	Closed Calculation
Days Since Last View - Adjuster	Claim.Status is "Closed"	Not applicable	Days between date last viewed by Claim.Owner and today	Not applicable
Days Since Last View - Supervisor	Claim.Status is "Closed"	Not applicable	Days between date last viewed by supervisor of the Claim.Owner's and today	Not applicable

Metrics with Other Calculations

In the base configuration, some metrics are valid for claims and others are valid for exposures. For example, the number of reserve changes applies only to claims.

Metric	Calculation
Activities Past Due Date	Number of activities with a status of "Open" and a target date before today
Open Escalated Activities	Number of activities with a status of "Open" that have been escalated
Number of Escalated Activities	Number of activities with an escalated property that is true
% of Escalated Activities	Number of activities that have been escalated divided by the total number of activities
Number of Reserve Changes	Count starts at 0 after claim is created. List of Reserves to Count: <ul style="list-style-type: none">• Regular Positive Reserves Created. One or multiple ReserveSets are counted as one change.• Negative Reserves Created. List of Reserves not counted: <ul style="list-style-type: none">• Zeroing offset Reserves from closed exposure or claim• Final Payment Created Reserves• Offsetting Reserves from void/stop/transfer/recode payments• Initial Reserves Created as claim is created• Removed Reserves
Net Total incurred	Total incurred net: Total Incurred Gross minus Total Recoveries
Total Paid	Total Payments, the sum of all submitted and awaiting submission payments with a scheduled send date of today or earlier.
Paid Loss Costs as % of Total Paid	Payments for Cost Type of claim cost divided by Total Payments.
Incurred Loss Costs as % of Net Total Incurred	Net Total Incurred for Cost Type of claim cost divided by Net Total Incurred.
% of Reserve Change from initial reserve	Using the same criteria for inclusion as Number of Reserve Changes, the percentage is calculated based on Reserve Amount changes. This percentage is the amount of the reserves that count in Number of Reserve Changes divided by initial reserves. Initial Reserves are defined as one of the following: <ul style="list-style-type: none">• Any reserves created during exposure creation• After creating first approved reserve set on the claim, any reserves created within the InitialReserveAllowedPeriod Uses the configuration parameter InitialReserveAllowedPeriod in the config.xml file. In the base configuration, the value of this parameter, which defines the number of days after first initial reserve, is 3 days. All reserve changes within that period count as initial reserves.
Deferred % of Reserve Change from initial user set reserve	(Current Incurred net minus Initial user-set reserve) divided by Initial user-set reserve

See also

- For detailed information on the organization of metrics and how to administer them from the **Administration** tab, see “Administering Metrics and Thresholds” on page 399.
- For information on the financial calculations and what each value means, see:
 - “Definitions of Reserve Calculations” on page 292
 - “Definitions of Total Incurred Calculations” on page 292

Claim and Exposure Tiers

To effectively evaluate a claim’s status, ClaimCenter provides a way to compare it against other claim targets. The application groups similar claims and exposures by using the following hierarchy: policy type, claim metrics, and then exposure metrics. Within each claim and exposure metric, there are multiple levels, or *tiers*, that you can define. Define tiers to add further granularity within the type. If you do not define tier-specific target values, the tier inherits the default targets for that metric.

- **Policy Type** – Every line of business contains its own claim and exposure metric tiers.
- **ClaimTier.ttx Typelist** – A typelist that groups similar claims. It shows the type, complexity, and size of the claim, so that you can see this information while reviewing the metric values and the thresholds that might have been triggered. Gosu defines the claim tiering logic in preupdate rules. You enter metric data on the **Business Settings → Metrics & Thresholds** screen on the **Administration** tab. Guidewire recommends that the claim tier be broadly defined so that it makes sense as a category for analysis. In other words, do not define many tiers that are so specific that only a handful of claims fall into each tier.
- **ExposureTier.ttx Typelist** – A typelist that groups similar exposures. Similar to the **ClaimTier.ttx** typelist, the **ExposureTier.ttx** typelist indicates the type, complexity, and priority of the exposures grouped into these tiers.

Note: While claim and exposure tiers can span policy types, the system manages the targets by policy type for each claim or exposure tier.

ClaimCenter evaluates initial and subsequent tiering for claims. A claim is assigned to a tier when first created. Then, as claim information is added or changed, ClaimCenter can change the claim tier. After the claim tier changes, ClaimCenter recalculates the metrics for the claim.

Example

In the **New Claim** wizard, an adjuster entered only partial information about the loss, and the claim tier was set as Low Severity. At a later date, the adjuster determined that there were injuries, and the claim was reclassified to High Severity. Because new information can change the tier, the evaluation for tiering happens at every update on the claim. The preupdate rules evaluate the properties that make up the tiers and re-evaluate those values after the claim changes to determine if the claim needs to be re-tiered.

See also

- For information on using the **Metrics and Thresholds** screen to enter tier values, see “Defining Claim Tiers” on page 400.
- For information on using Guidewire Studio to configure tiers, see “Adding a New Tier” on page 553 in the *Configuration Guide*.

Aggregated Metric Data

In the base configuration, ClaimCenter provides aggregated metrics information. You can see aggregated metrics on the **Team** tab and the **Dashboard**. This data includes information like the number of claims and exposures assigned to employees, aggregated by employee groups, as defined in the User and Group hierarchy.

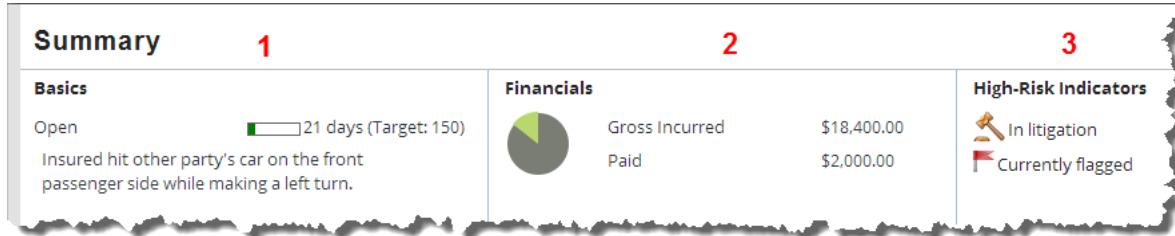
ClaimCenter aggregates those metrics specifically by group hierarchy based on well-defined time frames.

Because ClaimCenter calculates these metrics and runs them separately from the non-aggregated metric calculations, those numbers might not be consistent with the claim metric numbers. See “Team Management” on page 403.

Non-aggregated metrics are visible on the **Claim Health Metrics** screen, as described at “Claim Health Metrics” on page 392.

Claim Summary

View the claim **Summary** screen to see summarized information relating to the most important aspects of a claim’s overall condition. To open this screen, with a claim open, click **Summary** in the sidebar. There are icons providing visual cues that ClaimCenter updates on a regular basis. The claim **Summary** screen draws your attention to essential information, such as the age of the claim, the level of funding available, and other high risk indicators.



1. The **Basics** section indicates the age of the claim. The number of days combined with the graphic help you to see if the claim is in critical condition. You can also see how long has it been in that condition and compare it to your company targets to determine if you need to act quickly on it. If you have defined company targets, the **Target** number shows what the average number might be for this type of claim. This number is based on your business requirements and how the claim measures against that number. There is also a description that originates from the **Loss Details** screen.
2. The **Financials** section indicates the a claim’s current cost—the total gross incurred and what monies have been paid to date, if any. These numbers originate from the **Financials** screens. The **Gross Incurred** amount is calculated as Open Reserves plus all payments made today or earlier. To see additional details relating to this section, navigate to **Summary** → **Health Metrics** to open the **Claim Health Metrics** screen. These details are in the **Claim Financials** section of that screen. Also, you can click **Financials** in the sidebar to see more detailed information.
3. The **High-Risk Indicators** section shows attributes that make the claim a high risk. You can see details for these indicators by navigating to **Summary** → **Status** to open the **Claim Status** screen. For information regarding flags, see “Flags” on page 398.

High-risk indicator icons are also shown on the **Info bar**, which is always visible above the claim screens.

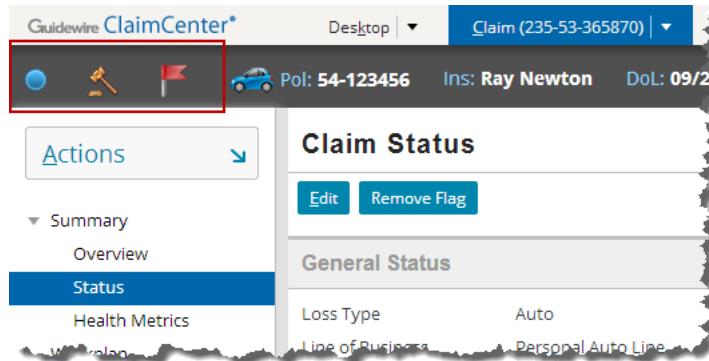
Other claim summary information is also available on the **Summary** screen, including **Loss Details**, **Exposures**, **Services**, **Parties Involved**, **Latest Notes**, **Planned Activities**, **Litigation**, and **Associated Claims**.

On the **Summary** screen in the **Exposures** section, the first column has an icon that indicates whether an exposure is open or closed. The icon can indicate open  or closed . These same icons also indicate if the claim is open or closed on the Info bar. See “Claim Status Screen” on page 397 for a figure that shows the Info bar.

Claim Status Screen

The **Claim Status** screen provides a deeper level of detail than the **Summary** screen. This screen is organized into **General Status** and **High Risk Indicators** sections. To open this screen, open a claim and then navigate to **Summary** → **Status**.

Note: In addition to the **Claim Status** and **Summary** screens, indicators and flags are also present on the Info bar, which is always visible at the top of a claim. The following figure shows the Info bar with the Open, Litigation, and Flagged indicators outlined in red:



General Status Section

This section displays the status of a claim in several areas. These areas include fields showing the line of business, claim status, claim creation date, primary adjuster, claim validation level, and so forth: the pertinent claim data. For convenience, you can update some of these fields by clicking **Edit**.

High Risk Indicators Section

In the default configuration, ClaimCenter considers the following areas to be potentially high-risk: litigation, fatalities, large loss, coverage in question, SIU, and flags. High risk indicators help identify claims that might

require increased attention. Visible also at the top of the **Claim Summary** screen, icons and statuses shown on this screen notify you of important events in a claim's lifecycle.

High-Risk Indicators	
Litigation	
Litigation Status	Ray Newton matter.ll,arbit,hearin,medit
Litigation Identified	10/09/2013
Days after FNOL	11
First Notice Suit	
Next Trial Date	
Fatalities	
Fatalities?	(None)
Large Loss	
Large Loss?	(None)
Net Total Incurred	\$18,400.00
Coverage in Question	
Coverage in Question?	(None)
SIU	
SIU Status	(None)
SIU Score	1
Referred to SIU team?	No
Flag Details	
Flagged	Currently flagged
Date Flagged	10/25/2013
Reason for Flag	Overdue, high-priority activity; Overdue high priority activity: Send reservation of rights letter

The base configuration provides the following high risk indicators:

- **Litigation** – Claims that are in litigation. In edit mode, you can change the **Litigation Status** and **First Notice Suit**.
- **Fatalities** – Usually involve a fatality, but can also be configured to indicate a severe injury.
- **Large Loss** – Indicates whether there might be a large loss on the claim. The large loss number is set by navigating to **Administration** → **Business Settings** → **Metrics and Thresholds** → **Large Loss Threshold**. It represents the Net Total Incurred, which is the remaining reserves, plus total payments, minus any recoveries.
- **Coverage in Question** – In edit mode, you can select the Yes radio button to indicate situations in which the policy coverage is in question.
- **SIU** – Special Investigation Unit (SIU) contains information about possible fraudulent claims, such as the SIU status and score or if the claim was referred to the SIU team. This indicator is controlled by the SIU question set accessible by navigating to **Loss Details** → **Special Investigation Unit**.
- **Flag Details** – Show if the claim has been flagged, when it was flagged, and the reasons. See “Flags” on page 398.

The default configuration provides functioning indicators, some of which can be configured in Studio. See “Configuring Claim Health Metrics” on page 553 in the *Configuration Guide* for details.

Flags

Flags are a type of indicator and are set through rules. A flag’s purpose is to notify you to act on the claim. In the base configuration, ClaimCenter displays a flag after one of the following occurs:

- A critical or high priority activity that has not been closed or skipped reaches the escalation date.

- In the personal auto line of business, a vehicle is marked as a total loss by the **Total Loss Calculator**. See “Vehicles, People, and Property” on page 83.

You cannot manually flag a claim, but a supervisor can remove a flag. Or, in the case of the vehicle, if the **Total Loss Calculator** no longer indicates that the vehicle is a total loss, the application removes the flag. The claim has a **Flagged** field to track the current status, which takes values from the **FlaggedType** typelist. In the default configuration, the typecode names are **Is Flagged**, **Was Flagged**, and **Never Flagged**. A claim also has a **FlaggedDate** and a **FlaggedReason** field. If a claim is flagged and the `Claim.removeFlagReason` method removes the last reason from the **FlaggedReason** field, then value of the **Flagged** field changes to **Was Flagged**.

You can search for claims that have flags by using advanced search.

Removing a Claim Flag

The person who can remove a flag from a claim is the supervisor or manager of the group to which the claim is assigned. This person can also be the supervisor of any parent group. A supervisor needs to first attend to the issue as appropriate, and then remove the flag.

To remove a claim flag

1. Navigate to **Summary** → **Status**.
2. In the **Claim Status** screen, click **Remove Flag**.
3. Enter a reason in the **Note** field, and then click **Remove Flag** again.

You can see the reason that you entered in the **Latest Notes** section on the **Summary** screen of the claim.

Note: You can also remove flags by using the **Team** tab. See “Using Flags” on page 408.

Administering Metrics and Thresholds

If you have the administration permission `metriclimitmanage`, you can edit health claim metrics target values. Navigate to **Administration** tab → **Business Settings** → **Metrics & Thresholds** to open the **Metrics & Thresholds** screen. You can assign values to metrics in this screen. To create new metrics, you must use Guidewire Studio. This topic describes how to assign values to metrics.

Note: To create new metrics, define them by using Gosu in Studio. See “Configuring Claim Health Metrics” on page 553 in the *Configuration Guide*.

Metrics and thresholds are administered by claim, exposure, and policy type in the claim and exposure. You must first select the policy type—the *line of business*—and then enter the values for either claim or exposure. All policy types have the same metrics, but each policy type can have different target values associated with it.

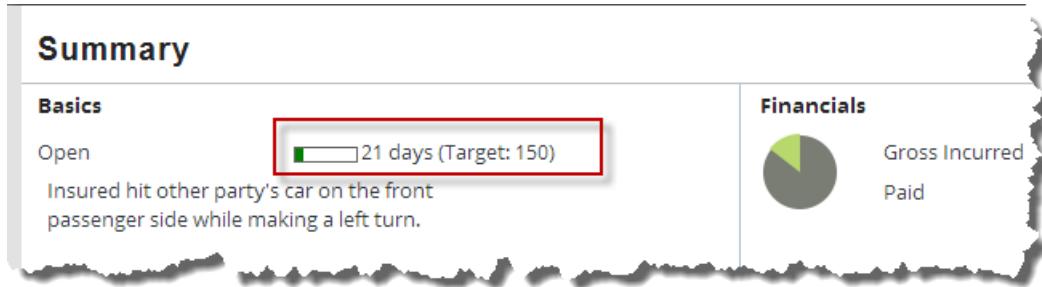
The **Metrics & Thresholds** screen has the following tabs:

- **Claim Metric Limits** – Choose a policy type and click **Edit**, and then enter values for overall claim metrics, claim activity, and claim financials. You can enter the value indicating if the metric is within target for service level, the value for At Risk , and the value for Requires Attention . Click **Update** to save your changes.
- **Exposure Metric Limits** – Choose a policy type and click **Edit**, and then enter values for exposures, which can differ based on the policy type. As with claim metrics, you can enter the units for the measurement, the value for meeting the target/service level, and values indicating At Risk and Require Attention. Click **Update** to save your changes.
- **Large Loss Threshold** – Choose a policy type and click **Edit**, and then enter an amount that indicates a large loss. Click **Update** to save your changes. If you have integrated PolicyCenter with ClaimCenter, you can also enter a different threshold amount.

Claim Duration Indicator

The **Claim Duration** indicator is a bar graph representing the **Days Open** metric. You set this metric in the **Metrics & Thresholds** screen on the **Claim Metric Limits** card, in the **Overall Claim Metrics** section. This screen is described in the preceding topic. The indicator, which you can see on the claim **Summary** page, shows the percentage value of days opened divided by the limit and compares it to your company's benchmark.

The changes are based on the set targets and thresholds, and the color of the **Claim Duration** indicator can change accordingly.



Note: The **Claim Duration** indicator does not display if targets have not been defined, if the claim is closed, or if the limits are null.

The following table shows the range of colors if targets have been set. You can set the Target/Service Level, the yellow warning level , and the red over-target level for the Days Open metric.

Did you set the target?	Set Yellow?	Set Red?	Claim Duration Indicator Color
No	Yes	Yes	Green until yellow warning level, yellow until red warning level, red at 100%
No	No	No	No indicator shown
Yes	No	No	Green only
Yes	Yes	Yes	Green until yellow warning level, yellow until red warning level, red at 100%
Yes	Yes	No	Green until yellow warning level, yellow at 100%
Yes	No	Yes	Green until red warning level, red at 100%

To learn how to add or change target values, see “Administering Metrics and Thresholds” on page 399. Guidewire recommends being consistent in how you set the targets.

Defining Claim Tiers

You have the option in ClaimCenter to have *tiers*—different target values for a particular metric within a specific policy type. Tiers are a way to have further granularity within the policy type.

In the following figure showing **Days Open** settings for the personal auto policy type, values for the high severity tier have been entered. No values have been set specifically for low severity and medium severity, so they do not

show unless you click the picker. If tier-specific target values are not set, the tier inherits the default targets for that metric. In this example, low and medium severity claims inherit the Days Open values 5/4/6.

The screenshot shows the 'Metrics & Thresholds' configuration page. At the top, there are 'Update' and 'Cancel' buttons, and a 'Policy Type' dropdown set to 'Personal Auto'. Below this, there are three tabs: 'Claim Metric Limits' (selected), 'Exposure Metric Limits', and 'Large Loss Threshold'. A 'Remove' button is available. The main table has columns: 'Attribute', 'Units', 'Target/Service Level', and two icons (yellow exclamation mark and red X). The table title is 'Overall Claim Metrics'. The data rows are:

Attribute	Units	Target/Service Level	!	X
Days Open	Days	5	4	6
High Severity	Days	6	2	3
Initial Contact with I...	Days	1	1	2

A dropdown menu is open over the 'Days' column for the 'Days Open' row, showing options: 'Low Severity' (highlighted) and 'Medium Severity'.

Health Metrics Permissions

Health metrics use the following permission: `metriclimitmanage`.

Team Management

ClaimCenter provides a management tool that helps supervisors and managers manage their groups. For each group, you can see the number of claims, exposures, matters, and activities and how many are open, closed, flagged, new, overdue, or completed. This tool also displays *aging* data, which categorizes claims and exposure by the number of days they have been open. If you log in with a role that has the View Team permission, you can access this tool from the **Team** tab. You can use it to monitor and manage your teams' workloads and activities.

Note: There is no **Team** entity in ClaimCenter. Assigning work, supervising users, and managing users are all done through groups, the **Group** entity.

This topic includes:

- “Team Management Overview” on page 403
- “My Groups on the Team Tab” on page 404
- “Groups on the Team Tab” on page 405
- “Group Members on the Team Tab” on page 406
- “Using Flags” on page 408
- “Administering the Team Tab” on page 408

Team Management Overview

Supervisors and managers can manage their teams, obtain status information, monitor caseloads, identify backlogs, and reassign activities by using the team management functionality in ClaimCenter. In some respects, team management is a reporting tool, where you can see data for all groups' workloads, all members of a group, or a single group member.

When the **Team** tab is selected, the **Actions** button has the same menu selections for a manager or supervisor as it does when the **Desktop** tab is selected:

- The first three choices, **Statistics**, **Preferences**, and **Vacation Status**, enable you to make personal settings. For a description of these three settings, see “Personal Administration Settings and Views” on page 470.

- The fourth choice, **Load and Vacation**, shows the load factors, vacation statuses, and backup users for your team members. You can see this item and the **Load and Vacation** screen if you have the group load factor permission View. If you have the Admin permission, you can both view and edit this screen. An administrator can set these permissions for a user by navigating to **Administration tab** → **Users & Security** → **Users**, finding the user, and editing the user's **Groups** settings. The **Load Factor Permissions** setting for a group determines if the user can only view or both view and edit the **Load and Vacation** screen for that group.

The permissions on the groups are not inherited. Therefore, the administrator must set permissions on each child group that the manager or supervisor needs to view or edit, not just the parent group.

The top portion of the sidebar of the **Team** tab shows a an organization tree. If you expand the tree, you can see subgroups and, eventually, group members for groups that have no subgroups. You can select nodes of the tree to see data for subgroups and for group members. In the bottom portion of the sidebar below the tree are reporting categories that show different kinds of information about what the selected group or member is doing. The default category for any group is **Summary**.

- When you first click the **Team** tab, ClaimCenter defaults to the **My Groups** selection in the tree view. The screen shows high level **Summary** data for all groups for which you are the supervisor or manager. You can also choose to see **Aging** data for the group. The reporting categories for workloads of all groups are **Summary** and **Aging**. For more information, see “[My Groups on the Team Tab](#)” on page 404.
- If you choose one of the groups from the tree in the sidebar, you see a set of **Summary** data for all subnodes of that group. If the nodes are subgroups, you see data for subgroups and for the manager of those groups. If the nodes are users, you see data for users who are members of the group. As with the selection showing all your groups, you can select categories in the sidebar area below the organization hierarchy to get different information. The information is shown in both a tabular format and, under the table, as a bar graph. The reporting categories for workloads of groups are **Summary**, **Aging**, **Claims**, **Exposures**, **Activities**, and **Matters**.
- You can also navigate under a group to a subgroup or group member and view and manage their workloads. The reporting categories for workloads of group members are **Claims**, **Exposures**, **Activities**, and **Matters**.

See also

- “[My Groups on the Team Tab](#)” on page 404
- “[Groups on the Team Tab](#)” on page 405
- “[Group Members on the Team Tab](#)” on page 406

My Groups on the Team Tab

On the **Team** tab, when you choose the **My Groups** category in the left sidebar, you are at the highest level of the groups that you supervise. This node enables you to see all your groups' high level statistics for claims, exposures, matters, and activities. You can also see if there are flagged claims that need immediate attention in the group. You can see **Summary** data and **Aging** data for all your groups.

- Summary** – Shows a summary of claims, exposures, matters, and activities owned by all groups listed. For each group, you see summary data for:
 - Open, flagged, new, and closed claims
 - Open and closed exposures
 - Open and closed matters
 - Open activities, overdue activities, and activities that were completed today
- Aging** – Lists information about the number of days that claim and exposures assigned to each group have been open and have not yet been closed. The numbers in parentheses indicate claims under litigation. You see the time for which claims and exposures have been open for 0 – 30, 31 – 60, 61 – 120, and over 120 days.

See also

- “[Team Management Overview](#)” on page 403

- “Groups on the Team Tab” on page 405

Groups on the Team Tab

On the **Team** tab, you can choose a group name under **My Groups**, in the left sidebar. You can see groups that you directly supervise and any subgroups of those groups.

If you drill down to a subgroup that has only members, and no subgroups, you can see statistics for individual team members. You can see the team's current case load and the statistics for each adjuster's claims, exposures, matters, and activities. For example, you can see which group member has flagged claims that need immediate attention, and you can see if any members have a disproportionate caseload. For a single group that has members, and not subgroups, you can see the following types of data:

- **Summary** – Shows a summary of claims, exposures, matters, and activities owned by the members of the group. There is a local total for this group. In parentheses there is also a global total in case the member is also a member of other groups. If the member has claims, exposures, matters, or activities from other groups, the global total includes them as well.

For each member, you see summary data for:

- Open, flagged, new, and closed claims
- Open and closed exposures
- Open and closed matters
- Open and overdue activities and activities that were completed today
- **Aging** – Lists information about the number of days that claim and exposures assigned to each member of the group have been open and have not yet been closed. The numbers in parentheses indicate claims under litigation. You see the time for which claims and exposures have been open for 0 – 30, 31 – 60, 61 – 120, and over 120 days.
- **Claims** – Shows a list of all claims owned by members of the group. You can see which claims are flagged , and you can select the check box for a claim to reassign it or clear its flag. To see how to clear a flag, see “Using Flags” on page 408. Additionally, you can click a claim number to open the claim, and you can click the name of the insured to see the insured’s data.

There is a drop-down filter at the top of this table that enables you to filter the list. You can filter by categories like All open owned, New owned (this week), and Flagged. Data listed for each claim includes the adjuster that owns the claim, the policy number, the insured, the claimants, net total incurred, and the date of the loss.

You can sort the claims by any column. Click the drop-down arrow on the right side of a column heading to choose sort options.

You can click the following linked data items to open the screens indicated:

- **Claim** – Opens the **Claim** at its **Summary** screen. This link takes you away from the **Team** tab.
- **Insured** – Opens the insured’s contact detail screen at the **Basics** card. This screen has a link that connects back to the **Team** tab.
- **Exposures** – Shows a list of all exposures owned by members of the group. If you select the check box for an exposure, you can reassign it by clicking **Assign**. There is a drop-down filter at the top of this table that enables you to filter the list. You can choose categories like All open owned, New owned (this week), and Closed in the last 90 days. Data listed for each exposure includes the claim number, the exposure number, the exposure type, the coverage, the claimant, the adjuster, and net total incurred.

For any exposure, you can click the following linked data items to open the screens indicated:

- **Claim** – Opens the claim at the claim **Summary** screen. This link takes you away from the **Team** tab.
- **#** – Opens the claim at the detail screen for that exposure. This link takes you away from the **Team** tab.
- **Type** – Same as **#**. Opens the claim at the detail screen for that exposure. This link takes you away from the **Team** tab.

- **Claimant** – Opens the claimant’s contact detail page at the **Basics** card. This screen has a link that connects back to the **Team** tab.
- **Activities** – Shows a list of all activities belonging to the group. If you select the check box for an activity, you can reassign it by clicking **Assign**. Activities that have been escalated have an escalated icon  in the first column, and those that are overdue have a due date that is red. There is a drop-down filter at the top of this table that enables you to filter the list. You can choose filters like All open, Today’s activities, Overdue only, and Escalated only. Data listed for each activity includes if escalated, due date, priority, subject, claim number, insured party, assigned user or group, if external, line of business, and claim state.
You can sort the activities by any column. Click the drop-down arrow on the right side of a column heading to choose sort options.
You can click the following linked data items to open the screens indicated:
 - **Subject** – Opens the claim at the **Workplan** screen, with the worksheet for the selected activity open below. This link takes you away from the **Team** tab.
 - **Claim** – Opens the claim at the **Summary** screen. This link takes you away from the **Team** tab.
 - **Insured** – Opens the insured’s contact detail screen at the **Basics** card. This screen has a link that connects back to the **Team** tab.
- **Matters** – Shows a list of all legal matters belonging to the group. If you select the check box for a matter, you can reassign it by clicking the **Assign** button. There is a drop-down filter at the top of this table that enables you to filter the list. You can choose filters like All open, New open (this week), and Closed in last 90 days. Data listed for each matter includes the name of the legal action, case number, claim number, final settlement amount, trial date, and assigned user.

You can click the following linked data items to open the screens indicated:

- **Name** – Opens the claim at the **Detail** screen for the matter, one level below the **Litigation** screen. This link takes you away from the **Team** tab.
- **Claim** – Opens the claim at the **Summary** screen. This link takes you away from the **Team** tab.

See also

- “Team Management Overview” on page 403
- “My Groups on the Team Tab” on page 404
- “Group Members on the Team Tab” on page 406
- “Incidents, Exposures, and Claims” on page 236
- “Definitions of Total Incurred Calculations” on page 292
- “Working with Activities” on page 217
- “Legal Matters” on page 243

Group Members on the Team Tab

On the **Team** tab in the organizational hierarchy section of the sidebar, you can drill down to groups that have members. Members of a group can be either other groups or users who are members of that group. If you expand the group node, you see all members of the group listed under it in the sidebar. In addition, there are three group categories that are not member names.

Group Categories

In addition to member names, there are three categories that are not member names:

- **Pending Assignment** – Displays claims, exposures, activities, and matters that have been assigned to the group, but not to an individual user. You can select and assign any item you see listed, and you can filter items as well by using the drop-down filter.

- **Other** – Displays claims, exposures, activities, and matters assigned to the group under which the node appears, but that were assigned to an invalid user. An invalid user is someone who is no longer a member of the group. For example, the user might have switched groups or retired.
- **In Queue** – Displays activities that are in this group's queue, but that have not been assigned yet. You can sort these activities by using the filter. For example, selecting **Overdue only** from the drop-down filter displays overdue activities that need to be attended to or assigned to someone who can address them.

Group Members Who Are Users

When you choose a group member who is a user, you can see the following data for the member, listed as menu links in the sidebar below the organizational hierarchy:

- **Claims** – Shows a list of all claims owned by this member of the group. You can see which claims are flagged, and you can click a claim number to open a claim. If you select a claim, you can reassign it by clicking the **Assign** button. To see how to reset a flag, see “Using Flags” on page 408.

There is a drop-down filter at the top of this table that enables you to filter the list. You can filter by categories like All open owned, New owned (this week), and Flagged. Data listed for each claim includes the adjuster that owns the claim, the policy number, the insured, the claimants, net total incurred, and the date of the loss.

You can click the following linked data items to open the screens indicated:

- **Claim** – Opens the claim at the **Summary** screen. This link takes you away from the **Team** tab.
- **Insured** – Opens the insured's contact detail page at the **Basics** card. This screen has a link that connects back to the **Team** tab.
- **Exposures** – Shows a list of all exposures owned by this member of the group. If you select the check box for an exposure, you can reassign it by clicking **Assign**. There is a drop-down filter at the top of this table that enables you to filter the list. You can choose categories like All open owned, New owned (this week), and Closed in the last 90 days. Data listed for each exposure includes the claim number, the exposure number, the exposure type, the coverage, the claimant, the adjuster, and net total incurred.

You can click the following linked data items to open the screens indicated:

- **Claim** – Opens the claim at the claim **Summary** screen. This link takes you away from the **Team** tab.
- **#** – Opens the claim at the detail screen for that exposure. This link takes you away from the **Team** tab.
- **Type** – Same as **#**. Opens the claim at the detail screen for that exposure. This link takes you away from the **Team** tab.
- **Claimant** – Opens the claimant's contact detail page at the **Basics** card. This screen has a link that connects back to the **Team** tab.
- **Activities** – Shows a list of all activities belonging this member of the group. If you select the check box for an activity, you can reassign it by clicking **Assign**. Activities that have been escalated have an escalated icon  in the first column, and those that are overdue have a due date that is red. There is a drop-down filter at the top of this table that enables you to filter the list. You can choose filters like All open, Today's activities, Overdue only, and Escalated only. Data listed for each activity includes if escalated, due date, priority, subject, claim number, insured party, assigned user or group, if external, line of business, and claim state.

You can click the following linked data items to open the screens indicated:

- **Subject** – Opens the claim at the **Workplan** screen, with the worksheet for the selected activity open below. This link takes you away from the **Team** tab.
- **Claim** – Opens the claim at the **Summary** screen. This link takes you away from the **Team** tab.
- **Insured** – Opens the insured's contact detail screen at the **Basics** card. This screen has a link that connects back to the **Team** tab.
- **Matters** – Shows a list of all legal matters belonging to this member of the group. If you select the check box for a matter, you can reassign it by clicking the **Assign** button. There is a drop-down filter at the top of this table that enables you to filter the list. You can choose filters like All open, New open (this week), and Closed

in last 90 days. Data listed for each matter includes the name of the legal action, case number, claim number, final settlement amount, trial date, and assigned user.

You can click the following linked data items to open the screens indicated:

- **Name** – Opens the claim at the **Detail** screen for the matter, one level below the **Litigation** screen. This link takes you away from the **Team** tab.
- **Claim** – Opens the claim at the **Summary** screen. This link takes you away from the **Team** tab.

See also

- “Team Management Overview” on page 403
- “My Groups on the Team Tab” on page 404
- “Groups on the Team Tab” on page 405
- “Incidents, Exposures, and Claims” on page 236
- “Definitions of Total Incurred Calculations” on page 292
- “Working with Activities” on page 217
- “Legal Matters” on page 243

Using Flags

Only a supervisor or manager of the group to which the claim is assigned, or the supervisor of any parent group, can remove a flag from a claim. Typically, a supervisor removes the flag after the task has been completed.

To remove a flag

1. Navigate to the **Team** tab and drill down to a group with a flagged claim or to a specific user.
2. Click **Claims** in the sidebar.
3. Select the check box for the claim whose flag you want to remove.
The **Remove Flag** button becomes enabled.
4. Click **Remove Flag**.
5. Provide a reason in the **Note** field, and then click **Remove Flag**.

The reason shows in the **Latest Notes** section on the **Summary** screen of the claim.

Administering the Team Tab

To make administrative changes to the **Team** tab, you can set configuration parameters in the `config.xml` file and you can change the settings for the batch process and its workers.

Team Tab Configuration Parameters

You can set a number of configuration parameters that affect the **Team** tab. These configuration parameters, most of which are in the **Statistics**, **Team** and **Dashboard Parameters** section of the `config.xml` file, include the following:

- **AgingStatsFirstDivision** – Used in the **Aging** screen to determine the number of days in the lowest aging group for claims and exposures, by default 0 – 30 days. The default value is 30 days. See “**AgingStatsFirstDivision**” on page 80 in the *Configuration Guide*. See also the description of this screen at “**Groups on the Team Tab**” on page 405.

- **AgingStatsSecondDivision** – Used in the **Aging** screen to determine the number of days in the second aging group for claims and exposures. This group ranges from **AgingStatsFirstDivision + 1** to the value of this parameter. The default value is 60 days. See “**AgingStatsSecondDivision**” on page 80 in the *Configuration Guide*. See also the description of this screen at “Groups on the Team Tab” on page 405.
- **AgingStatsThirdDivision** – Used in the **Aging** screen to determine the number of days in the third aging group for claims and exposures. This group ranges from **AgingStatsSecondDivision + 1** to the value of this parameter. This parameter also determines the final group of aging for claims, which is all claims over this value. The default value is 120 days. See “**AgingStatsThirdDivision**” on page 80 in the *Configuration Guide*. See also the description of this screen at “Groups on the Team Tab” on page 405.
- **CalculateLitigatedClaimAgingStats** – Whether to show the number of litigated claims on the **Aging** screen. The default value is **true**. See the description of this screen at “Groups on the Team Tab” on page 405.
- **MaxTeamSummaryChartUserBars** – The maximum number of user’s bars to show in the chart on the **Summary** screen. The default value is 10. Setting it to 0 to removes the chart entirely. Otherwise, there are chart bars for the number of users indicated by this parameter with the highest values, and for the others there is one bar labeled **All Other Users**. For a description of the **Summary** screen, see “Groups on the Team Tab” on page 405.
- **GroupSummaryShowUserGlobalWorkloadStats** – If set to **true**, ClaimCenter shows global workload statistics for individual users. See “**GroupSummaryShowUserGlobalWorkloadStats**” on page 81 in the *Configuration Guide*.
- **UserStatisticsWindowSize** – Sets the time window used to calculate user statistics. By default, this parameter is set to 0, which means *this week*, defined as the start of the current business week up to and including today. See “**UserStatisticsWindowSize**” on page 81 in the *Configuration Guide*.

The following parameters also apply to the **Team** tab. They are settings for Oracle databases and are typically set by a database administrator.

- **DisableIndexFastFullScanForTeamGroupActivities** – In the base configuration, ClaimCenter works around query plan problems related to the index fast full scan when executing the team group activities page's main query on Oracle. This parameter controls the work around and is **true** by default. If a future version of Oracle fixes the defect this parameter might be removed. The parameter has no effect on databases other than Oracle.
- **DisableHashJoinForTeamGroupActivities** – In the base configuration, ClaimCenter works around query plan problems related to hash joins when executing the team group activities page's main query on Oracle. This parameter controls part of the work around and is **true** by default. The parameter has no effect on databases other than Oracle.
- **DisableSortMergeJoinForTeamGroupActivities** – In the base configuration, ClaimCenter works around query plan problems related to sort merge joins when executing the team group activities screen's main query on Oracle. This parameter, which is **true** by default, controls part of the workaround when **DisableHashJoinForClaimSearch** is set to **true**. The parameter has no effect on databases other than Oracle.

See also

- For more information on configuration parameters and instructions on how to set the parameters, see “Statistics, Team, and Dashboard Parameters” on page 80 in the *Configuration Guide*.

Batch Process for Calculating Team Statistics

There is a Statistics batch process that calculates the data used in the **Team** tab screens. In the base configuration, this process is scheduled to run every hour at 3 minutes after the hour. For more information, see “Statistics” on page 142 in the *System Administration Guide*.

See also

- For information on administering batch processes, see “Batch Process Info” on page 160 in the *System Administration Guide*.

- For information on configuring batch processes, see “Scheduling Batch Processes and Work Queues” on page 143 in the *System Administration Guide*.

Dashboard

The **Dashboard** tab provides a high-level summary of ClaimCenter data. A manager can use it to gain an overview of claims and related financial information during a standard time period. The information shown on the Dashboard includes the number of open claims, recent claim activity, current financial data, and summary financial data.

For more information, see “Dashboard Tab” on page 60.

part IX

Reinsurance Management

Reinsurance Management Concepts

Guidewire Reinsurance Management provides reinsurance for all lines of business. This topic provides a general introduction to what reinsurance is and how insurance companies often set it up.

If you have Guidewire PolicyCenter 7.0 or later installed and have opted to use reinsurance, see the PolicyCenter documentation for information on setting up reinsurance programs.

This topic includes:

- “Reinsurance General Overview” on page 415
- “Reinsurance Agreements” on page 417

Reinsurance General Overview

Reinsurance is insurance risk transferred to another insurance company for all or part of an assumed liability. Reinsurance can be thought of as insurance for insurance companies. When a company reinsures its liability with another company, it cedes business to that company. The amount an insurer keeps for its own account is its retention. When an insurance company or a reinsurance company accepts part of another company’s business, it assumes risk. It thus becomes a reinsurer.

Note: The insurance company directly selling the policy is also known in the industry as the carrier, the reinsured, or the ceding company. This topic uses the term *carrier* to refer to this company. An insurance company accepting ceded risks is known as the *reinsurer*.

A carrier might want to transfer their risk of loss for several reasons:

- To protect capital and maintain solvency
- To provide a more even flow of net income over time by flattening out claims losses
- To take on more business and across a larger set of risks than the carrier would normally retain
- To spread risk over the globe and take advantage of currency advantages
- To provide catastrophe relief
- To withdraw from a line of business

The carrier might find it advantageous to bundle various types of reinsurance in a way that maximizes its ability to achieve these business goals.

For instance:

- Carriers that want to increase capacity benefit from reinsurance that either takes a percent of the risk or takes a loss above a certain point. If a carrier can be free of fear of multiple large losses, it can comfortably take on more risk.
- Carriers that seek to stabilize their net income flow benefit from reinsurance that takes a percent of the loss above a certain point.
- Carriers that want to withdraw from a line of business benefit from reinsurance that takes on a percentage of risk under a certain loss point for that line of business.

Whether a carrier has one or more of these business goals in mind, common industry practice has established that the carrier can achieve these goals through reinsurance. In setting up reinsurance programs, carriers take into account factors such as:

- The carrier's average policy claim losses and premium intake
- Likelihood of catastrophe
- Proximity of policies taken out in a geographic location

Carriers group reinsurance treaties into reinsurance programs to cover policy risks in a way that maximizes their business goals. They also group treaties into programs to ensure that they have no gaps in coverage and to ensure that they do not duplicate coverage.

Reinsurance Programs

Note: ClaimCenter is not designed to be the system of record for reinsurance agreements. ClaimCenter is designed to integrate with such a system, which can be a reinsurance system or policy system like PolicyCenter.

A reinsurance *program* is a set of reinsurance treaties designed to insure policy risks for all policies held by the carrier that fall:

- Within one type of line of business or peril.
- Under a certain monetary cap.

The line of business or peril covered by the reinsurance program is also known as the *reinsurance coverage group*. Carriers typically assemble one reinsurance program per reinsurance coverage group.

There are two types of reinsurance agreements. Carriers procure reinsurance in the form of facultative agreements for specific risks and treaties that provide coverage for all risks of a certain type.

A carrier typically operates several reinsurance programs. Each reinsurance program is structured to cover a class of risks in a monetary range. Risks that are large and rare are not usually covered by treaties in a reinsurance program. These risks are handled by facultative agreements.

To build a reinsurance program, the carrier assembles one or more reinsurance treaties with the same reinsurance coverage type. Each treaty provides a different type of risk or loss coverage and provides it for a monetary layer or range that is different from the other treaties. These various treaties are arranged in the program to yield a measurable business advantage.

Each individual treaty can be drawn up with a different reinsurer from the other treaties. In addition, each individual treaty covers one and only one of the following:

- A different layer of monetary risk against all policies that have coverables in that reinsurance coverage group
- A different monetary range of loss for qualifying risks above a certain attachment point and below a cap

Reinsurance Agreements

There are two kinds of reinsurance agreements, *treaties* and *facultative agreements*.

- **Treaty** – An agreement between the carrier and the reinsurer to provide coverage for all risks of a certain type.
- **Facultative agreement** – An agreement for a specific risk that is negotiated on an individual case basis.

Each of these agreement types can be drawn up as either a proportional or a non-proportional agreement. Proportional and non-proportional agreements share the risk, premium, and payment for loss with the reinsurer in different ways:

- **Proportional Reinsurance** – Transfers a percentage of the risk to the reinsurer. The reinsurer receives that percentage of the premium and is responsible for that percentage of each loss. Proportional reinsurance is always per risk coverage—it covers one risk.
- **Non-proportional Reinsurance** – There is no proportional ceding of the risk and no proportional sharing of the premium or the losses. The carrier pays the entire loss up to an agreed amount called the attachment point. The reinsurer pays all or part of the loss that exceeds the attachment point up to a limit previously agreed upon by the carrier and reinsurer.

This topic includes:

- “Treaties” on page 417
- “Facultative Agreements” on page 417
- “Proportional Agreements” on page 418
- “Non-proportional Agreements” on page 421
- “Summary of Agreement Types” on page 425

Treaties

A treaty is an agreement between the carrier and the reinsurer that provides reinsurance without the carrier having to submit every risk to the reinsurer. The treaty is a contract, usually arranged on a yearly basis, that covers a class of risks for a monetary range of total insured value. The carrier cedes to the reinsurer a portion of each risk that the treaty covers.

For example, the carrier has a treaty with a reinsurance company. The reinsurance company agrees to pay 40% of property damage claims when the claim amount is between \$1 million and \$5 million.

See also

- “Proportional Treaties” on page 418
- “Non-proportional Treaties” on page 422

Reinsurance Coverage Groups for Treaties

You can group individual coverages into a reinsurance coverage group. Treaties are written to cover losses against a broad category of coverages. For example, a reinsurance group might contain coverages for building, contents, and business interruption. A treaty provides coverage for one or more of these reinsurance coverage groups.

Facultative Agreements

Facultative agreements are always for per risk insurance. They are used to reinsure risks that do not fall within the reinsurance coverages provided by the treaties in a program.

For a specific risk, the carrier and the reinsurer each have free choice in arranging the reinsurance. The carrier is free to decide whether or not to reinsure a particular risk and can offer the reinsurance to any reinsurer it chooses.

By the same token, it is at the reinsurer's discretion whether to accept any risk offered, decline it, or negotiate different terms.

A facultative agreement provides reinsurance for claims that fall within a specified range. The facultative agreement reinsures a specific amount.

For example, a policy provides insurance up to \$4 million. A number of treaties provide coverage for claims up to \$2 million. For a specific risk on the policy, the carrier negotiates two proportional facultative agreements to provide coverage for claims valued at \$2 million to \$4 million. One facultative agreement provides reinsurance coverage for \$500,000. The second facultative agreement provides reinsurance coverage for \$1.5 million. If the risk suffers a loss of \$4 million, the treaties provide reinsurance for the first \$2 million. The two facultative agreements provide reinsurance for the remaining \$2 million.

See also

- "Proportional Facultative Agreements" on page 419
- "Non-proportional Facultative Agreements" on page 425

Proportional Agreements

Reinsurance Management provides proportional reinsurance for both treaties and facultative agreements.

Proportional reinsurance transfers a percentage of the risk to the reinsurer. The reinsurer receives that percentage of the premium and is responsible for that percentage of each loss. Proportional reinsurance is always *per risk* coverage—it covers one risk.

Proportional Treaties

Reinsurance Management provides two types of proportional treaties:

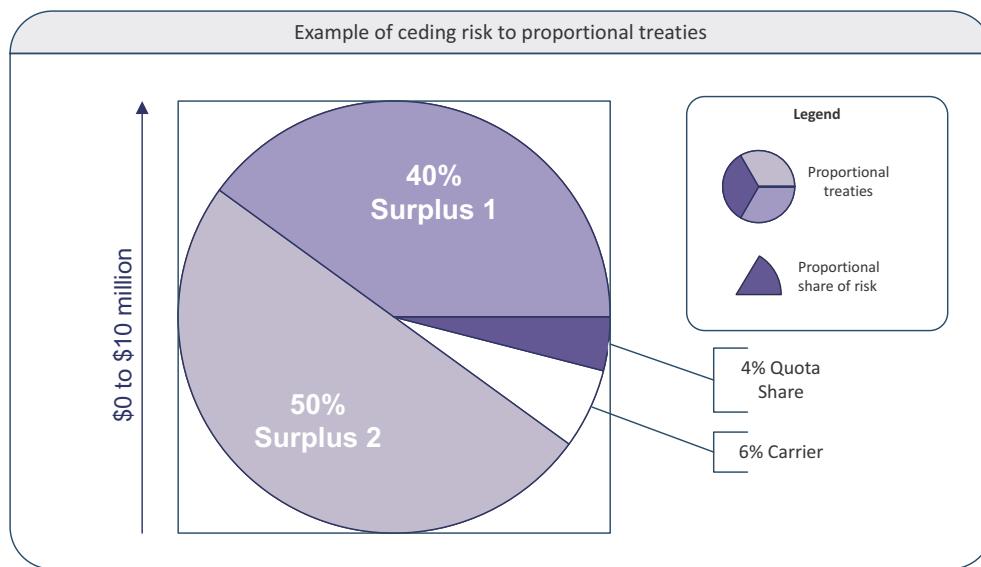
- **Quota share** – The reinsurer assumes an agreed-upon percentage of each relevant risk and shares all premiums and losses accordingly with the reinsured. For example, a carrier has a 40% quota share on all homeowners policies. For every policy, 40% of the premium is ceded to the reinsurer. The reinsurer is responsible to pay for 40% of all losses. A quota share treaty provides reinsurance coverage starting at \$0 up to a coverage limit.
- **Surplus** – The surplus treaty provides reinsurance coverage from a starting value up to the coverage limit. The way in which the percentage of premium is ceded and losses are paid is similar to quota share.

Example of Ceding Risk to Proportional Treaties

In a reinsurance program, quota share and surplus treaties provide layers of reinsurance coverage. In the following example, three proportional treaties provide reinsurance coverage up to \$10 million:

Treaty	Layers of reinsurance	Monetary risk ceded to reinsurer	Proportional share of risk
Surplus 2	From \$5 million to \$10 million	\$5 million	\$5 million of \$10 million = 50%
Surplus 1	From \$1 million to \$5 million	\$4 million	\$4 million of \$10 million = 40%
Quota share	From \$0 to \$1 million ceding 40% of the risk to the reinsurer	\$400,000	\$400,000 of \$10 million = 4%
Carrier's share	From \$0 to \$1 million 60% of the risk retained by the carrier	\$600,000	\$600,000 of \$10 million = 6%

The treaties share a \$10 million risk proportionally as shown in the following illustration:



When there is a loss of \$10 million or less on a risk with a total insured value of \$10 million, the proportional treaties share the loss proportionally. The amount of each treaty's share is shown in the last two columns of the following table:

Treaty	Proportional share of loss	\$10 million loss	\$5 million loss
Surplus 2	50% of loss amount	\$5 million	\$2.5 million
Surplus 1	40% of loss amount	\$4 million	\$2 million
Quota share	4% of loss amount	\$400,000	\$200,000
Carrier's share	6% of loss amount	\$600,000	\$300,000

When there is a loss of \$2 million on a risk with total insured value of \$3.7 million, Surplus Treaty 2 does not apply. This treaty does not apply because the risk does not exceed \$5 million. Only the Quota Share Treaty and Surplus Treaty 1 apply. The proportional treaties share the loss proportionally as shown in the last two columns of the following table:

Treaty	\$4 million risk proportional share calculation formula	Proportional share of loss	Actual monies tendered on the \$2 million loss
Surplus 2	N/A since the total risk < \$5 million	0%	\$0.00
Surplus 1	$100\% \times 2.7 \text{ million} / 3.7 \text{ million}$	73%	\$1.46 million
Quota share	$(40\% \times \$1 \text{ million}) / 3.7 \text{ million}$	11%	\$220,000
Carrier's share	$(60\% \times \$1 \text{ million}) / 3.7 \text{ million}$	16%	\$320,000

Proportional Facultative Agreements

Proportional facultative agreements differ in several ways from proportional treaties.

Proportional treaties define how much risk within the coverage group is ceded to the reinsurer in terms of either:

- A percentage share—the *quota share*
- Layers to be ceded—the *surplus*

A treaty applies to all risks within the scope of the treaty. New risks within the coverage group signed by carrier are automatically covered by existing treaty.

Facultative agreements, on the other hand, reinsure a specific risk. The agreement can simply cede a monetary value, such as \$2 million of the risk, or a percentage, such as 15% of the risk. If the agreement cedes a monetary value, the system determines a percentage share for determining ceded loss. In practice, you might think of the agreement as representing the layer above the highest surplus treaty.

A proportional facultative agreement, like a proportional treaty, shares premiums and losses from the first dollar.

Example of Ceding Amount of Risk to Proportional Facultative Agreements

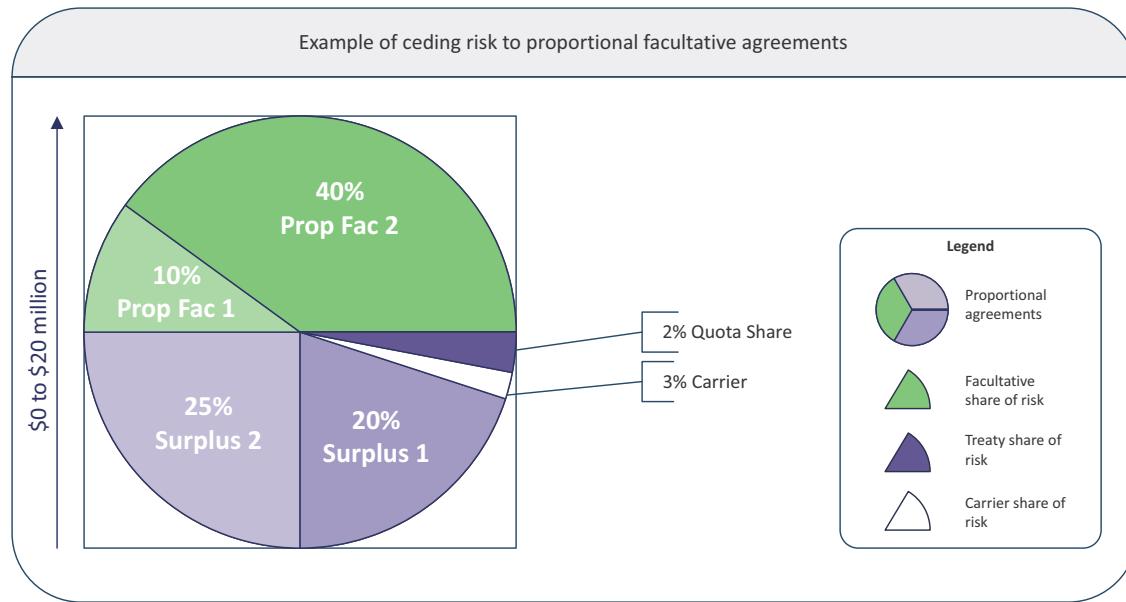
This example shows how risk is ceded in a proportional facultative agreement with a monetary amount entered in the **Amount of Risk Ceded** field on the **Facultative** screen. This example builds upon “Example of Ceding Risk to Proportional Treaties” on page 418, which provided reinsurance from \$0 to 10 million on a specific risk.

However, in this example the risk is valued at \$20 million. The carrier negotiates two proportional facultative agreements to provide coverage for claims up to \$20 million. One facultative agreement cedes \$2 million in risk. A second facultative agreement cedes \$8 million of risk.

In a reinsurance program, quota share and surplus treaties often provide reinsurance coverage as in the following example. In this example, the risk is equal to the total risk covered by the treaties and facultative agreements put together. If the risk had been smaller, some of the treaties might drop out of the coverage. Also, if the risk were smaller, the smaller risk would replace the \$20 million in the proportional share of risk calculation in the last column.

Treaty	Layers of reinsurance	Amount of risk ceded	Proportional share of risk
Proportional Facultative Agreements			
Proportional Facultative 2		\$8 million	\$8 million of \$20 million = 40%
Proportional Facultative 1		\$2 million	\$2 million of \$20 million = 10%
Proportional treaties			
Surplus 2	From \$5 million to \$10 million	\$5 million	\$5 million of \$20 million = 25%
Surplus 1	From \$1 million to \$5 million	\$4 million	\$4 million of \$20 million = 20%
Quota share	From \$0 to \$1 million ceding 40% of the risk to the reinsurer	\$400,000	\$400,000 of \$20 million = 2%
Carrier's share	From \$0 to \$1 million 60% of the risk retained by the carrier	\$600,000	\$600,000 of \$20 million = 3%

The following illustration shows the coverage provided by the reinsurance program:



When there is a loss of \$20 million or less, the proportional agreements share the loss proportionally, as shown in the last two columns of the following table. In this example, the risk equals the risk limit of the combined treaties:

Agreement	Proportional share of loss	\$20 million loss	\$5 million loss
Proportional facultative agreements			
Proportional facultative 2	40% of loss amount	\$8 million	\$2 million
Proportional facultative 1	10% of loss amount	\$2 million	\$500,000
Proportional treaties			
Surplus 2	25% of loss amount	\$5 million	\$1.25 million
Surplus 1	20% of loss amount	\$4 million	\$1 million
Quota share	2% of loss amount	\$400,000	\$100,000
Carrier's share	3% of loss amount	\$600,000	\$150,000

Example of Ceding a Share Percentage to Proportional Facultative Agreements

The previous example shows how risk is ceded to proportional facultative agreements by entering a monetary amount in the **Amount of Risk Ceded** field on the **Facultative** screen. Instead of entering a monetary amount, you can specify a **Ceded Share (%)** field on the **Facultative** screen. For example, the ceding is the same if the two proportional facultative agreements specify 40% and 10% instead of \$8 million and \$2 million, respectively.

Non-proportional Agreements

Reinsurance Management provides non-proportional reinsurance for both treaties and facultative agreements.

In non-proportional reinsurance there is no proportional ceding of the risk and no proportional sharing of the premium or the losses. The carrier is responsible for the entire loss up to an agreed amount called the *attachment point*. The reinsurer then pays all or part of the loss that exceeds the attachment point up to a limit previously

agreed upon by the carrier and reinsurer. The reinsurance premium charged by the reinsurer does not have a direct proportional relationship to the amount of loss that the reinsurer is responsible for.

Note: In the base configuration, ClaimCenter does not automatically create reinsurance transactions for non-proportional agreements. A reinsurance manager can manually enter transactions for this type of agreement. You can configure ClaimCenter and add automatic creation of reinsurance recoverables for non-proportional facultative agreements. This configuration is not trivial, and is likely to require some time and effort to accomplish.

Non-proportional Treaties

Reinsurance Management provides the following types of non-proportional treaties:

- **Excess of Loss** – The reinsurer pays a percentage of the amount of a loss in excess of a specified retention for each risk coverage. An excess of loss treaty has an attachment point and coverage limit, and coverage applies to one risk.

For example, if a storm destroys 10 covered locations, the limit is applied 10 times, once for each location.

- **Net Excess of Loss** – Similar to an excess of loss agreement. However, *net excess of loss* covers losses net of any recoveries from excess of loss or proportional agreements. A net excess of loss treaty has an attachment point and coverage limit.

- **Per Event** – Cover aggregate losses from an event with multiple risks. A per event agreement is similar to a net excess of loss agreement. The carrier determines its net loss after deducting any amounts recoverable from per risk proportional or non-proportional agreements. Then the per event agreement provides coverage if those net losses are above the attachment point of the per event agreement.

Per event treaties are typically catastrophe, for property, or clash cover, for liability.

- **Annual Aggregate** – Similar to a per event treaty, but based on a time period rather than an event. An annual aggregate treaty provides aggregate coverage, net of any per risk coverage or more specific aggregate coverage, such as per event coverage. The annual aggregate treaty covers total losses for an entire book of business for a defined period of time. The period of time is usually one program year. Annual aggregate treaties are defined to start at a specified attachment point or for losses above a specified loss ratio. In either case, the treaty defines a coverage limit. The coverage limit is the maximum amount the reinsurer pays under the treaty, not the top of a layer as in other non-proportional treaties.

For example, an aggregate agreement provides reinsurance for net losses to all covered buildings after recovering per risk reinsurance for each building.

See “Example of Ceding Risk to Per Event and Annual Aggregate Treaties” on page 424.

Example of Ceding Risk to a Single Excess of Loss Treaty

An excess of loss treaty has an attachment point of \$1 million, and a coverage limit of \$3 million with 0% carrier share. The reinsurer does not cover the first \$1 million of any loss, but does cover 100% of the loss above \$1 million up to the limit of \$3 million. The reinsurer provides \$2 million in excess coverage, the Coverage Limit minus the Attachment Point, often referred to as *\$2 million in excess of \$1 million*.

Treaties	Layers of reinsurance
	From \$3 million and up, the carrier provides 100% coverage.
Excess of Loss	Attachment point \$1 million Coverage limit \$3 million
	From \$0 to \$1 million, the carrier provides 100% coverage.

Losses would be covered by this agreement as follows:

- \$900,000 loss – The reinsurer pays nothing because it is under the \$1 million attachment point.
- \$2,500,000 loss – The carrier pays the first \$1 million, and the reinsurer pays the next \$1,500,000.

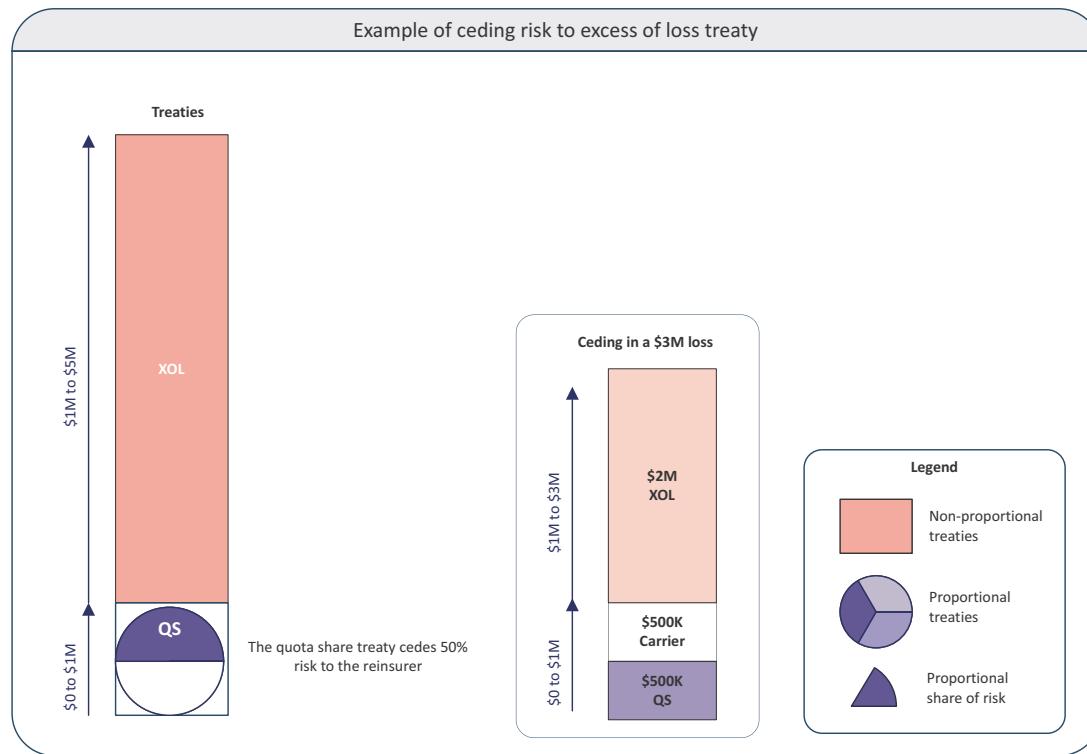
- \$4,500,000 loss – The carrier pays the first \$1 million. The reinsurer pays the next \$2 million up to the reinsurance limit of \$3 million. The carrier pays the last \$1.5 million, unless the carrier has another reinsurance agreement that covers a higher band of losses, which would typically be the case.

Example of Ceding Risk to Multiple Excess of Loss Treaties

The carrier has a program that contains two treaties. A quota share treaty covers 50% up to \$1 million. An excess of loss treaty covers \$4 million in excess of \$1 million.

Treaty	Layers of reinsurance
Excess of loss	Attachment point: \$1 million Coverage limit: \$5 million
Quota share treaty	50% up to \$1 million

If there is a \$3 million loss, the carrier pays a 50% share of the first \$1 million. The excess of loss agreement pays the \$2 million above the \$1 million attachment point. The carrier's gross retention is \$1 million, where the excess of loss attaches, and total net retention for any loss under \$5 million is \$500,000.



Example of Ceding Risk to a Net Excess of Loss Treaty

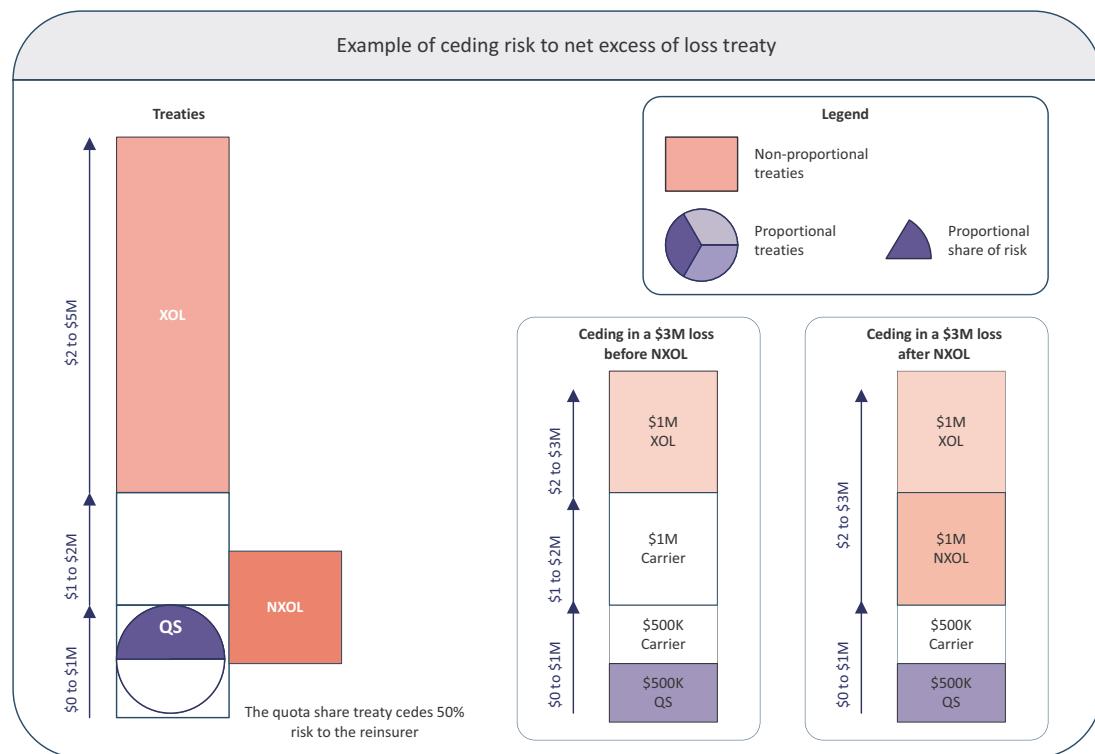
The carrier has a program that contains three treaties:

- A quota share treaty covers 50% up to \$1 million.
- An excess of loss treaty covers \$3 million in excess of \$2 million.

- A net excess of loss treaty covers \$1 million in excess of \$500,000.

Layers of reinsurance	
Treaties	
Excess of loss	Attachment point: \$2 million Coverage limit: \$5 million
Quota share treaty	Attachment point: \$500,000 Coverage limit: \$1 million
Net treaties	
Net excess of loss	50% up to \$1 million

If there is a \$3 million loss, the carrier pays a 50% share of the first \$1 million and 100% of the next \$1 million. The excess of loss pays the \$1 million above \$2 million. The carrier's net loss is \$1.5 million, but the carrier collects \$1 million from the net excess of loss agreement for the amount of net loss above \$500,000. The carrier's *gross retention* is \$2 million, where the excess of loss attaches, and total net retention for any loss under \$5 million is \$500,000.



Example of Ceding Risk to Per Event and Annual Aggregate Treaties

A carrier might be willing to hold a \$1 million net retention for any one risk to property. However, if there are widespread losses from a single catastrophic event such as a tornado or flood, 100 separate losses could add up to \$100 million in retained risk. To protect against a loss of this magnitude, the carrier can have a per event agreement to provide coverage for \$100 million in excess of \$20 million. The carrier retains \$20 million in aggregate net risk. The carrier collects \$80 million from the per event agreement in the case of a \$100 million net loss (after per risk insurance) from a single event.

Annual aggregate treaties provide reinsurance coverage for multiple catastrophic events in a single year. For example, the carrier had planned for 2,000 slip and fall liability losses in a year, but there are claims for 10,000.

The carrier's risk retention is unacceptably high. To protect against this eventuality, the carrier negotiates an annual aggregate treaty to cover yearly net losses for \$500 million in excess of \$200 million. The annual aggregate treaty cedes 75% of the risk to the reinsurer.

Non-proportional Facultative Agreements

Non-proportional facultative agreements can be excess of loss or net excess of loss agreements.

Excess of Loss

Non-proportional facultative agreements are usually excess of loss agreements.

If a facultative excess of loss agreement insures amounts above other excess of loss agreements, it provides another layer of coverage when no standard treaty is in place. There is no difference from a standard excess of loss situation.

However, if a facultative excess of loss agreement insures amounts above a set of proportional agreements, the behavior is different. When a set of proportional treaties are in place, the idea is to share risks up to the limit of the highest surplus, such as \$2 million. For larger risks, a facultative excess of loss agreement can remove the potential for losses larger than \$2 million. The risk still looks like a \$2 million risk to all the proportional participants.

The carrier charges a premium to cover the cost of the facultative excess of loss agreement plus other costs such as commissions to agents. Since all proportional participants benefit from the facultative excess of loss agreement, the premium is shared proportionally after deducting the cost of the facultative excess of loss agreement.

Net Excess of Loss

The other type of non-proportional facultative agreement is a net excess of loss agreement. This agreement provides reinsurance after proportional reinsurance and protects only the carrier's share of the risk.

The net excess of loss premium is not deducted in advance of determining what is shared among the proportional participants.

Summary of Agreement Types

Reinsurance agreements are categorized into different types based on how the risk is shared. The agreement records the parameters to be used in the calculation of how to divide the risk and how to distribute the premiums.

The following table shows the types of agreements in the default configuration. The marked cells indicate that the item applies to that agreement type. The final column, Transaction Generation, shows how ClaimCenter handles reinsurance transactions for the type of agreement. For more information, see “Handling of Transactions for Reinsurance Agreements” on page 428.

Agreement Type	Treaty	Facultative	Per Risk	Aggregate	Policy Attachment	Loss Date Attachment	Transaction Generation
Non-proportional							
Annual Aggregate	●			●		●	reporting
Per Event	●			●		●	reporting
Excess of Loss	●		●		●	●	configurable
Net Excess of Loss	●		●		●	●	configurable
Facultative Excess of Loss		●	●		●		configurable
Facultative Net Excess of Loss		●	●		●		configurable

Agreement Type	Treaty	Facultative	Per Risk	Aggregate	Policy Attachment	Loss Date Attachment	Transaction Generation
Proportional							
Quota Share	●		●		●		automated
Surplus	●		●		●		automated
Facultative Proportional		●	●		●		automated

The Policy Attachment column shows the types of agreements that apply to all losses against the policy for the entire term. Excess of Loss and Net Excess of Loss treaties can be specified as either policy attachment or loss date attachment.

Reinsurance Management in ClaimCenter

This topic describes how to work with Guidewire Reinsurance Management in ClaimCenter.

For a general overview of reinsurance, see “Reinsurance Management Concepts” on page 415.

This topic includes:

- “Reinsurance in ClaimCenter” on page 427
- “Setting up Reinsurance Users and Groups” on page 429
- “Working with Reinsurance Agreements and Transactions” on page 430
- “Marking a Claim as Reinsurance Reportable” on page 432
- “Associating Claims” on page 433

Reinsurance in ClaimCenter

Carriers must correctly identify claims that qualify for reinsurance. Otherwise, leakage occurs.

ClaimCenter helps the carrier reduce this leakage by providing features that support tracking reinsurance agreements that apply to specific claims and retrieving recoverable amounts from the reinsurers.

ClaimCenter sets up this information in two steps:

- **Claim Center retrieves reinsurance agreements** – ClaimCenter retrieves information about how the carrier’s reinsurance applies to individual policy risks when an exposure is created against that risk in a claim. ClaimCenter pulls over the reinsurance agreements that apply to the exposures on a claim and groups them according to the policy risk.
- **Claim Center provides a way to create reinsurance transactions** – ClaimCenter uses the information retrieved to create reinsurance transactions. These transactions can then be sent to a billing system to collect the money that the reinsurer owes the carrier.

Reinsurance Agreements Retrieval

ClaimCenter retrieves all reinsurance agreements associated with a particular risk from the external reinsurance system of record when exposures are added to the claim. ClaimCenter refers to this set of agreements as an agreement group.

Note: ClaimCenter does not retrieve reinsurance agreements for unverified policies or for exposures that do not have a coverage. Because the identity of the risk is required, reinsurance agreements are retrieved only when exposures are created by coverage, and not by coverage type.

Reinsurance agreement information for a claim is on the **Reinsurance → Reinsurance Financials Summary** screen. In the base product, this screen is available to a user with the Reinsurance Manager role. It is also available to a user who has been granted the View RI Transactions and Agreements permission `riview`. Agreements can be edited by a user with the Reinsurance Manager role or by a user who has been granted the Edit RI Transactions and Agreements permission `redit`.

To enable reinsurance retrieval, see “Reinsurance Integration” on page 247 in the *Integration Guide*.

Reinsurance Transactions

Under some circumstances, the base configuration of ClaimCenter automatically creates reinsurance transactions when the corresponding regular claim financial transactions are created. These transactions include reserves and payments. A user with the Reinsurance Manager role or with the permissions to view and edit reinsurance transactions and agreements, `riview` and `redit`, can also create and edit reinsurance transactions. Users with `riview` permission can view these transactions in read-only mode.

Reinsurance Transaction Types

There are two kinds of reinsurance transactions. The following reinsurance transactions are fundamental to the ClaimCenter reinsurance management process:

- **Ceded reserve** – A reserve created for the portion of reserves that the reinsurer must cover.
- **Reinsurance (RI) recoverable** – A transaction to track the amount to be billed to the reinsurer. An RI recoverable is the portion of the payment that the reinsurer must cover.

Note: RI recoverables are different from normal claim recoveries, in that RI recoverables are created when the reinsurer is to be billed. Normal claim recoveries are entered when the recovery is received by the carrier.

All reinsurance transactions are created based on the regular financial transactions created for the claim.

ClaimCenter identifies potential reinsurance ceded reserves and recoverables for a claim in the **Reinsurance → Reinsurance Financials Summary** screen. To see this screen, you need either the Reinsurance Manager role or the `riview` and `redit` permissions described previously under “Reinsurance Agreements Retrieval” on page 428.

Automatically Creating Reinsurance Transactions

ClaimCenter automatically creates reinsurance transactions under the following conditions:

- There must be at least one reinsurance agreement associated with the exposure.
- The agreement is a proportional agreement.
- The claim financial transactions have reached Submitting status.

It is also possible to configure ClaimCenter to automatically create transactions for non-proportional agreements.

Handling of Transactions for Reinsurance Agreements

The table in “Summary of Agreement Types” on page 425 summarizes reinsurance agreements and shows how reinsurance transactions are handled in ClaimCenter. The final column of that table shows that reinsurance trans-

action calculation is automated in ClaimCenter for proportional agreements and can be configured for non-proportional per risk agreements. For per-event and aggregate agreements, you can use reporting to calculate reinsurance recoveries.

Reinsurance recoveries are calculated correctly by the system only if all agreements that apply to a risk are proportional. When both proportional and excess of loss agreements apply to a risk, the recoveries are calculated by ignoring the reinsurance recoverable from the excess of loss agreement.

Setting up Reinsurance Users and Groups

Reinsurance processing is a separate process from claims adjudication. In the base configuration of ClaimCenter, reinsurance processing is handled by a separate type of Reinsurance Manager user in a special Reinsurance Unit. The Reinsurance Manager user can see and edit all data in ClaimCenter that is associated with reinsurance.

The adjuster can see if a claim has been marked for reinsurance and, if so, the Reinsurance Manager who has been assigned. The insured has no knowledge of reinsurance.

Reinsurance Manager Role

The base configuration of ClaimCenter provides a Reinsurance Manager role that has the permissions required for a user to work with reinsurance. A user who has this role can:

- View and perform edits on the **Reinsurance → Reinsurance Financials Summary** screen of a claim.
- View and edit the reinsurance reportable information on the **Claim Status** screen of a claim, at **Summary → Status**.
- View and edit the **Administration tab → Business Settings → Reinsurance Thresholds** screen. See “Managing Reinsurance Thresholds” on page 498.

The Reinsurance Manager, just like anyone else who can view a claim, can also:

- See all reinsurance notes in the **Summary** screen of a claim, at **Summary → Overview**.
- See if a Reinsurance Manager has been assigned to a claim on the **Parties Involved → Users** screen of a claim.

For a list of Reinsurance Permissions, see “Reinsurance Permissions” on page 429.

Reinsurance Permissions

The following permissions are specific to reinsurance and can be seen in the Reinsurance Manager role. Navigate to **Administration tab → Users & Security → Roles** to see the complete list of permissions for the Reinsurance Manager in the base configuration.

Permission Name	Code	Description
Edit reinsurance reportable	reinsuranceedit	Can edit the reinsurance reportable status on a claim
Edit reinsurance reportable thresholds	reinstresholdedit	Can edit the reinsurance reportable thresholds
Edit RI transactions & agreements	riedit	Can edit reinsurance transactions and agreements
View reinsurance reportable thresholds	reinstthresholdview	Can view the reinsurance reportable thresholds
View RI transactions & agreements	riview	Can view reinsurance transactions and agreements

Other user roles can be set to use one or more of these permissions. These permissions can also be used to set visibility of certain regions of the user interface.

Note: The **Edit reinsurance reportable thresholds** permission is included for compatibility with previous versions of ClaimCenter. The reinsurance thresholds on the **Administration tab → Business Settings → Reinsurance Thresholds** screen are not used in the base configuration of ClaimCenter.

Reinsurance Unit Group Type

Typically, a user in the Reinsurance Manager role is in a group with a group type of Reinsurance Unit. Besides serving as a grouping mechanism, the Reinsurance Unit group type is used as the basis for assigning reinsurance activities.

Reinsurance Unit Group Activity and Claim Assignment

Users with the Reinsurance Manager role, or users who have a role with added reinsurance permissions, can have activities and claims assigned to them. For this assignment to happen, they must be part of a user group with the group type Reinsurance Unit. In the base configuration, ClaimCenter assigns a reinsurance manager to a claim and creates a Review Claim for Reinsurance activity based on the group type.

Every reinsurance agreement has a notification threshold, defined as the point at which the reinsurer needs to be contacted. The notification threshold is a monetary amount. When the gross total incurred on an exposure is greater than the notification threshold of any agreement in the exposure's associated agreement group, ClaimCenter does the following two things:

- Assigns a reinsurance manager to the claim, if one has not been already assigned.
- Creates a Review Claim for Reinsurance activity and assigns it to the reinsurance manager. In the **Default-GroupActivityAssignmentRules** ruleset, the rule **DGA04000 - Assign reinsurance review activity to reins user** accomplishes this task. The rule uses one of the following activity patterns:
 - `claim_reinsurance_review`
 - `reinsurance_review`
 - `reinsurance_needs_synchronization`

These same two actions are taken when a claim has been marked as Reinsurance Reportable on the **Claim Status** screen at **Summary → Status**.

You can create the **Review Claim for Reinsurance** activity on a claim manually. With the claim open, navigate to **Actions → New Activity → Reminder → Review Claim for Reinsurance**. This activity is also assigned to a member of a group with group type Reinsurance Unit.

Identifying the Reinsurance Manager Assigned to a Claim

After a reinsurance manager has been assigned to a claim, you can see the user listed on the claim's **Parties Involved → Users** screen.

Working with Reinsurance Agreements and Transactions

ClaimCenter provides visibility into reinsurance agreements and financials to users in the Reinsurance Manager role or with `review` permissions. To access the **Reinsurance Financials Summary** screen, open a claim and click **Reinsurance** in the sidebar.

The **Reinsurance Financials Summary** screen helps identify agreements applied to a claim, their ceded reserves, and their reinsurance recoverables by showing four types of information:

- The reinsurance agreements that apply to the loss on the claim.
- The percentage that an agreement shares in the loss, if the agreement is a proportional agreement.

- The ceded reserve line for each reinsurance agreement. For proportional agreements, this reserve is automatically calculated by multiplying the reserve line by the proportional share.
- The reinsurance recoverable amount for each agreement. For proportional agreements, this amount is automatically calculated each time a payment is made on the claim by multiplying the payment amount by the proportional share.

You can edit the calculated reserve and recoverable amounts by manually entering amounts related to the non-proportional agreements, such as excess of loss treaties and facultative agreements.

The information that appears on the **Reinsurance → Reinsurance Financials Summary** screen can be sent to a financial system. For example, the information could be used to send notifications of reinsurance recoverables and invoice the reinsurers.

Viewing Reinsurance Financials

The main reinsurance screen in ClaimCenter, **Reinsurance Financials Summary**, has information about reinsurance financials. To access this screen, open a claim and click **Reinsurance** in the sidebar.

The top of the screen shows the **Reinsurance Financials Summary**. This summary has three columns:

- **Submitted Claim Financials** – Summaries of the claim financials without reinsurance.
- **Reinsurance Financials** – Reinsurance financials by themselves.
- **Claim Financials with Reinsurance** – Claim financials when reinsurance financials are included.

The section below the summaries shows a list view of all the reinsurance agreements that are associated with exposures on this claim. For each agreement, ClaimCenter shows the associated exposure and the agreement name in the **Agreement** column and other relevant information, such as:

- **Start** – For example, the attachment point of an Excess of Loss agreement.
- **End** – For example, the recovery limit of an Excess of Loss agreement.
- **Proportional Share** – Applicable if this agreement is a proportional agreement.
- **Exceeds Not. Threshold** – Whether or not the exposure has passed this agreement's notification threshold.
- **RI Recoverable** – The amount to be billed to the reinsurer—the portion of the payment that the reinsurer must cover.
- **Ceded Reserves** – The amount of the reserve that the reinsurer must cover.

Clicking the name of any agreement in this list view opens the **Agreement Details** screen. The top of the **Agreement Details** screen has all the details of the individual agreements as they were supplied to ClaimCenter. The bottom of this screen has the details of how each reserve line on every exposure associated with this agreement mapped its financials to the reinsurance financials.

Manually Editing Reinsurance Transactions

The reinsurance manager can manually edit or add reinsurance transactions. There is an **Edit** link on the line for each agreement in the **Reinsurance Financials Summary** list view. Clicking **Edit** takes you to the **Adjust Recoverables** screen. On this screen, you can modify the Ceded Reserves and RI Recoverable and enter a reason for the adjustment.

Adding, Editing, and Deleting Reinsurance Agreements and Agreement Groups

On rare occasions, it might be necessary for the reinsurance manager to add or edit reinsurance agreements or agreement groups in ClaimCenter. You can edit only agreements and agreement groups that were added in ClaimCenter.

In the base configuration, you cannot edit or delete agreements and agreement groups that were retrieved from an external system. You also cannot add an agreement created in ClaimCenter to an agreement group that was

retrieved from an external system. Additionally, you cannot add exposures to or remove exposures from externally retrieved agreement groups.

The reinsurance manager can add, edit, move, and delete eligible reinsurance agreements as follows:

- Add new agreements from the **Reinsurance Financials Summary** screen by clicking **Add Agreement** and choosing the agreement type. All new agreements must be associated with an agreement group, so it might also be necessary to add an agreement group.
- Open the **Reinsurance Financials Summary** screen by opening a claim and clicking **Reinsurance** in the sidebar.
- Click the name of a reinsurance agreement on the **Reinsurance Financials Summary** screen to open the **Agreement Details** screen. Besides editing details of the agreement, you can move the agreement to a different agreement group.
- Move exposures from one agreement group to another on the **Exposures and Reinsurance** screen. You can open this screen by clicking **Manage Exposures** on the **Reinsurance Financials Summary** screen.
- Delete reinsurance agreements added in ClaimCenter. Click the name of a reinsurance agreement on the **Reinsurance Financials Summary** screen to open the **Agreement Details** screen, where there is a **Delete** button. When you delete a reinsurance agreement, the RI ceded reserves and RI recoverable calculated automatically by the system are zeroed. If there are manually entered RI transactions on the reinsurance agreement being deleted, you must manually zero out the adjustments to be able to delete the reinsurance agreement

Manually Retrieving Reinsurance Agreements

With a claim open, you can manually retrieve reinsurance agreements. Navigate to the **Reinsurance → Reinsurance Financials Summary** screen and click **Manage Exposures** to open the **Exposures and Reinsurance** screen. Then click the **Retrieve Reinsurance** button to force a retrieval from the reinsurance system of record. Manual retrieval can be useful in some cases, including, but not limited to, the following cases:

- If an exposure that was not associated with a risk was added to the claim, the reinsurance agreements for that exposure would not have been retrieved when it was created. For example, you create the exposure by using the *create exposure by coverage type* method. After the exposure has been associated with a risk, the reinsurance manager can retrieve the proper agreements manually.
- If the reinsurance agreements have been changed in the source system since the initial retrieval in ClaimCenter, manual retrieval updates ClaimCenter with the proper information.

Marking a Claim as Reinsurance Reportable

When an exposure is set up on a claim, the claim is also automatically marked to show whether reinsurance is applied to it. This indicator is set in the **Reinsurance Reportable?** field on the **Claim Status** screen. An activity is also sent to the reinsurance manager to review the reinsurance information for this claim.

You can manually mark a claim to be reported for reinsurance. You might manually mark a claim if you think reinsurance applies to the claim, but no reinsurance agreements have been pulled over from the reinsurance system.

Note: Marking a claim as reported for reinsurance does not retrieve reinsurance agreements from the external reinsurance system of record or automatically create reinsurance transactions.

To mark a claim to be reported for reinsurance

1. Open the claim and navigate to **Summary → Status** to open the **Claim Status** screen.
2. Click **Edit** and, in the **General Status** section, select **Yes** for the **Reinsurance Reportable?** field.
3. Provide a reason in the **Reinsurance Edit Reason** field.
4. Click **Update** to save your changes.

This action creates:

- A note you can see on the **Summary** screen in the **Latest Notes** section.
- A **Review Claim for Reinsurance** activity.

Associating Claims

You can associate claims with one another. Associating claims enables the reinsurance manager to run reports to find examples of reinsurance-related associated claims and analyze them for reinsurance reportability. To associate a claim with another claim, open the claim and navigate to **Loss Details** → **Associations**, and then click **New Association**.

part X

ClaimCenter Administration

Users, Groups, and Regions

ClaimCenter organizes people into Users, Groups, and Regions. A *user* is someone with permission to use ClaimCenter. Users then form work-related groups, which you can further aggregate into regions. The **Administration** tab models this structure and presents it in the sidebar in a tree view.

This topic includes:

- “Understanding Groups” on page 437
- “Understanding Users” on page 438
- “Understanding Roles” on page 439
- “Understanding Assignment Queues” on page 443
- “Understanding Regions” on page 444

See also

- “Security: Roles, Permissions, and Access Controls” on page 447 for additional details about how ClaimCenter uses this structure to enforce security
- “Work Assignment” on page 197 for a description of how ClaimCenter assigns work to groups and users
- “Managing Users and Groups” on page 472 and “Searching For Regions” on page 480
- “Creating New Users and Groups” on page 473
- “Managing Users” on page 473
- “Managing Attributes” on page 474 and “Managing Authority Limit Profiles” on page 476
- “Managing Groups” on page 474
- “Managing Regions” on page 479

Understanding Groups

The basic way ClaimCenter organizes a carrier’s employees, the people available to handle claims, is the *group*. A group’s members can either be other groups—teams or subgroups—or users, people who work on claims. Groups are often defined to mirror the carrier’s organizational structure—a main office has departments that contain divisional offices that control local offices, and so on. But groups can also be defined virtually. A *virtual*

group is a set of people who are not part of the same team or department, but who are related in some other way. For example, a virtual group could contain all adjusters in a large region with expertise in commercial arson. The members do normal work in different local offices and are members of their own office groups as well.

All the carrier's groups must form a regular hierarchy, a tree structure, in which each subgroup has a single parent and zero or more child groups. There is no limit to the number of levels in this tree. Such a group hierarchy can model any organization. The parent can be the home office, which has regional offices as its children, which in turn could have children corresponding to different lines of business. These lines of business in turn could have local offices as their children. Virtual groups can also be part of this hierarchy.

Groups have the following additional properties:

- There can be only one group with no parent. This group is the top level, root group.
- There is no limit to the number of members and child groups—subgroups—a group can have.
- A group always has one supervisor. Guidewire recommends that the supervisor be a member of the group. While a supervisor is not required to be a member of the group, making the supervisor a group member is often useful. For example, it is likely that you will want group work like pending claim assignments to be assigned to the group supervisor.
- A group can be associated with one or more regions, which can be specified in assignment rules.
- Groups control data security. Each group is a member of a single security zone.
- A default rule set governs how work is assigned to a group. Each group can have its own default rule sets that can assign activities, claims, exposures, and matters to it.
- A group is described further by its group type, used in rules to determine if work is to be assigned to the group.
- Similar to users' having individual load factors that indicate the ideal distribution of work in a group, a group itself can have a load factor, which assignment rules can consider.

Administrators add, edit, and delete groups, and can do the same with their members. Editing a group includes choosing its parent group and supervisor, and setting its region, group type, security zone, and permissions to change load factors. You can delete a group only if it is empty and has no child groups. Otherwise, you break the tree structure and create orphan users.

Understanding Users

Users are people who are permitted to log into ClaimCenter. They are involved with the process of settling claims. The goal of assignment is to assign work to users, which makes them owners of that work. After assigning work to the correct group, you or a rule pick a user from that group. Therefore, each user must belong to at least one group.

Each user is characterized by:

- **Credential** – Defines a user name and password for logging into ClaimCenter.
- **Roles** – Restrict what the user can view and work on. For more information, see “Role-Based Security” on page 448.
- **Authority Limits** – Cap the monetary amount of financial transactions the user can authorize. See “Managing Authority Limit Profiles” on page 476.

The following additional user characteristics help in the assignment process:

- **Location information** – Includes name, address, email, and phone and fax numbers. The address can be used to assign based on proximity.
- **Custom user attributes** – Examples are languages spoken or a special expertise, like familiarity with fraud investigation.
- **User experience rating** – Helps in steering complex claims away from new adjusters.

- **User role** – Examples are doctor, lawyer, vehicle inspector, police, or fraud investigator, called *Special Investigator* in ClaimCenter.
- **Load factor** – Gives the correct proportion of work to a part-time or apprentice adjuster. ClaimCenter uses load factors to balance the number of work assignments among all the users in a group. Other load factors allow balancing work across groups.
- **Vacation status** – Can be used to prevent new work from being automatically assigned to someone who is out of the office.

Administrators define users, giving them membership in groups as well as the characteristics listed previously. Both the **Team** tab and the **Administration** tab have **User Profile** screens that enable administrators to define and edit these characteristics. Users can also be imported into ClaimCenter.

It can be useful to make users members of several groups. An experienced fraud investigator can be a member of:

- A region's Special Investigation (SI) team, a special group.
- The local office group. This group mirrors the user's position in the company and reporting relationship.

Multiple memberships make it easier for assignment rules to find the user because the rules take different paths down the group hierarchy.

Understanding Roles

Users have one or more *roles*, which are a collection of permissions. Permissions enable users to create, view, edit, and delete various ClaimCenter objects. For example, assigning a claim to a user who is an adjuster guarantees that the user has the necessary permissions to complete the work.

Custom User Attributes

ClaimCenter provides a general way to describe user attributes that is helpful in deciding how to assign work. There is also a rule that assigns work based on these attributes. The rule selects the user with the attribute who has waited longer for this type of work than any other user with the same attribute.

These attributes are found in the `UserAttributeType.ttx` typelist, accessible through Guidewire Studio. In the base configuration, this typelist contains the typecodes `default`, `Account`, `Expertise`, and `Language`. You can extend this typelist.

Custom user attributes themselves have optional attributes that increase their usefulness.

- **Type** – A way to group custom user attributes. For example you can give French and Spanish the type `Language`.
- **State** – Defines where the attribute is valid. An expert in workers' compensation claims usually has expertise in just one state.
- **Value** – Defines an integer value for an attribute. Language fluency might be rated on a 1-5 scale.

Custom user attributes are listed in the **Administration** tab on the **Users & Security → Attributes** screen. An administrator can create user attributes in the **Attributes** screen and apply them to users.

For example, you can select the **Administration** tab, click **Users & Security → Users** in the sidebar menu and search for a user. When you find a user, you can click the **Attributes** card and click **Edit** to add an attribute for that user. When you add the attribute, you see **Type**, **State**, and **Value** settings that you can specify for that user.

User Roles

Users can also possess one or more *user roles*, which are distinct from regular roles. User roles are granted to a user for a specific claim. User roles include doctor, attorney, nursing care manager, and so on. You can define or remove user roles in Guidewire Studio in the `UserRole.ttx` typelist.

Use Gosu in rules to assign work to a user with a specific user role. The method `claim.assignToClaimUserWithRole` assigns work to a user with a specific user role, who is also a member of the group that owns the claim. The claim must already be assigned to a group before this method is useful.

An example of user role assignment is a workers' compensation claim that requires a nursing case manager. ClaimCenter, through assignment, makes the user with the role of adjuster the owner of the claim. However ClaimCenter might assign activities or even an exposure to a user with the user role of nursing case manager. As a user, the case manager can also have assigned roles, which give access to the claim screens related to the case manager's work. However, the case manager is prevented from viewing other claim information. If this case manager were assigned to an exposure, the exposure could be reassigned to the claim owner after the activities were completed.

Users granted a user role on a claim or exposure have the same permissions as the claim or exposure owner on that entity. The same is true for contacts granted a contact role. Constraints on user roles can restrict these permissions. Also, administrators can grant ACL permissions to users with specific user roles.

Granting a User a User Role

Assigning a user role already in the `UserRole.ttx` typelist is subject to conditions, or constraints, defined in the `UserRoleConstraint.ttypelist`.

To grant a user role

1. Open a claim.
2. Navigate to **Parties Involved** → **Users**.
3. Select the user to open the **User Details** screen for that user.
4. In the **User Details** screen, click **Edit**.
5. In the **Roles** section, click **Add**.
6. Click the **Role** field in the new row and choose a role from the drop-down list.
7. Click **Update** to save your work.

Granting a Contact a Contact Role

You can similarly grant contact roles to contacts. Some contact roles are constrained from being given to certain classes of contacts. For example, a person, but not a vendor, can be given the role of supervisor. In Guidewire Studio, the `ContactRole.ttx` typelist contains all defined contact roles. The typecodes in the `ContactRoleCategory.ttx` typelist define the constraints governing to whom the contact roles can be given.

To grant a contact role to a contact on a claim

1. Open a claim.
2. Navigate to **Parties Involved** → **Contacts**.
3. Select the contact to open the contact's detail view below the list of contacts.
4. On the **Basics** tab, and click **Edit**.
5. In the **Roles** section, click **Add**.
6. Click the **Role** field in the new row and choose a role from the drop-down list.
7. Click **Update** to save your work.

Constraints on User and Contact Roles

Granting a user a user role gives that user access to the claim. However, you can restrict users with a specific user role from working on a claim unless they have the correct system permissions. You can also limit the number of users with a specific role. Apply these restrictions by using the following user role constraints:

User Role Constraint	Definition
ObjectOwner	The user given a user role on an object must have the same permissions needed to own the object. Default value is true.
ClaimExclusive	Each claim can have at most one user given this user role. Default value is true.
ExposureExclusive	Each exposure can have at most one user assigned to this role. Default value is true.

The `entityroleconstraints-config.xml` file defines how role constraints are used. See “Defining Role Constraints” on page 588 in the *Configuration Guide*.

User Experience Rating

All users can be granted an experience attribute by an administrator from the choices in the `UserExperienceType.ttx` typelist. In the base configuration, this typelist contains typecodes describing level of experience: `low`, `medium`, and `high`. Assignment rules can use this characteristic to keep complicated work from inexperienced users.

To assign a user an experience level:

1. Navigate to Administration tab → Users & Security → Users and find a user.
2. On that user’s User Details screen, click Edit and then click the Profile card.
3. In the Extended Profile section, chose a level from the Experience Level drop-down list.
4. Click Update to save your changes.

Load Factors

Not all members of a group are equal. Supervisors, new hires, members who belong to other groups, and those working on special projects can have a reduced workload when work is distributed. To balance workloads, administrators assign each user a number from 0 to 100 to reflect the percentage of the group’s normal workload each user must have.

This number, called a *load factor*, appears in manual assignment screens to help in manual assignment.

Round-robin automatic assignment rules take these load factors into account. These rules assign only half the work to a user with a load factor of 50 that they assign to others in the same group. The algorithm assigns equal amounts of items because it cannot know how difficult each item is.

See also

- “Team Management” on page 403 for information on setting a user’s load factor.

Workload Counts

After becoming a member of multiple work teams, a user can be assigned a full workload as a member of each team. This assignment does not take into account the workload the user is assigned as a member of other groups. Besides using load factors, ClaimCenter manages this potential problem by providing a summary of the total of all the work assigned to each user.

Supervisors see total workloads by using the Team tab. Each member of a supervisor’s group is listed. The table shows all activities, claims, exposures, and matters that are assigned to that member. Information is broken down

by whether each item is new, open, flagged, closed, or overdue, or completed today, depending on the work category. Not all these types are shown for each work category. In each category, the table shows the total count of items assigned to the user as a team member as well as the entire total. Supervisors can use this information to reduce overworked subordinates' load factors. See "Team Management" on page 403.

Gosu functions can also return this information. For example, auto-assignment rules can exclude overworked users from round-robin assignment or to reduce their load factors. See "How Work is Assigned" on page 199.

ClaimCenter updates these global numbers hourly when running the Statistics batch process.

See also

- "Batch Process for Calculating Team Statistics" on page 409
- "Batch Processes and Work Queues" on page 123 in the *System Administration Guide*

Inactive Status

A user always has the status of active or inactive. After becoming inactive, a user cannot log into ClaimCenter and cannot be assigned anything. Only an administrator can change this status.

To assign a user active or inactive status:

1. Navigate to **Administration** → **Users & Security** → **Users** and find a user.
2. In the detail view for the user, click **Edit** and then click the **Basics** card.
3. Set **Active** to Yes or No.
4. Click **Update** to save your changes.

Related Users

Related users are users or contacts who either:

- Have a user role on the claim. See "User Roles" on page 439.
- Own the claim, or one or more of its exposures, activities, or matters.

By contrast, a *claim user* is a person meeting the second criteria of having been assigned work on the claim.

To View all Related Users on a Claim

To see all related users on a claim, as well as all the claim's other users, do the following.

1. Open a claim.
2. Navigate to **Parties Involved** → **Users**.

This screen lists all users on the claim. It describes both the work assigned and the users' user role on the claim, if any. You can edit this screen to grant or remove user roles, but not assignments. After a user has no work to complete and has no user role on the claim, ClaimCenter removes the user from the claim or exposure and from this list.

This screen is similar to the **Contacts** screen except it displays the relationship of ClaimCenter users to a claim, as opposed to outside parties, like a witness or body shop.

To View Claims or Exposures Where You are a Related User

To view all claims on which you are a related user:

1. Navigate to **Desktop** tab → **Claims**.
2. On the **Claims** screen in the filter drop-down list choose either of the following filters:

- All opened related
 - New related (this week)
3. View all claims on which you are a related user.

If you own an exposure, this filter lists you as a related user on the claim.

To view all exposures on which you are a related user:

1. Navigate to Desktop tab → Exposures.
2. On the Exposures screen in the filter drop-down list choose either of the following filters:
 - All opened related
 - New related (this week)
3. View all exposures on which you are a related user.

Both these filters return claims or exposures owned by the user, but not claims and exposures for activities or matters owned by the user.

Viewing All Your Assignments

You can view all claims on which you are assigned work by navigating to Desktop tab → Exposures. Then in the filter drop-down list choose All open owned or New opened (this week).

Additionally, the Desktop tab → Activities screen also shows all your activities.

There is no screen that shows all matters that you have been assigned. However, you can view all matters related to a claim.

To view all matters related to a specific claim

1. Open a claim.
2. Click Litigation in the sidebar menu.
3. All matters assigned to anyone for that claim are listed in the Matters screen.

Understanding Assignment Queues

ClaimCenter creates, maintains, and displays queues of activities for each group.

In the Assignment rules visible in Guidewire Studio, a call to `activity.assignActivityToQueue` assigns the current activity to the current group. It also generates the necessary queue if it does not already exist.

Only activities can be assigned to a queue. Claims, exposures, and matters cannot be assigned to a queue. However, there is a way to use queues to indirectly assign claims, exposures, and matters.

Using a Queue to Assign Claims

Although only activities can be assigned to queues, they can be used to indirectly assign claims, exposures, or matters. The following example describes how to use a queue to assign first notice of loss (FNOL) claims. After importing an FNOL, ClaimCenter triggers the rule sets in the following table. These rule sets generate review

activities and put them in a queue. A group member then takes an activity from the queue and completes it by manually assigning the FNOL to a final user and group. The following table summarizes these tasks:

This task is performed by a rule	Rule set	Rule performs this action
Assign FNOL claim to an intake group.	Global Claim Assignment Rules	Select the current group that makes the final claim assignment.
Assign claim to the group supervisor.	Default Group Claim Assignment Rules	Assign the claim to a temporary owner until it can be properly assigned.
Create FNOL review activity.	Claim Workplan	Use a pre-defined activity pattern to make a new activity.
Assign FNOL review activity to same group.	Global Activity Assignment Rules	Both the claim and the activity have the same current group.
Assign FNOL review activity to queue.	Default Group Activity Assignment Rules	A current group's user takes the activity from the queue and manually assigns the claim to another group and user.

Using the Pending Assignment Queue

After assignment selects a group, the `confirmManually` method puts an activity for manually assigning the work in that group supervisor's **Pending Assignment** queue. By completing this activity, the supervisor assigns the related work. For example:

```
activity.CurrentAssignment.confirmManually(activity.CurrentAssignment.AssignedGroup.Supervisor)
```

Until supervisors are comfortable with automatic assignment, rules can put most work into their pending assignment queues. The **Pending Assignment** queue is part of the **Desktop**, but visible only by administrators and supervisors.

Understanding Regions

A region is a named area that contains one or more states, postal codes, or counties. For example, you can define a Western region that includes the states California, Nevada, and Washington. You can also configure the application to use other address elements, such as Canadian provinces, to define regions.

Define as many regions as you want. The regions can overlap. State-level regions can describe the office to which a claim is sent. A postal code or county-level region might govern which person is assigned to inspect a damaged vehicle.

You can assign users and groups to cover one or more regions, and ClaimCenter can associate its business rules to provide location-based assignment. For example, a claim has a loss location of California. ClaimCenter can determine that the responsibility falls in the Western region and then assign that claim to a group that covers that region.

A group can also cover multiple regions. For example, you define one region to be Arizona and New Mexico, and another region to be all counties in Southern California. You can then assign both these regions to your Southwest Regional Office.

How Regions Compare to Security Zones

Use regions for assignment. Administrators can define the regions and assign them to groups by using Assignment by Location rules. In the base configuration, a region is a defined collection of states, ZIP codes, and counties, and one region can overlap another. A group can belong to multiple regions.

Security zones, however, are only names. They are not defined as collections of geographical areas such as states. A group can belong to just one security zone. An administrator performs add, edit, and delete operations in the **Security Zones** menu item of the **Administration** tab. See “Managing Security Zones” on page 490.

Working with Regions

You can create and edit regions, associate them with groups, and assign work to groups based on the region they are in. In the base configuration, a user with the role User Admin has the permissions required to perform these tasks.

The following graphic shows the screen you use to create a region:

The screenshot displays the 'Add Region' interface. At the top, there are 'Update' and 'Cancel' buttons. Below them is a section titled 'Region' with a 'Name' field containing 'New England' and an 'Areas Covered' field showing '38927'. Under 'Country', a dropdown menu is set to 'United States'. Under 'Type', a dropdown menu is set to 'State'. A list of state abbreviations is shown: AK, AZ, CA, CO, FL, RI, MA, and PA. The state 'PA' is highlighted with a blue background, indicating it is selected or being added to a group.

To create a region

1. Navigate to Administration tab → Users & Security → Regions → Add Region.
2. Enter a name and pick a type: state, ZIP code, or county.
3. Choose the items appropriate to the type and click **Update**.

If picking a group of items that are ZIP codes or counties, they can come from many states.

To edit a region

1. Navigate to Administration tab → Users & Security → Regions and select a region.
2. Click **Edit** and choose the type.
3. Add or remove states, ZIPs, or counties.
4. Click **Update** to save your work.

Note: You can also rename a region. However, because renaming effectively deletes the original region, Guidewire recommends avoiding renaming. Instead, create a new region with the new name.

To delete a region

- Note:** Avoid deleting regions because deleting a region can result in leaving users without a region. Instead, create and use new regions.
1. Navigate to Administration tab → Users & Security → Regions and select the check box for a region.
 2. Click **Delete**.
 3. Click **Update** to save your work.

Associating a Group or User with a Region

You assign users to a region by adding the region to a group they belong to.

To add a region to a group

1. Navigate to Administration tab → Users & Security → Groups, and then find and select a group.
2. Click the Regions card.
3. Click Edit.
4. Click Add and then search for regions.
5. Select one or more regions in the list by clicking their check boxes, and then click Select.
6. Click Update to save your work.

To remove a region from a group

1. Navigate to Administration tab → Users & Security → Groups, and then find and select a group.
2. Click Edit.
3. Click the Regions card.
4. Click the check box next to each region you want to remove from the group.
5. Click Remove.
6. Click Update to save your work.

Security: Roles, Permissions, and Access Controls

Security is critical for both general data and financial information. For example, a carrier does not want the details of a famous client's claim to appear in the tabloids. The carrier also does not want an adjuster to have sole control over claim payments made to the spouse. Therefore, ClaimCenter implements the following types of security methods:

- **Role-based security** – Defines the actions you are allowed to perform. This type of security includes defining permissions, bundling groups of related permissions into roles, and assigning these roles to users based on the ClaimCenter work they must perform. Role-based security applies to all entities. For example, if you can access one claim, you can access all claims.

Following are examples of role-based security:

- Give legal staff access to a very limited view of any claim file, mostly to matters.
- Give nursing care managers access to injury exposures, but not property exposures, on all claims.

- **Data-based security** – Defines what data you have access to. ClaimCenter can segregate the claims and other entities it provides into different subsets, or security levels, and restrict access to sensitive data by using claim access control. Data-based security can also be implemented for notes, documents, and exposures. This type of security provides you access to some categories of claims, but not to others.

Data-based security can also grant different levels of authority to users in different groups or security zones. For example, certain claim summaries might be visible to all adjusters in the same security zone. However, only the adjusters in the same office handling the claim could edit them. For more information, see “Security Zones” on page 464.

Following are examples of data-based security:

- Restrict owners of bodily injury and vehicle damage exposures to accessing only the documents, notes, and activities related to these respective exposures.
- Control access to claims filed by your employees or access to other types of sensitive claims.
- Give users access to a claim only if they have an assigned activity or exposure on that claim.
- Grant users the ability to edit a claim if they are in the same group as users who own that claim.

- Grant users the ability to view a claim if they are in the same region as the user who owns that claim.

This topic includes:

- “Role-Based Security” on page 448
- “Data-based Security and Claim Access Control” on page 451
- “Access Control for Documents and Notes” on page 456
- “Access Control for Exposures” on page 460
- “Working with Exposure Security” on page 461
- “User Login and Passwords” on page 465
- “Security Dictionary” on page 466
- “Configuration Files for Access Control Profiles” on page 467
- “Security for Contacts” on page 467

Role-Based Security

Use role-based security to define the actions a user of ClaimCenter is allowed to perform. Working with this type of security includes defining permissions, adding related permissions to roles, and assigning these roles to users based on the work they perform. Role-based security applies to all entities.

This topic includes:

- “Permissions” on page 448
- “Roles” on page 449
- “Working with Permissions and Roles” on page 449

Permissions

The fundamental units of security in ClaimCenter are permissions. With proper authority, you can create permissions. After they exist, you can group permissions into roles and assign one or more of these roles to each user.

Note: You can also bundle permissions into claim security types and use access control to restrict user access to certain claims. See “Claim Security Types” on page 452.

Permissions cover all data of the same type. For example, permission to view a claim is permission to view all claims. No claim can be excluded from this permission.

Permissions are always in force. You can never override or ignore them. However, it is possible to override use of access control, as described in “Turning Off Access Control” on page 451.

There are two subcategories of permissions. These permissions can either affect which screens of the user interface you can access or restrict the entities you can view or manipulate:

- **Screen permissions** – Control access to a particular screen. With proper permission, an administrator can create new screen permissions, collect them into groups by using roles, and assign the roles to users.
- **Domain permissions** – Relate to a specific ClaimCenter entity, like a claim or a bulk invoice. The most important entities have domain permissions associated with them. Only ClaimCenter can define these permission. An administrator can add these permission to roles and then grant these roles to users.

Narrowly Defined Permissions

Typically, individual permissions restrict access in very narrow and specific ways. For example, over two dozen permissions relate to viewing and editing claims. A similar number affect exposures, such as viewing claim contacts or editing loss details.

Some permissions can be even more narrowly defined. For example, the permission to edit claim storage information, **StorageUpdate**, restricts access to a screen that is part of the **Loss Details** screen. The screen contains information that tracks paper documents associated with the claim. People who store boxes of files need permission to edit this page so they can record where the paper files have moved. But they are not adjusters. Therefore, they cannot have the broader permissions required to edit loss details, which govern access to the entire loss details screen, including the page they need permission to edit.

Roles

A role is a collection of permissions. By grouping permissions into roles, a user's authority can be precisely defined by a few assigned roles, rather than by a much larger list of permissions. A user must have at least one role and can have any number of additional roles.

Working with Permissions and Roles

You use Guidewire Studio to add or remove permissions themselves. To create roles, add permissions to roles, remove permissions from roles, modify roles, and assign roles to users, you use ClaimCenter administration screens.

Note: You must be logged in as an administrator to be able to access the **Administration** tab. Additionally, you must have a role with the **Manage Roles** and **View Roles** permissions to be able to view and edit the **Roles** screen.

Creating Permissions and Adding Them to User Roles

To create a new permission and apply it to a screen

1. Start Guidewire Studio.

At a command prompt, navigate to `ClaimCenter/bin` and enter `gwcc studio`.

2. Press **CTRL+SHIFT+N** and enter `SystemPermissionType`, and then double-click `SystemPermissionType.ttx` in the search results.

3. Add the permission name and typecode to the `SystemPermissionType.ttx` file in the editor.

4. Add code to the PCF file that looks for the new permission before displaying the screen.

For example, you can set the `editable` attribute of the file or of a widget in the file to a permission typecode. Adding a permission typecode is the same as testing if the permission is `true`—if the current user has that permission—before allowing the user to edit in the screen. For example:

```
editable="perm.System.editSensSIUdetails"
```

5. Restart the ClaimCenter server to pick up these changes.

6. Optionally regenerate the *Security Dictionary* as well.

Note: You can delete permissions by removing them from the same typelist. However, if you do so, you must also remove all references to them in every PCF file in the application. The *Security Dictionary* helps in locating these references. See “Data-based Security and Claim Access Control” on page 451.

See also

- “Using the PCF Editor” on page 295 in the *Configuration Guide*

To add permissions to a user role

1. Navigate to **Administration** tab → **Users & Security** → **Roles**.
2. Click a role, and then click **Edit**.

3. Click **Add** above the list of roles.
4. Click the **Permission** field for the new permission and choose a permission from the drop-down list.
5. To add more permissions, click **Add** for each one and select it from the drop-down list.
6. Click **Update** to finish.

To remove permissions from an existing user role

Note: Deleting permissions from an existing role is not a good idea. Users who need the deleted permissions are adversely affected. Instead, create a new role without that permission and assign the new role to users.

1. Navigate to **Administration tab** → **Users & Security** → **Roles**.
2. Click a role.
3. Click **Edit**.
4. Select the check boxes next to the permissions you want to remove, and then click **Remove**.
5. Click **Update**.

[Creating, Adding, and Removing Roles](#)

To create a new user role

1. Navigate to **Administration tab** → **Users & Security** → **Roles** → **Add Role**.
2. Enter a name and description.
3. Add permissions as described in “To add permissions to a user role” on page 449.
4. Optionally click the **Users** card and add users to the role, as described in the next topic.
5. When finished adding permissions, click **Update**.

To assign a role to one or more users

1. Navigate to **Administration tab** → **Users & Security** → **Roles**.
2. Click a role.
3. Click **Edit**.
4. Click the **Users** card.
5. Click **Add**.
6. Search for users you want to add.
7. Select check boxes next to the users you want to add, and then click **Select**.
8. Click **Update**.

To remove a role

Note: Removing a role is not recommended, because you can cause users to lose permissions they need to perform their jobs.

1. Navigate to **Administration tab** → **Users & Security** → **Roles**.
2. Select the check box for each role you want to delete.
3. Click **Delete**, then confirm the delete.

Applying Permissions to Search Results

Normally, you never see either an entity's name or details if you lack the view permission for that type of entity. But, if you search for that entity, the search results can include entities that you cannot view. You then know that they exist. You can set two configuration parameters in the `config.xml` file that, by default, prevent this behavior.

- `RestrictSearchesToPermittedItems` – If `true`, the default value, search results include only the items for which you have view permission.
- `RestrictContactPotentialMatchToPermittedItems` – If `true`, the default value, searching or using auto-complete for a `Contact` entity restricts search results to items that you have permission to view.

Data-based Security and Claim Access Control

Role-based security provides users of ClaimCenter access to all claims and can be used to restrict access to specific screens in ClaimCenter. See “Role-Based Security” on page 448.

ClaimCenter provides a second security mechanism, *Access Control*, to restrict access to defined subsets of claims and to a lesser degree, subsets of exposures and documents.

Note: *Access Control* is also known as *Access Control Lists* (ACLs).

See also

- “Exposure Level Security” on page 460
- “Access Control for Documents and Notes” on page 456

How Access Control Works

A user creating or editing a claim decides whether to restrict access to the claim by applying a special category of a restricted claim security type to the claim. There can be several to choose from. The claim owner can later put the claim in another subset, the unrestricted subset. See “Claim Security Types” on page 452.

Users trusted to have access to a restricted claim have either special permissions or a role that contains these permissions. See “`ClaimOwnPermission` and `SubObjectOwnPermission` Elements” on page 455.

An access profile is defined for each restricted claim type. The access profile grants users with the special permissions in the profile the ability to:

- Become a restricted claim or exposure owner.
- Have a special user role on the claim or exposure.

The access profile grants an access level to these users in addition to their groups and security zones. Typically, an access profile grants only two kinds of access, view and edit, unless more levels have been defined.

See “Claim Access Levels” on page 453 and “Access Profiles” on page 453.

Configuration Parameters That Affect Access Control

The following configuration parameters in the `config.xml` file control the overall behavior of access control.

Turning Off Access Control

The `UseACLPermissions` system parameter must be `true` for claim access control to be functional. The default value is `true`. Document and Exposure access control cannot be disabled with this parameter. Even if you turn access control off, its related system permissions still apply. If access control is in use, a user's effective permissions on a claim are the intersection of their role permissions and access control permissions.

Even if access control is on in ClaimCenter, it can still be turned off for users with specific user roles. See “[ClaimAccessLevels Element](#)” on page 455.

Access Control and Searches That Find Restricted Claims

The `RestrictSearchesToPermittedItems` system parameter in `config.xml` determines the items a user can view in search results. If this parameter is set to `false`, search results can include claims that the user cannot view or edit.

Inheriting Access Control Permissions

ClaimCenter supports *downline access* for supervisors, which gives supervisors the same access as any user, group, or security zone that they administer. In other words, if a user has access to a claim, the user’s supervisor also has access. The supervisor must also have a role that grants the proper claim permissions as well.

Normally, a user’s supervisor inherits all access control permissions from all those supervised. But if the system parameter `EnableDownLinePermissions` in `config.xml` is set to `false`, supervisors must be explicitly added to access control.

Note: Access controls for documents and exposures do not have similar configuration parameters. They cannot be turned off, cannot restrict search results, and do not support downline inheritance. They can be deleted.

Elements of Access Control

This topic describes the components of claim access control. It covers:

- [“Claim Security Types” on page 452](#) – Claim subsets, like fraudulent, sensitive or litigated, to be affected by access control.
- [“Claim Access Types” on page 453](#) – Groupings of permissions like roles. They define what access means, typically View or Edit.
- [“Claim Access Levels” on page 453](#) – How access control affects claim owners, users with specific user roles, and their groups and security zone.
- [“Access Profiles” on page 453](#) – Using the previous concepts, how to restrict claim access by using access control.

Claim Security Types

Claim security types are subsets of claims that can be given extra security restrictions by access control. You can create these subsets in the `ClaimSecurityType.ttx` typelist. A claim can belong to only one of these security types. These subsets appear in the **Special Claim Permission** drop-down list of the claim **Claim Status** screen. With a claim open, navigate to **Summary → Status** to see this screen. After clicking **Edit**, you can assign a claim one of these claim security types.

Claims not assigned any of these types are given the type `UnsecuredClaim`. Each claim security type has a matching access profile. ClaimCenter provides these claim security types:

- **Employee Claim**– A claim covering one of your coworkers.
- **Fraud Risk**
- **Sensitive** – A claim you would like to keep out of the public eye.
- **Under Litigation**
- **UnsecuredClaim** – None of the previous types. Used if none of the previous types have been assigned.

Claim Access Types

A *claim access type* is a collection of system permissions, similar to a role, that access control grants to users, groups, and security zones. Defined in the typelist `ClaimAccessType.ttx`, they are another way of grouping claim-specific system permissions, and then granting groups of permissions.

ClaimCenter defines the following claim access types:

- **Edit** – Cannot view, but can change and operate on claims by closing them or making payments on them.
- **View** – Can search for and see all claim information, including its exposures, activities, and financial data.

To create more claim access types, and group permissions into them, see:

- “Creating a New Claim Access Type” on page 454
- “Mapping Permissions to a Claim Access Type” on page 454

Claim Access Levels

The following access levels can be defined as required for getting on access control for a claim. They have slightly different meanings, depending on usage. See “ClaimAccessLevels Element” on page 455. In general, they define the relationship one must have with the claim’s owner:

Level	Access permission
user	User with a specific user role defined in the access profile.
group	Users who belong to the same group as the user with that role.
securityZone	Users who belong to the same security zone as the user with that role.
anyone	All users.

Access Profiles

Access profiles define whether a user, group, or security zone joins access control for a claim of a particular claim security type. They also define what access types users, groups, or security zones have for that claim. Each claim security type has one access profile. Access profiles also define what access types are permitted for the claim’s exposures and activities.

An access profile specifies:

- Special permissions, if any, that a user must have to have access to that claim security type. See “ClaimOwnPermission and SubObjectOwnPermission Elements” on page 455.
- Access types to grant to all allowed users.
- Access types to grant to allowed users with specific user roles.
- Access types to grant to groups and security zones to which the user belongs.
- Access types to grant for claim-related exposures and activities.

See “Creating or Editing an Access Profile” on page 454 for an example of an Access Profile and how it uses these special permissions and grants Access Types.

Working with Access Control

Creating a New Claim Security Type

Open Guidewire Studio and add a new typecode to the `ClaimSecurityType.ttx` typelist to create a new claim security type.

Adding Access Control to a Claim

After creating a claim, navigate to **Summary** → **Status** and click **Edit** on the **Claim Status** screen. Then click the **Special Claim Permission** drop-down list and select the claim security type: **Employee claim**, **Fraud risk**, **Under litigation**, **Sensitive**, or **UnsecuredClaim**. If you do not select any of these types or you select **<none>**, the claim is assigned the **UnsecuredClaim** claim security type. The claim owner can later change this assignment.

Note: If you select a security type for which you do not have access permission, after you exit the claim, you are unable to subsequently access that claim.

Creating a New Claim Access Type

In the base configuration, **View** and **Edit** are the only claim access types available with ClaimCenter. You can define others. Claim access types are typecodes of the **ClaimAccessType.ttx** typelist, which you can access in Guidewire Studio. You can make as many claim access types as there are claim-related system permissions, just as you can create many roles. However, large numbers of claim access types can degrade performance.

Although the **View** and **Edit** claim access types grant broad permissions, access control restricts them to few users.

Mapping Permissions to a Claim Access Type

You can open Guidewire Studio and map permissions to claim access types. Every claim-related system permission can be added to a single claim access type. You can similarly map any new claim-related permissions you create. The **security-config.xml** file holds these mappings. The following are examples:

```
...
<AccessMapping claimAccessType="view" systemPermission="claimview"/>
<AccessMapping claimAccessType="view" systemPermission="plcyview"/>
<AccessMapping claimAccessType="view" systemPermission="claimviewres"/>
...
```

In mapping, be sure to:

- Map only permissions that are related to claims. For example, mapping **ruleadmin** to **View** or **Edit** creates a configuration error.
- Map each system permission to only one claim access type. For example, mapping **paycreate** to **View** is allowed unless it is already mapped to **Edit**, which is the more likely mapping.

Creating or Editing an Access Profile

Access profiles are located in **security-config.xml**. Following is the access profile for the **employeeclaim** security type:

```
<AccessProfile securitylevel="employeeclaim">
  <ClaimOwnPermission permission="ownsensclaim"/>
  <SubObjectOwnPermission permission="ownsensclaimsuB"/>
  <ClaimAccessLevels>
    <AccessLevel level="group" permission="view"/>
    <AccessLevel level="group" permission="edit"/>
    <DraftClaimAccessLevel level="group"/>
  </ClaimAccessLevels>
  <ActivityAccessLevels>
    <AccessLevel level="user" permission="view"/>
    <AccessLevel level="user" permission="edit"/>
  </ActivityAccessLevels>
  <ExposureAccessLevels>
    <AccessLevel level="user" permission="view"/>
    <AccessLevel level="user" permission="edit"/>
  </ExposureAccessLevels>
</AccessProfile>
```

This example specifies the access to all claims that have the **employeeclaim** claim security type. The elements perform the following actions:

ClaimOwnPermission and SubObjectOwnPermission Elements

If an access profile defines the `ClaimOwnPermission` or the `SubObjectOwnPermission` element, you must give the user the Trusted For Sensitive Claims role. This role contains these two permissions. Otherwise, access control restricts that user from the claim:

```
<ClaimOwnPermission permission="ownsensclaim" />
<SubObjectOwnPermission permission="ownsensclaimsu" />
```

You can also create your own permissions (for example, `ownEmployeeClaim`), grant them to trusted users, and add similar lines to the appropriate access profile to restrict access to those users.

ClaimAccessLevels Element

The `ClaimAccessLevels` element must contain at least one of the defined subelements. The previous example shows the default subelements.

- `AccessLevel` – Restricts and defines access to those users with a specific relationship to the claim owner, in the same group or security zone, or even any user, anyone.

```
<AccessLevel level="group" permission="view" /> <!-- anyone in the user's group can view -->
```

Level	Access permission
user	All users who own the claim, one of its exposures, or claim activities.
group	All users who belong to the group to which the claim, exposure, or activity is assigned.
securityZone	All users who belong to the security zone of the group owning the claim, exposure, or activity.
anyone	All users.

- `DraftClaimAccessLevel` – Same as `AccessLevel`, but applies only after a claim is in draft status.
- `ClaimUserAccessLevel` – This subelement grants access to users with a specific user role, or related to another user with such a user role level as defined in the next table. User roles, defined in the `UserRole.ttx` typelist, are assigned by the claim owner while adding another user to the **Parties Involved → Users** screen of a claim. For example, the user handling subrogation for the claim can be assigned the Subrogation Owner user role, which for an Unsecured Claim is defined as follows:

```
<ClaimUserAccessLevel role="subrogationowner" level="user" permission="view"/>
<ClaimUserAccessLevel role="subrogationowner" level="user" permission="edit"/>
```

Level	Access permission
user	All users with this user role.
group	All users in the same group as any user with this user role.
securityZone	All users in the same security zone as any user with this user role.
anyone	All users.

IMPORTANT Be careful after adding a `ClaimUserAccessLevel` element, a user role, to an access profile. Later assignment of this user role to one user can grant access to large groups and security zones.

ExposureAccessLevels and ActivityAccessLevels Elements

The `ExposureAccessLevels` and `ActivityAccessLevels` elements grant claim access to users owning a claim exposure or activity. The previous access profile example shows how this access is granted. It also grants View access to those in the same group as an exposure owner, but not to members of an activity owner's group. See “Access Control for Exposures” on page 460 and “Access Control for Documents and Notes” on page 456 for more details.

Applying Access Control Retroactively

To force access control to apply to an existing claim, assign it to the security access type you want and save it. If you have changed a claim's access profile, assign the claim to another access type, save it, and then restore its original access type and re-save it.

Joining Access Control

You join access control at the user access level after you have the special permissions required by the access profile and:

- You are assigned to the claim or one of its exposures or activities.
- The claim's access profile grants access to a specific user role, as defined in the `UserRole` typelist, and your administrator has granted you that role.

You join access control at the group or security zone access level after you have the special permissions required by the access profile and:

- You are related to—in the same group or security zone as—a user assigned to the claim or one of its exposures or activities.
- You are related to—in the same group or security zone as—a user with a user role on the claim allowed by its access profile.

Although ClaimCenter defines an access level of All, no access profile permits access at this level, even for the `UnsecuredClaim` claim security type.

Rebuilding Access Control Lists

After you have access to an entity through an ACL, that access is permanent. But if you join another group or region, it might not be appropriate to retain that access. The only way to remove access is to redo, or rebuild, the ACL that allows access. Removing access can be a manual operation as covered in previous descriptions of creating ACLs. Finding and editing the correct ACL can be time-consuming and can introduce errors. Another possibility is to use the `rebuildClaimACL` method to write rules that can remove reassigned users.

Access Control for Documents and Notes

Besides the standard document and note-related system permissions, you can control access to a claim's documents and notes by configuring access permissions for both entities. To do so, a document or note must have its security type set. To see documents of a particular type, you must have both permission to view documents or notes in general and access to the document or note security type. A document access profile, analogous to a claim access profile, grants this access.

Note and document access control requires:

- **Document Security Types or Note Security Types** – Document subsets, like `unrestricted` or `sensitive`, to be affected by access control are analogous to claim access types. These security types are defined in the `DocumentSecurityType.ttx` typelist. They appear in the **Security Type** drop-down list of the **Documents** and **New Document** screens of a claim. You can assign a document at most one of these security types. Similarly, the `NoteSecurityType.ttx` typelist containing `medical`, `private`, `public`, and `sensitive` type-codes defines the types of note security available.
- **System Permissions** – Users must be assigned roles containing permissions to access documents and notes in general. They must also have special permissions that match those required by the access profile of the document's or note's security type. Different permissions affect notes and documents.
- **Document and Note Access Profiles** – Using the previous two concepts, these profiles relate permissions and security types to restrict access to a subtype of documents.

Unlike claim access control, document and note access control cannot be modified by configuration parameters. Document and note access control:

- Cannot be disabled.
- Always finds restricted documents in searches.
- Does not support downline access.

See also

- “Configuration Parameters That Affect Access Control” on page 451

Working with Access Control for Documents and Notes

The topics that follow describe how to define and use document and note access control.

Example

A carrier has three groups that access claims and attach documents to them, Adjusters, Subrogation, and Special Investigations. The subrogation documents, special investigation documents, and sensitive notes are confidential and are seen only by members of their respective groups.

For example, there is a single claim with the following six documents:

- Three documents added by the adjuster
- One document added by the Special Investigations Unit
- Two documents added by the subrogation specialist

Create your configuration so that:

- A Subrogation user viewing the claim sees five documents
- Special Investigations see four documents.
- Adjusters see only three documents.
- Further, you want a member of the Managers group to see all six documents.

The process for creating such a configuration requires you to perform the tasks described in the following topics:

- “Creating Document and Note Security Types” on page 457
- “Assigning a Document or Note to a Security Type” on page 458
- “Creating Document Access Profiles and Note Access Profiles” on page 458
- “Creating and Assigning New Permissions” on page 459

Creating Document and Note Security Types

A document type is set by using the document’s **Security Type** field in the user interface or through Gosu. In the base configuration, the `DocumentSecurityType` typelist contains the `sensitive` and `unrestricted` security types. You can add more, such as `internalonly`. Documents that are not assigned a special security type are given the `unrestricted` security type.

To add subrogation and special investigation document security types

1. Start Guidewire Studio and navigate to **configuration** → **config** → **Extensions** → **Typelist**.
2. Double-click `DocumentSecurityType.ttx` to open it in the editor.
3. Right-click an existing typecode and click **Add new** → **typecode**.

4. Enter the following values:

Name	Value
Code	subrogation
Name	Subrogation Doc
Description	Subrogation document

5. Right-click an existing typecode and click **Add new → typecode**.

6. Enter the following values:

Name	Value
Code	specialinv
Name	Special Inv Doc
Description	Special investigations document

To add a note security type

1. Start Guidewire Studio and navigate to **configuration → config → Extensions → Typelist**.
1. Double-click **NoteSecurityType.ttx** to open it in the editor.
2. Click **NoteSecurityType** to open the Typelist editor for that typelist.
3. Right-click an existing typecode and click **Add new → typecode**.
4. Enter values for the **Code**, **Name**, and **Description** columns.

Note: You must restart ClaimCenter for these changes to take effect.

Assigning a Document or Note to a Security Type

Create a new document. For example, with a claim open, navigate to **Actions → New Document → Create from a template**. In the **New Document** screen, choose the security type to assign to the document from the **Security Type** drop-down list.

Note: You cannot assign a document a security type unless you possess the permissions defined in the corresponding document access profile.

Creating Document Access Profiles and Note Access Profiles

Access to document types is controlled by adding a document access profile section—analogous to a claim access profile—to **security-config.xml**. You must open Guidewire Studio to edit this file.

You do the same for notes. You must have a document or note access profile for each document or note security type that you want to put under document access control.

Use the following syntax in the **security-config.xml** file to define document and note access profiles:

```

<DocumentPermissions>
    <DocumentAccessProfile securitylevel="type">      <!-- define for each security type -->
        <DocumentViewPermission permission="perm"/>      <!-- allow this permission to view-->
        <DocumentEditPermission permission="perm"/>      <!-- allow this permission to edit-->
        <DocumentDeletePermission permission="perm"/>     <!-- allow this permission to delete-->
    </DocumentAccessProfile>
</DocumentPermissions>

...
<NotePermissions>
    <NoteAccessProfile securitylevel="type">            <!-- define for each security type -->
        <NoteViewPermission permission="perm"/>          <!-- allow this permission to view-->
        <NoteEditPermission permission="perm"/>          <!-- allow this permission to edit-->
    </NoteAccessProfile>
</NotePermissions>

```

```
<NotetDeletePermission permission="perm"/>      <!-- allow this permission to delete-->
</NoteAccessProfile>
</NotePermissions>
```

In the previous code, *type* specifies a document or note security type, and *perm* is a system permission.

ClaimCenter provides the three document permissions `viewsensdoc`, `editsensdoc`, and `deletesensdoc` for the sensitive security level.

For notes, ClaimCenter provides four security levels, each with its own set of view, edit, and delete document permissions. For example for the sensitive security level, there are the `viewsensnote`, `editsensnote`, and `deletesensnote` permissions. There are similar sets of three permissions each for the public, private, and medical note security levels.

These permissions restrict access to documents and notes of each defined security type to users with a role that contains these permissions.

Continuing the example, the following code shows definitions for the document access profiles for subrogation and SIU document types:

```
<DocumentPermissions>
<!--
  Add to unrestricted and sensitive defs already in file
-->
<DocumentAccessProfile securitylevel="subrogation">
  <DocumentViewPermission permission="viewsubdoc" />
  <DocumentEditPermission permission="editsubdoc"/>
  <DocumentDeletePermission permission="delsubdoc"/>
</DocumentAccessProfile>
...
<DocumentAccessProfile securitylevel="specialinv">
  <DocumentViewPermission permission="viewspecinvdoc" />
  <DocumentEditPermission permission="editspecinvdoc"/>
  <DocumentDeletePermission permission="delspecinvdoc"/>
</DocumentAccessProfile>
</DocumentPermissions>
```

For notes, the XML is analogous. Because the base configuration has the sensitive note security level already defined, there is no need to add it to `security-config.xml`.

After saving the file, you must restart ClaimCenter for these changes to take effect.

Creating and Assigning New Permissions

After creating the new document access profiles in the previous topic, you must create and assign new system permissions that match the new permissions. You add the new system permissions to the `SystemPermissionType` typelist. Adding typecodes to this typelist is the normal way of creating permissions for documents and notes.

To add the new document system permissions

1. Start Guidewire Studio and navigate to `configuration` → `config` → `Extensions` → `Typelist`.
2. Double-click `SystemPermissionType.ttx` to open this typelist in the editor.
3. Right-click an existing typecode and click `Add new` → `typecode`.
4. Enter the following values:

Name	Value
code	viewsubdoc
name	View subro documents
desc	Permission to view a subro document

5. Right-click an existing typecode and click **Add new** → **typecode** each time to enter each of the following system permission settings:

code	name	desc
delsubdoc	Delete subro documents	Permission to delete a subro document
editsubdoc	Edit subro documents	Permission to edit a subro document
delspecinvdoc	Delete SIU documents	Permission to delete an SIU document
editspecinvdoc	Edit SIU documents	Permission to edit an SIU document
viewspecinvdoc	View SIU documents	Permission to view an SIU document

Note: The note system permissions `delsensnote`, `editsensnote`, and `viewsensnote` already exist in the typelist.

6. Regenerate the *Security Dictionary*, and then restart ClaimCenter for these changes to take effect. For example:

- a. At a command prompt, navigate to `ClaimCenter/bin` and enter `gwcc regen-dictionary`.
- b. After the dictionaries regenerate, enter `gwcc dev-start`.

An administrator can add these newly created permissions to roles and then assign roles to users who can access these document and note subsets. In this example, based on the previous access profile, you would log in to ClaimCenter as a user administrator. Then navigate to **Administration tab** → **Users & Security** → **Roles** to add the following permissions to the following roles:

- Add a Subrogation role and then add the three new subrogation permissions to the new role. Then add the users to this role who need these permissions.
- Add an SIU role and then add the three new special investigations permissions to the new role. Then add the users to this role who need these permissions.
- Add a Trusted Adjuster role and then add the note permissions to the new role. Then add the users to this role who need these permissions.
- Add all six permissions to the Manager role.

All subrogation users, SIU experts, trusted adjusters, and managers have been assigned these roles, so they have the correct permissions. Users in the Adjuster role have none of these permissions. To finish this example:

- Managers are now able to access all documents.
- SIU inspectors have access to their documents and those added by adjusters, and so on.

Access Control for Exposures

Some jurisdictions demand that certain kinds of claim data be protected. These requirements are typically necessary for personal injury, accident injury, and workers' compensation data. This data is almost always available at the exposure level rather than claim level. For example, many Canadian insurers must insulate auto body adjusters' information from that of personal injury adjusters. Exposure level security provides this data protection.

Exposure Level Security

Exposure access control restricts access to exposures in a claim. With this kind of access control in place, an adjuster on a claim could have access to some, but not all, exposures on a claim. Users granted access through exposure security see:

- The exposure screen.

- The existence and contents of all notes related to that exposure.
- The existence and contents of all documents tied to that exposure.
- The contents of activities related to that exposure.
- The contents of matters related to that exposure.

Exposure access control does not prevent users from viewing:

- The existence of exposures that they are not allowed to see—all exposures are listed on the claim.
- The existence of matters and activities that they are not allowed to see—the exposure lists them.
- Financial transactions related to an exposure that they are not allowed to see.

If users attempt to view an object to which they do not have access, they receive a permissions error.

The exposure-level security feature can secure variously the content, existence, and search results of various entities related to an exposure, as shown in the following table:

Entity	Hide existence	Hide contents	Hide in searches
Exposures	no	yes	no
Notes	yes	yes	yes
Documents	yes	yes	yes
Activities	no	yes	no
Financials	no	no	no
Matters	no	yes	no
History	no	no	no
All others	no	no	no

Static and Claim-based Exposure Security

You can implement either static or claim-based exposure security.

- **Static exposure security** – Gives every user with the correct system permissions access to all their associated exposure security types. The exposure access profile alone defines this association.
- **Claim-based exposure security** – Combines claim access control with exposure security. A user must have permissions both for access control of the claim and for static exposure security.

Working with Exposure Security

To implement exposure level security on a subset of all exposures, you must:

1. Create subsets of exposures. See “Creating Exposure Security Types” on page 461.
2. Assign exposures to these subsets. See “Assigning a Security Type to an Exposure” on page 462.
3. Give a new permission to trusted users. See “Creating and Assigning New Permissions” on page 459.
4. Associate this permission with the security type. See “Creating Exposure Access Profiles” on page 462.
5. If you want static access control, independent of claim access control, you are finished.
6. If you want claim-based access control, see “Implementing Claim-Based Exposure Access” on page 463.

Creating Exposure Security Types

You can create exposure security types in Guidewire Studio by adding typecodes to the `ExposureSecurityType` typelist. In the base configuration, this typelist is empty and contains no internal codes, so you have full control

in defining types. Exposures not given a security type have the default type of `null`. These types differ from claim and document security types, which have the type `unsecured` unless given a security type.

To add typecodes to the `ExposureSecurityType` typelist, open Guidewire Studio and navigate to `configuration → config → Extensions → Typelist`. Then double-click `ExposureSecurityType.ttx`. For an example of how to add security types to a typelist, see “Creating Document and Note Security Types” on page 457.

Assigning a Security Type to an Exposure

ClaimCenter does not provide screens that an administrator can use to assign security types to exposures as it does for claims. For example, see “Adding Access Control to a Claim” on page 454. However, you can modify an exposure page to show a **Security Type** drop-down list, similar to the implementation for claims or documents. See also “Assigning a Document or Note to a Security Type” on page 458.

If you have segmented exposures, you can create a preupdate rule to assign a security type to all exposures given the same segment. For example, a rule could implement the business rule, “If an exposure segment is Personal Injury, set its security type to `injury`.”

Creating and Granting New Permissions for Exposures

The following system permissions, defined in the `SystemPermissionType.ttx` typelist, control access to exposures:

- `expclose` – Permission to close an exposure.
- `expcreate` – Permission to create a new exposure.
- `expedit` – Permission to edit an exposure on a claim.
- `expeditcls` – Permission to edit a closed exposure.
- `expown` – Permission to own an exposure and to see the **Desktop** tab → **Exposures** screen.
- `expraown` – Permission to reassign your own exposures.
- `expraunown` – Permission to reassign exposures owned by others.
- `expreopen` – Permission to reopen an exposure.
- `expvalidate` – Permission to run validation rules on exposures.
- `expview` – Permission to view exposures on a claim.

To create more permissions, add them as described at “Creating and Assigning New Permissions” on page 459.

You then add these permissions to the appropriate roles or create new roles and assign the roles to users in the usual way. For example, see “Creating and Assigning New Permissions” on page 459.

You must also map these new permissions to claim access types. See “Mapping Permissions to a Claim Access Type” on page 454. These permissions also grant the user permission to view the claim containing the exposure.

Creating Exposure Access Profiles

To create exposure access profiles, create a block in `security-config.xml` called `ExposurePermission`. This block, if used, must be the last block in `security-config.xml`. For example:

```
<ExposurePermissions>
  <ExposurePermission securitylevel="secured" permission="expeditsec"/>
  <ExposurePermission permission="unsecexpedit"/>
</ExposurePermissions>
```

In this example, the user must have the `expeditsec` permission to access an exposure of the `secured` exposure security type and the content of its related notes, documents, and activities. The user must also have the `unsecexpedit` permission to access all exposures without a security type. If you omit this line, users without any special permissions can access all such exposures.

For more information, see “Creating Document Access Profiles and Note Access Profiles” on page 458.

Implementing Static Exposure Access

After you have completed the previous four tasks, you have implemented static exposure access.

Static security applies to all exposures and is solely based on the `ExposurePermissions` element in `security-config.xml`. As described in the previous example, any user with the `expeditsec` permission and the relevant system permissions can access all exposures that have the secured security type.

Implementing Claim-Based Exposure Access

To implement the static form of exposure security

1. Add a new `abexposure` exposure security type, as described at “Creating Document and Note Security Types” on page 457.
2. Add a new `abexposures` system permission, as described at “Creating and Assigning New Permissions” on page 459.
3. Create an `ExposurePermissions` element in the `security-config.xml` file that associates the security type and the system permission:

```
<ExposurePermissions>
    <ExposurePermission securitylevel="abexposure" permission="abexposures"/>
</ExposurePermissions>
```

To implement claim-based exposure security

1. Add the `abexposure` typecode to the `ClaimAccessType.ttx` typelist. Right-click an existing typecode and click **Add new** → **typecode**.
2. Enter the following values:

Name	Value
Code	abexposure
Name	Auto body
Description	Auto body exposure

See “Creating a New Claim Access Type” on page 454.

3. Create a mapping element in the `security-config.xml` file to map your new permission to your new claim access type. The code is:

```
<AccessMapping claimAccessType="abexposure" systemPermission="abexposures"/>
```

See “Mapping Permissions to a Claim Access Type” on page 454.

4. Add this new claim access type to the access profile in the `security-config.xml` file. For example:

```
<AccessProfile securitylevel="sensitiveclaim">
    ...
    <ExposureAccessLevels>
        <AccessLevel level="user" permission="abexposure"/>
    </ExposureAccessLevels>
</AccessProfile>
```

See “Creating or Editing an Access Profile” on page 454.

After this access control is in place, users that attempt to access an exposure must have both the `abexposures` permission for exposure security and access to `sensitive` claims. This access control is claim access control defined by the claim’s access profile.

Guidewire recommends that you implement claim-based access control only with custom claim access types. To implement this kind of access control, you need one custom claim access type for each exposure security type.

IMPORTANT Having many custom claim access types can put a performance load on your system. Use this security implementation with care.

Note: You cannot use the default claim access types for claim-based exposure security. For example, mapping the claim View access type to both the `abexposures` and the `expview` permissions would eliminate the distinction between all claim exposures and `abexposure` exposures.

Security Zones

Security zones provide a means of describing a section of your organization larger than a group, within which information is shared more freely than with those outside the section. For example, a carrier allows all claims to be seen, but allows edit access only to people within that claim's handling office. To implement this scenario, you can create security zones corresponding to offices so that people outside an office cannot edit another office's claims.

Claim access control is the part of ClaimCenter that uses security zones. See “Creating or Editing an Access Profile” on page 454.

Security zones are just names. They are not defined as collections of geographical areas like regions, described at “Understanding Regions” on page 444. Every claim, exposure, and activity is owned by both a user and a group. Each group belongs to a single security zone. Users are part of a security zone if they are a member of a group within that security zone. Thus, users in multiple groups can belong to more than one security zone.

You might want to create security zones that are related to something besides geography. For example, you could define workers' compensation, auto, and property as separate security zones, thus restricting information flow between them.

To create or edit security zones

1. In ClaimCenter, navigate to **Administration tab** → **Users & Security** → **Security Zones**.
2. Add or edit a security zone as follows:
 - To add a new security zone, click **Add Security Zone**.
 - To edit a security zone, click the zone name and then click **Edit**.
3. Enter data and then click **Update**.

Notes:

- Changing the name of a security zone effectively deletes the old zone and assigns the zone with the new name to all groups that had used the old name.
- If you have defined only one security zone, there is no difference between the anyone and security zone security levels of Access Profiles used by Access Control.

To change a group's security zone

1. Navigate to **Administration tab** → **Users & Security** → **Groups**.
2. Search for groups.
3. In the search results list, click a group name to open its **Profile** screen.
4. Click **Edit**.

5. Pick a zone from the **Security Zone** drop-down list and click **Update**.

Note: If permission is granted to a user on a claim that the user is related to, ClaimCenter evaluates if the user has the correct security zone. See “Related Users” on page 442.

User Login and Passwords

ClaimCenter is password protected. An administrator must give each new user a user name and password. Both are required to log in to ClaimCenter. After you are logged in, ClaimCenter has other features to control access to information.

Anyone with a valid user name and password can log in to ClaimCenter. The password does not control any aspect of what a logged-in user can see or do. Other than requiring that a password have a minimum and maximum length, ClaimCenter does not require that passwords have any specific format, or that they be changed regularly.

Users can be locked out of ClaimCenter if they enter incorrect passwords several times in a row during login. Configuration parameters specify the number of login attempts before lockout and how long the user must wait after an unsuccessful login attempt before being allowed to try again. Alternatively, ClaimCenter can be set up to require that an administrator get involved before the user is allowed to retry. For details, see “Changing Password Behavior” on page 466.

After a browser connects to ClaimCenter, a session is created for that browser connection. The session has a time-out parameter.

The following considerations apply to logging in, logins, and passwords:

- **You must always log in to ClaimCenter** – In the initial login screen, you must provide a valid user name and password, and then click **Log In** or press **Enter** before being allowed entry.
- **You can change your password** – After you are logged in, to change your password, click the **Desktop** tab. Then click **Actions** → **Preferences** to open the **Preferences** worksheet at the bottom of the screen. Enter passwords in the **Old Password**, **New Password**, and **Confirm New Password** fields, and then click **Update**. If you do not remember the old password., an administrator must reset you password for you.
- **Administrators can change a user’s password** – Log in as a user that has the User Admin role and navigate to **Administration** tab → **Users & Security** → **Users**. Then search for a user and, in the list of search results, click the user’s name. On the details screen for the user, in the **Basics** card, click **Edit**, and then enter a new password in both the **New Password** and **Confirm Password** boxes. Click **Update**. This procedure does not enable the administrator to view the original password.
- **You can lock yourself out of ClaimCenter** – If you provide several incorrect passwords or user names while attempting to log in, you will be locked out. This lockout can continue for a certain period of time or until an administrator unlocks your user name.
- **Administrators can unlock and lock users** – Log in as a user that has the User Admin role, and then navigate to **Administration** tab → **Users & Security** → **Users**. Then search for a user and, in the list of search results, click the user’s name. On the details screen for the user, with the **Basics** card selected, click **Edit**. For the **Locked** field, click **No** to unlock a user or **Yes** to lock a user. Click **Update** to save your work.
- **Administrators create passwords and user names after creating new users** – On the **Administration** tab, click **Actions** → **New User**. Enter information such as first and last name, user name, initial password, roles, and group assignments. Click **Update** to save your work.

Changing Password Behavior

The following configuration parameters in the Security section of the `config.xml` file, control login passwords. The Default column is the value of the parameter in the base configuration.

Configuration parameter	Description	Default
SessionTimeoutSecs	How long in seconds a user's session remains active since the end of its last use.	10800
MinPasswordLength	Minimum length of a user's password.	2
MaxPasswordLength	Maximum length of a user's password.	16
FailedAttemptsBeforeLockout	How many login failures are allowed before user is locked out. A setting of -1 disables this account lockout feature.	3
LoginRetryDelay	The number of milliseconds of delay before a user can retry after being locked out.	0
LockoutPeriod	How many seconds a user's account will stay locked after being locked out. A value of -1 means that the account must be manually unlocked by an administrator.	-1

Security Dictionary

The ClaimCenter *Security Dictionary* is web-based documentation that you can generate from the command line by entering the following command:

```
gwcc regen-dictionary
```

Whenever you change the ClaimCenter data model, regenerate the *Security Dictionary* to view the changes.

Use the *Security Dictionary* to view:

- **Application Permission Keys** – View them individually, or click the **Summary** link to view the grouped individual functions that you are allowed to perform on that entity if given that particular permission.
- **Pages** – Select a file to see the permissions used on that page.
- **System Permissions** – Select a permission to see any associated roles, related application permission keys, related pages, and related elements. For example, click `catmanage`, the permission to manage catastrophes, to see which roles use this permission—Catastrophe Admin and Superuser. A user with a role that has this permission can also create, delete, and edit catastrophes. Knowing which PCF files and widgets use this permission is also useful for troubleshooting purposes when configuring these files.
- **Roles** – While you can see the role information by choosing **Administration tab → Users & Security → Roles**, you can use the *Security Dictionary* to see other roles that share permissions. For example, if you click **Adjuster**, you see the list of permissions that an adjuster has. If you select a permission such as `sendemail`, the permission to send email, you also see the roles that share that permission. For `sendemail`, you see the additional roles claims supervisor, clerical, customer service representative, manager, new loss processing supervisor, reinsurance manager, and supersuer.

See also

- To learn more about the `regen-dictioanry` command, see “Regenerating the Data Dictionary and Security Dictionary” on page 30 in the *Configuration Guide*
- To learn how to export the *Security Dictionary* from the **Administration** tab, see “Exporting the Security Dictionary” on page 489

Configuration Files for Access Control Profiles

These files affect claims:	Affects
config.xml	See “Configuration Parameters That Affect Access Control” on page 451.
security-config.xml	Defines access profiles and the mapping of system permissions to claim access types.
ClaimAccessType.ttx	Type of access that access control provides to a claim - view or edit. Can be extended.
ClaimSecurityType.ttx	Subsets of claims - sensitive, employee, litigated, fraud, or other - typelist. Can be extended.
The following file affects exposures:	
ExposureSecurityType.ttx	This typelist is similar to ClaimSecurityType.ttx.

Security for Contacts

You might need more granular control over who gets to view, edit, create, and delete contacts, rather than using the simple view and edit permissions. For example, you might have specific contact managers that manage certain subtypes of contacts and, therefore, want the system to enforce permissions at the contact subtype level. Enforcing permissions at this level is especially important for the Service Provider Management feature, where the list of contact subtypes, service providers, is an integral part. Only specific contact managers can manage the lists of these contact subtypes.

For information on security for contacts, see “Securing Access to Contact Information” on page 109 in the *Contact Management Guide*.

Administering ClaimCenter

This topic describes how to perform administrative tasks in Guidewire ClaimCenter.

This topic includes:

- “Personal Administration Settings and Views” on page 470
- “Administration Tab” on page 470
- “Managing Accounts” on page 472
- “Managing Users and Groups” on page 472
- “Managing Activity Patterns” on page 474
- “Managing Attributes” on page 474
- “Managing Catastrophes” on page 475
- “Managing Authority Limit Profiles” on page 476
- “Managing Roles” on page 479
- “Managing Regions” on page 479
- “Managing Holidays” on page 481
- “Managing Messages Queues” on page 481
- “Managing Script Parameters” on page 483
- “Managing Workflows” on page 484
- “Managing Importing and Exporting Data” on page 484
- “Managing Security Zones” on page 490
- “Creating and Managing Reference Tables” on page 491
- “Managing Coverage Verification” on page 492
- “Managing WC Parameters” on page 492
- “Managing Reinsurance Thresholds” on page 498
- “Managing ICD Codes” on page 499
- “Managing Metrics and Thresholds” on page 500
- “Managing Business Weeks” on page 504

Personal Administration Settings and Views

There are a number of personal administration actions any user can perform, such as viewing statistics, changing preferences, and changing vacation status.

Click the **Action** button on the **Desktop** tab to perform the following tasks:

- “Statistics” on page 470

Statistics

Select **Statistics** to see an overview of how many claims and activities you have. The number of claims reflects all claims, including those that are incidents only. If you are a supervisor, this screen also shows statistics for your team.

Preferences

Select **Preferences** to change your password or your **Startup View**, the first set of screens, tabs, and menus you see after you log into ClaimCenter. You can also set your default country, your default phone region, and how many entries you see in your recent claims list when you click the **Claim** tab.

- **Password** – Reset your password. See “User Login and Passwords” on page 465.
- **Startup View** – You can change the default screen to open the New Claim wizard or show a list of your current claims or exposures, or a claim search screen. If you are an administrator, you have other options, such as showing the **Team** screens or starting on the **Administration** tab.
- **Regional Formats** – Set the regional formats that ClaimCenter uses to enter and display dates, times, numbers, monetary amounts, and names.
- **Default Country** – Determines the settings for names and addresses.
- **Default Phone Region** – Determines how phone number entries are handled, especially the country code setting.
- **Entries in recent claims list** – Determines how many claims are listed when you click the **Claim** tab.

See also

- “Setting Preferences” on page 52
- “Selecting International Settings in ClaimCenter” on page 53
- “Understanding Global Addresses” on page 104 in the *Globalization Guide*

Vacation Status

Change your vacation status from **At Work** to **On Vacation** or **On Vacation (Inactive)**. You can also specify a backup to accept new work assigned to you. If you are an administrator or supervisor, you can also see and edit group load and vacation details. See “Vacation Status” on page 265.

Administration Tab

If you are logged in as a user with administrator privileges, you can use the **Administration** tab to view and maintain many business elements that define how ClaimCenter is used. You can define your organization’s group structure and manage the users that belong to those groups. You can also specify permissions and roles, such as adjuster, manager, supervisor, and so on, for your users to control who is allowed to perform certain ClaimCenter actions.

Groups and users in ClaimCenter primarily correspond to adjusters who process claims and use the system. Supervisors manage groups. They can view their team members’ work status and quickly identify problems.

Anyone with administrative privileges can view basic group and user information, set permissions for workload management, and define assignment rules.

In the **Administration** tab, clicking menu links in the sidebar menu on the left takes you to screens for managing the following areas:

Menu choice	Administrative task
Users & Security	Groups menu links for Users , Groups , Roles , Regions , Security Zones , Authority Limit Profile , and Attributes .
Users	Search for users and manage them. See “Managing Users and Groups” on page 472.
Groups	Manage groups. See “Managing Users and Groups” on page 472.
Roles	Add permissions to and delete permissions from roles, and add roles to or remove roles from users. See “Managing Roles” on page 479.
Regions	Define and edit regions. See “Managing Regions” on page 479.
Security Zones	Edit the coverage verification reference tables. See “Coverage Verification Reference Tables” on page 491. See also “Managing Security Zones” on page 490.
Authority Limit Profile	Add or edit authority limit profiles to a role. See “Managing Authority Limit Profiles” on page 476.
Attributes	Define user attributes that can help in assigning work. See “Managing Attributes” on page 474.
Special Handling	Groups menu links for Accounts and Service Tiers .
Accounts	Manage accounts for people or organizations that have policies with your company. See “Managing Accounts” on page 472.
Service Tiers	Manage service tiers for people or organizations that have policies with your company. A <i>service tier</i> represents a level of customer service associated with a claim and categorizes policies by their level of importance. See “Service Tiers” on page 112.
Business Settings	Groups menu links for Activity Patterns , Business Week , Catastrophes , Coverage Verification , Holidays , ICD Codes , Metrics & Thresholds , Reinsurance Thresholds , and WC Parameters .
Activity Patterns	Edit or delete activity patterns or create new ones. See “Managing Activity Patterns” on page 474.
Business Week	Define your business week. See “Managing Business Weeks” on page 504.
Catastrophes	Add, deactivate, and edit catastrophes as well as bulk associate claims to a catastrophe. See “Managing Catastrophes” on page 475.
Coverage Verification	View information on which exposures are valid, or not valid, for the policy. Choose the menu link for the type of coverage or exposure verification you want to work with. ClaimCenter uses the policy of the claim and its coverages to verify that related exposures are valid. See “Managing Coverage Verification” on page 492.
• Invalid Coverage for Cause	
• Incompatible New Exposure	
• Possible Invalid Coverage Due to Fault Rating	
Holidays	Add holidays that can be zone specific. See “Managing Holidays” on page 481.
ICD Codes	Administer the International Statistical Classification of Diseases and Related Health Problems (ICD) medical diagnosis codes that classify diseases. See “Managing ICD Codes” on page 499.
Metrics & Thresholds	Define and manage metrics and large loss thresholds, such as claim metrics, exposure metrics, and large loss limit. See “Managing Metrics and Thresholds” on page 500.
Reinsurance Thresholds	Edit the reinsurance tables based on treaty type, policy, threshold value, reporting value, and dates. See “Managing Reinsurance Thresholds” on page 498.
WC Parameters	Edit workers’ compensation parameters to define benefit times and amounts. Choose the menu link for the screen you want to work with. See “Managing WC Parameters” on page 492.
• Benefit Parameters	
• PPD Min / Max	
• PPD Weeks	
• Denial Period	
Monitoring	Groups menu links for Message Queues , Workflows , and Workflow Statistics .

Menu choice	Administrative task
Message Queues	Control the message queues. See “Managing Messages Queues” on page 481.
Workflows	Troubleshoot workflows that are in the application. See “Managing Workflows” on page 484.
Workflow Statistics	Troubleshoot workflows that are in the application. See “Managing Workflows” on page 484.
Utilities	Groups menu links for Import Data, Export Data, and Script Parameters.
Import Data	Import and export certain types of data through the ClaimCenter interface. See “Managing Importing and Exporting Data” on page 484.
Export Data	Import and export certain types of data through the ClaimCenter interface. See “Managing Importing and Exporting Data” on page 484.
Script Parameters	Edit script parameters without restarting the application. See “Managing Script Parameters” on page 483.

Managing Accounts

An *account* represents an organization or person that has one or more policies. The settings in this screen enable you to add and edit accounts. You can set up automated notifications, automated activities, or notes to be shown to adjusters working on claims connected to the policies with these account numbers.

When you click **Administration tab** → **Special Handling** → **Accounts**, you see a list of accounts. You can:

- Click **Add Account** to add a new account to the list.
- Click an account number to see its details page and edit the existing account.
- Select the check box for an account and then click **Delete** to remove it from ClaimCenter.

You see a prompt warning you that removing an account can affect existing policies that reference the account. If you are sure that removing the account will not affect existing policies used in ClaimCenter, you can click **OK** to remove the account. Otherwise, click **Cancel**.

See also

- For general information, see “Accounts and Service Tiers” on page 109.
- For specific information on working with the account management screens, see “Working with Accounts” on page 110.
- “Administration Tab” on page 470

Managing Users and Groups

To manage existing groups or users, you must find them either in the organization tree or by searching for them.

- You can expand the organization tree, which appears in the upper left when you click the **Administration tab**, to see all groups and users in your organization. If you know the name of a user or group, you can navigate through the tree and selecting the user or group.
- You can search for a user or group. Navigate to the **Users & Security** → **Users** screen or the **Users & Security** → **Groups** screen to locate a user or group. Then you can select the user or group from the search results.

See also

- “Users, Groups, and Regions” on page 437
- “Administration Tab” on page 470

Creating New Users and Groups

Choose **New User** or **New Group** from the **Actions** link of the **Administration** tab to access screens in which you can define a user or group.

Managing Users

The **Users & Security → Users** menu link of the **Administration** tab is not just for locating users, but is also for editing the properties of users. After searching for and selecting a user and then clicking the **Edit** button, you can change the user data, including the following:

- **Name, user name, password** – Set these values on the **Basics** card.
- **Profile** – Click the **Profile** card to enter data like job title, department, address, phone numbers, email, and employee number.
- **Active** – On the **Basics** card. A status setting of **No** means that the user is inactive. An inactive user cannot be assigned work and cannot log in. The user remains inactive until an administrator changes the **Active** status to **Yes**.
- **Locked** – On the **Basics** card. A status setting of **Yes** means that the user is locked and is unable to login because of too many login attempts. A setting in the **config.xml** file determines how locked-out users are handled. Locked-out users can be allowed to log in again at a later time, or an administrator can be required to unlock them.
- **Vacation Status** – On the **Basics** card. Set a vacation status and designate a backup user to receive work assignments during vacation periods.
- **User roles** – On the **Basics** card. Add roles for a user or remove them. See “Understanding Roles” on page 439.
- **Group memberships** – On the **Basics** card. Includes characteristics, such as whether or not the user is a member or a manager, load factor, and weighted workload.
 - Setting the **Load Factor Permissions** to **Admin** for a user enables the user to both view and edit the **Load and Vacation** screen for the group. Setting this permission to **View** enables the user just to see the screen.
 - See “Load Factors” on page 441.
 - See “Weighted Workload” on page 207
- **Authority Limits** – For information on settings in this card, see “Managing Authority Limit Profiles” on page 476.
- **Attributes** – For information on settings in this card, see “Managing Attributes” on page 474.
- **Regions** – For information on settings in this card, see “Managing Regions” on page 479.
- **Details** – Show information on activities, claims, exposures, and matters that have various relationships to this user, such as **All open owned** and **All open related**.

Deleting a User

If you have the permissions to do so, you can click **Delete User** on the user screen and delete a user. However, the system checks if that user:

- Is the super user.
- Is the *default owner*, the assignee of last resort used by the assignment system.
- Supervises any groups.
- Has any items assigned, including claims, exposures, and transactions.

If any of the previous conditions are met, ClaimCenter prevents you from deleting that user by not showing the **Delete User** button. You can see some of the conditions preventing deletion in the data dictionary. The **User** entity’s virtual property **SafeToDelete** lists the conditions.

Managing Groups

The **Users & Security → Groups** menu link on the **Administration** tab opens the **Groups** screen. You can use this screen both to search for groups and to edit the properties of a group. After selecting a group and clicking **Edit**, you can change the following group settings:

- **Name and Type**
- **Parent** – The group to which this group belongs, which determines its location in the Organization tree.
- **Supervisor** – User who is the supervisor of the group.
- **Security Zone** – See “Managing Security Zones” on page 490.
- **Users** – Members of the group.
- **Load factor** – A percentage of the normal workload for the group. Assignment rules can consider this load factor in assigning work to the group. See “Load Factors” on page 441.
- **Queues** – The queues of activities for the group to which work can be assigned. Assigning an activity to a queue is an alternative to assigning the activity to individual members of a group. Activities in a queue wait for a group member to take ownership of them. See “Queues” on page 204.
- **Regions** – See “Managing Regions” on page 479.

You can also delete a group by clicking the **Delete** button. To create a new group, see “Creating New Users and Groups” on page 473.

Managing Activity Patterns

You can the **Activity Patterns** screen to manage all activity patterns in your installation. To open this screen, click the **Administration** tab and navigate to **Business Settings → Activity Patterns**. On this screen, you can:

- View all activity patterns or select a subset by category.
- Use the **Add Activity Pattern** button to add a new activity pattern.
- Select an activity pattern and use the **Edit** button to modify it.

Note: If you have multiple languages defined for your installation, when you click **Edit**, you can edit the **Subject** of the activity for each language. Use the table at the bottom of the screen.

IMPORTANT Guidewire recommends that you not delete an activity pattern because it might be used in more than one area. See “Understanding Activity Patterns” on page 225 for details of how activity patterns work and what their fields do.

See also

- “Administration Tab” on page 470

Managing Attributes

ClaimCenter provides a general way to describe any user attributes that you need to use in assigning work. ClaimCenter also has rules that assign work based on these attributes, such as selecting a user with a specified attribute by round-robin. To manage user attributes, navigate to **Administration tab → Users & Security → Attributes**.

Use the **Add Attribute** button to create a new attribute by specifying its **Name**, **Type**, and **Description**. You can also delete an existing attribute by selecting it and clicking **Delete**.

Attributes are grouped by **Type**, defined in the **UserAttributeType** typelist, which you can access from ClaimCenter Studio. In the base configuration, this typelist contains **Default**, **Expertise**, **Language**, and **Named account**.

types. This typelist can be extended. The **type** is a way to group custom user attributes. For example, you can give the French attribute the type **Language**.

See also

- “Custom User Attributes” on page 439
- “Administration Tab” on page 470

Managing Catastrophes

A *catastrophe* is a single incident or series of closely related incidents that cause a significant number of losses. The system provides a way to associate a claim with a CAT number. ClaimCenter maintains a list of catastrophes that affect the carrier’s business. ClaimCenter can associate one catastrophe from this list with a claim. After creating a new claim, the New Claim wizard displays a list of active catastrophes, and you can associate the claim with one of them.

When you navigate to **Administration tab → Business Settings → Catastrophes**, you can do the following:

- Add a catastrophe.
- Activate catastrophes.
- Deactivate catastrophes.
- Select a catastrophe and find claims to associate with it.

To add a new catastrophe

1. Navigate to **Administration tab → Business Settings → Catastrophes** and click **Add Catastrophe**.
2. Enter the required fields such as name, description, CAT number, type, dates covered and click **Update**.
The status of the catastrophe is active.

To activate or deactivate a catastrophe

Navigate to **Administration tab → Business Settings → Catastrophes** to see the list of catastrophes. Check the check box for a catastrophe and click either **Activate** or **Deactivate**. If you deactivate a catastrophe, you cannot see it in the user interface and you cannot associate a claim with it.

To associate a catastrophe with a claim

If you create a new catastrophe, you can find claims to associate with it.

1. Click the name of the catastrophe to open the **Catastrophe Details** screen.
2. Click **Find Unmatched Claims**.

The list of unmatched claims is built by using only active catastrophes. ClaimCenter runs a batch process that performs a search to find all claims with the following criteria:

- Claim loss date is within the catastrophe's effective dates.
- Claim loss location matches one of the catastrophe's affected zones.
- Claim loss cause is one of the catastrophe's coverage perils.
- The claim does not already have an activity on it for potential catastrophe match.
- **Claim.Catastrophe** is **null**.

The system shows the number of matching claims and creates an activity on the found claims.

Note: The count includes all claims that have a **Review for Catastrophe** activity open.

3. After the batch process runs, you must find the claim and navigate to its **Loss Details** screen. Generally, the quickest way is to click **Desktop** tab → **Activities** and set the filter on the **Activities** screen to **All open**. The activity subject is **Review for Catastrophe**.

4. If you select the claim number, you can navigate to the editable **Loss Details** screen to link the claim to the catastrophe.

This process results in running the batch process one time. You can also schedule the batch process to run periodically to find claims that match but have not yet been associated with active catastrophes.

See also

- “Catastrophes and Disasters” on page 155 to learn about catastrophes.
- “Administration Tab” on page 470

Managing Authority Limit Profiles

Authority limits are used in ClaimCenter to determine if a financial transaction can be automatically approved when it is created, or if it requires further manual approval by a supervisor. An Authority Limit Profile is a named collection of authority limits. Together, these authority limits determine the type of transactions a user can create and whether those new transactions require approval. The authority limits to which a user is subject are defined by the user’s assigned Authority Limit Profile. A user assigned the Custom profile has a customized set of authority limits.

You manage authority limit profiles by navigating to **Administration** tab → **Users & Security** → **Authority Limit Profile**.

See also

- “Working with Authority Limit Profiles” on page 478
- “Administration Tab” on page 470

Authority Limits

An authority limit is composed of an authority limit type and a limit amount. If no limit is specified for a particular authority limit type, typically the user cannot create transactions of the given type. If a user performs an action that exceeds the user’s limit, the action requires approval by a user with higher limits who is selected by the approval routing rules.

The **AuthorityLimitType** typelist, accessed from ClaimCenter Studio, contains the following types of limits. You cannot add others.

Authority Limit Name	Description
Claim available reserves	The available reserves for all exposures on a claim
Claim payments to date	The total amount of payments to date for the claim. Use this authority limit type to enforce total payments. If your authority limit profile does not have this limit type, you see an error message when trying to create a check. The system alerts you with the following message: “You do not have the authority to create this payment.”
Claim total reserves	The total reserves for all exposures on a claim. If the user’s authority limit profile does not have this limit type, the user will not see the menu option to create reserves. This authority limit type covers the sum of reserve transactions. If a claim has any supplemental payments, the Total Incurred on the financial summary screen will always be greater than the Claim Total Reserves for authority limit checking. Therefore, a user can exceed the claim total reserves limit by the amount of the sum of supplemental payments.
Exposure available reserves	The available reserves for a single exposure.
Exposure payments to date	The total amount of payments to date for a single exposure.

Authority Limit Name	Description
Exposure total reserves	The total reserves for a single exposure.
Payment amount	The amount of a single payment.
Payments exceed reserves	The amount by which payments are allowed to exceed reserves on a claim.
Reserve change size	The size of a single reserve change.

Configuration Parameters that Affect Authority Limits

The following parameters in the `config.xml` file, which you can access in ClaimCenter Studio, affect authority limits.

Parameter	Default	Description
CheckAuthorityLimits	true	This parameter determines if authority limits are checked when approving a transaction set. If set to <code>false</code> , it disables authority limit checking.
AllowPaymentsExceedReservesLimits	false	While this parameter does not affect authority limit behavior, it is related to it. The Payments Exceed Reserves authority limit makes sense only if this parameter is set to <code>true</code> . If set to <code>true</code> , you can submit payments that exceed available reserves up to the amount limited by the Payments Exceed Reserves authority limits. Otherwise, no partial or final payments that exceed reserves are allowed, other than first and final payments.
MulticurrencyDisplayMode	SINGLE	This parameter does not directly affect authority limit behavior. However, it must be set to <code>MULTIPLE</code> for ClaimCenter to show the currency selector. WARNING: The <code>MultiCurrencyDisplayMode</code> parameter setting is permanent. After you enable <code>MultiCurrencyDisplayMode</code> by setting the value to <code>MULTIPLE</code> , then start the server, you cannot change the value again.

Authority Limit Profiles in Another Currency

You can define an authority limit profile in a currency that is different from the base currency. Using a different currency is useful for carriers that write policies in more than one country, or in countries have different currencies. They can manage their claims for all these countries in one instance of ClaimCenter.

For example, a United Kingdom (UK) based carrier writes policies in both the UK and Ireland. The UK's currency is GBP and Ireland's currency is the Euro. The carrier wants all their claims for their British policies to be managed and tracked in GBP. The carrier also wants all of their claims for their Irish policies to be managed in the Euro. The base currency is GBP because the carrier is based in the UK. However, the carrier wants to create certain transactions in a different currency. The carrier administers authority limit profiles in different currencies for their users.

A user can be assigned only one Authority Limit Profile, which has all its limits defined in one currency. For a particular user, you would assign them an Authority Limit Profile with a currency that matches the claim currency of the claims they will typically handle. For example, an adjuster in Ireland would be assigned an Authority Limit Profile with a currency of Euro. A UK adjuster would have an Authority Limit Profile with limits defined in GBP.

No matter what the currency of the user's assigned Authority Limit Profile is, the user can still administer claims of any currency. If the currency of the user's profile does not match that of the claim for which the user is

creating transactions, the user's Authority Limit Profile currency is converted. This conversion to the claim currency happens on-the-fly using current exchange rates, and then is compared with the `ClaimAmount` value of the relevant transactions.

Working with Authority Limit Profiles

To manage complex sets of authority limits, ClaimCenter groups them into authority limit profiles, which you can assign to users. You can define additional profiles or edit the following profiles that are in the base configuration:

- Adjuster profile
- Claims Supervisor profile
- Regional Supervisor profile

To manage authority limit profiles

1. Navigate to Administration tab → Users & Security → Authority Limits Profile.
2. In this screen, you can:
 - **Create a new profile** – Click the Add Authority Limit Profile button.
 - **Delete a profile** – Select the profile's check box and then click Delete.
 - **Edit an existing profile** – Click the name of the profile to open its detail view, and then click Edit.
 - **Change a limit** – Edit a profile and then enter the limit type, coverage, cost type, and amount. All but the amount are available from drop-down lists.
 - **Create a new limit** – Edit a profile and click the Add button, and then set the values.
3. Click Update to save your changes.

Working with Authority Limits

For each of the authority limit types, you can define a limit amount that applies to the whole claim or only to transactions with a given coverage or cost type. For example, you can create different amounts for the payment amount, depending on the cost type and coverage selected. Therefore, you can design a complex set of authority limits. Also, the currency you select in the **Currency** drop-down list applies to all the limit types.

When applying authority limits, the coverage of the limit type determines what coverage type transactions the limit checks. If you leave it unspecified—`null`—the limit applies to all transactions, regardless of coverage.

To enforce limits on the claim's Total Incurred Gross financial calculation, create two limits with the same limit amount. One limit must be of type Claim Total Reserves and the other of type Claim Payments to Date.

Assigning Authority Limits to Users

You can edit a user and assign authority limit profiles. For example, navigate to Administration tab → Users & Security → Users, search for a user, and select the user in the search results. Then click Edit.

To assign authority limit profiles for the user, on the user's edit screen, click the **Authority Limits** card and select a profile from the **Authority Limit Profile** drop-down list.

You can also assign a customized profile.

To customize a profile

1. Select the profile closest to the one you want the user to have from the **Authority Limit Profile** drop-down list.
2. Select **Custom** from this same drop-down list. The screen contains a table of the authority limits of the **Authority Limit Profile** you first selected.

3. Modify the profile's existing limits, or add new ones, or both. Your changes affect only this user. To define generally available authority limit profiles, See "Working with Authority Limits" on page 478.

Managing Roles

Roles are named collections of system permissions that you assign to users. Both roles and permissions are listed and fully described in "Role-Based Security" on page 448.

The **Roles** screen, available at **Administration tab → Users & Security → Roles**, manages the roles themselves. You can create new roles, add or remove permissions from existing roles, and assign roles to users.

See also

- "Security: Roles, Permissions, and Access Controls" on page 447
- "Administration Tab" on page 470

Assigning Roles to Users

You can edit a user and assign roles. For example, navigate to **Administration tab → Users & Security → Users**, search for a user, and select the user in the search results. Then click **Edit**.

- **Add a role to this user** – On the **Basics** card in the **Roles** section, click **Add**. Select a new role from the drop-down list. Click **Update** to save your changes.
- **Remove a role from this user** – In the **Roles** section, select the check box next to the role you want to delete. Click **Remove** and then click **Update** to save your changes.

Changing Roles and Their Permissions

To work with roles and set the permissions assigned to each role, open the **Roles** screen. Navigate to **Administration tab → Users & Security → Roles**.

To add or delete a new role

To add a role, click **Add Role**. Give the role a name and a description. The name you choose appears in the table of roles. You can also add permissions to the role in this screen below the **Description** field. Click **Update** to add the new role to the list of roles.

To delete a role, in the **Roles** screen, select the check box next to the role you want to delete and click **Delete**.

To add or delete permissions for a role

Edit the role, either by clicking its name in the main **Roles** screen and then clicking **Edit**, or by clicking **Add Role**. You can add or delete system permissions from either screen.

Click **Add** below the **Description** field to add a line to the table of permissions. Then click in the **Permission** field and choose a permission from the drop-down list.

To delete a permission, select its check box and click **Delete**.

Click **Update** to save your changes.

Managing Regions

Regions are geographical areas that are used to define areas of responsibility for groups. Assignment rules use regions.

You define and name regions in the **Regions** screen. Navigate to **Administration tab** → **Users & Security** → **Regions** to open this screen.

You assign regions to groups when you edit a group's attributes, as described at "Managing Groups" on page 474. Regions can be defined as collections of states, counties, or ZIP codes, and can use another address element, such as postal codes, if so configured.

You can assign more than one region to a group, and more than one group can be given the same region. For example, you might want a group to be responsible for a region including both states and counties. You can create one region for the states, another region for the counties, and assign both regions to the same group.

See also

- "Understanding Regions" on page 444
- "Administration Tab" on page 470

Searching For Regions

To search for regions, navigate to **Administration tab** → **Users & Security** → **Regions** to open the **Regions** screen.

On the **Regions** screen, you can find all regions defined in your installation. You can filter the search by **Zone Type** and **Code**. You typically use this search feature when managing regions.

To list all regions, leave the **Region Name** blank, set the **Zone Type** to **All**, and click **Search**.

Creating, Editing, and Deleting Regions

To create, edit, and delete regions, navigate to **Administration tab** → **Users & Security** → **Regions** to open the **Regions** screen.

If the region you want to work with is not visible, you can use the **Search** button item to find it. For more information, see "Searching For Regions" on page 480.

To create a new region

1. Navigate to **Administration tab** → **Users & Security** → **Regions**.
2. On the **Regions** screen, click **Add Region**.
3. In the **Add Region** screen, give the region a **Name** and select its **Type**, which by default is **County**, **State**, or **Zip code**.
 - If you choose **County**, you must then choose a state. After choosing a state, you see two boxes separated by **Add-->** and **<--Remove** buttons that you use to build the set of counties.
 - If you choose **State**, two boxes separated by **Add-->** and **<--Remove** buttons. Use them to build the set of states.
 - If you choose **Zip code**, you can click **Add** and enter the value for each ZIP code you want to have in the region.
4. Click **Update** to save the new region.

To edit an existing region

1. Click the region name to open its edit screen, and then click **Edit**.
2. Proceed as in creating a region.
3. Click **Update** to save the changes to the region.

To delete a region

1. Select the check box for the region in the list.

2. Click Delete.**To assign a region to a group**

1. Select the group, either from the Organization tree or by searching for and selecting the group on the **Groups** screen.

To open the **Groups** screen so you can search, navigate to **Administration tab** → **Users & Security** → **Groups**.

2. Click the **Regions** tab to see the list of regions associated with this group.

3. Click **Edit** and then click **Add**. In the **Browse Group Regions** screen that opens, search for regions. You can filter by **Zone Type** or **Code**.

See “[Searching For Regions](#)” on page 480.

4. Select the check box next to the region or regions you want to add. Click **Select** to add your selections to the list.

5. Click **Update**.

To disassociate a region from a group

1. Select the group, either from the Organization tree or by searching for the group on the **Groups** screen.

Navigate to **Administration tab** → **Users & Security** → **Groups** to open the **Groups** screen.

2. Click **Edit**.

3. Click the **Regions** tab and select the check box for the region.

4. Click **Remove**.

Managing Holidays

You can administer holidays by navigating to **Administration tab** → **Business Settings** → **Holidays**. Holidays and weekends define the business calendar, the business days. Holidays can vary according to city, state, county, or country. In turn, ClaimCenter uses a business calendar to calculate many important dates. Given that holidays differ in different areas, ClaimCenter defines holidays associated with different regions.

Since many holiday dates change annually, it is a good practice to edit these holidays at the beginning of each new year. Information on setting holidays, weekends, and business weeks is available in the following topics.

See also

- “[Specifying Holiday Dates](#)” on page 260
- “[Working with Holidays, Weekends, and Business Weeks](#)” on page 260
- “[Administration Tab](#)” on page 470

Managing Messages Queues

This topic provides a brief overview of ClaimCenter messaging. For detailed descriptions, see:

- “[Messaging and Events](#)” on page 299 in the *Integration Guide*
- “[Monitoring and Managing Event Messages](#)” on page 64 in the *System Administration Guide*

After certain events occur, ClaimCenter can send a message to an external system to notify it of the event. Every message is related to a specific claim and has a particular external destination. Event messages could be sent to an email server, to the Metro Bureau, to a payment system, or to ContactManager to synchronize a contact. For

example, when a payment is ready to be made on a claim, ClaimCenter sends a message to your accounts payable system to have it issue a check.

After ClaimCenter sends a message, the message is said to be *pending* or *in flight* until the external system acknowledges receipt of the message. Only one message for a given claim and destination can be in flight at one time. Messages are ordered as first-in-first-out because one message can depend on reception of another message. This ordering is called *safe-ordered* messaging. Messages that relate to more than one claim are called *non-safe-ordered* messages. They can be sent at any time and can enter the FIFO queue in any position. The distinction between safe- and non-safe-ordered messages is important when you try to re-send a message that has failed because of an error.

To monitor and manage the message queues that ClaimCenter uses to send messages to these systems, navigate to **Administration tab** → **Monitoring** → **Message Queues**. You can manage re-sending failed messages and suspending, resuming, and restarting the messaging system.

See also

- “Administration Tab” on page 470

Monitoring Message Queues

To monitor message queues, navigate to **Administration tab** → **Monitoring** → **Message Queues**. The **Message Queues** screen can show several summary tables of messages:

- The summary table lists all external destinations for ClaimCenter messages and the ID and status of each message queue. It also shows the traffic statistics—the number of failed, retryable error, in flight, unsent (queued), and batched messages, and messages awaiting retry.
- You can click a destination name to open the **Destination** screen and see similar statistics for a single destination. This screen shows statistics for messages relating to each claim, as well as all non-ordered messages to that destination.
 - Use the filter to search for claims with failed messages, unfinished messages, or messages needing retry.
 - If the non-safe-ordered messages link is listed, you can click it to view the list of non-safe-ordered messages by claim. The **Non-safe-ordered messages** screen does not show any safe-ordered messages.

Suspending and Resuming Messaging

If you know that a message destination is not available, you can temporarily suspend sending messages to that destination. Messages are put in a queue during the time that their destination is suspended. You can later resume sending messages to the destination, and the queued messages are sent in the proper order. You can:

- **Suspend messaging to a specific destination** – Select the check box for the destination in the **Message Queues** screen, and then click **Suspend**. The **Status** for that destination changes to **Suspended**.
- **Resume messaging to a single destination** – Select the check box for the destination in the **Message Queues** screen, and then click **Resume**. The **Status** for that destination changes to **Started**.
- **Restart messaging to all destinations** – Click the **Restart Messaging Engine** button to resume sending messages to all destinations.
- **Skip a message** – Click the destination name for the message in the **Message Queues** screen to open the **Destination** screen. If you know that a message cannot reach its destination or is no longer relevant, you can skip it by selecting it and clicking **Skip first**. ClaimCenter stops trying to send it to the destination. Once you skip a message, you cannot retry it.
- **Skip all messages** – Click the destination name for the messages in the **Message Queues** screen to open the **Destination** screen. Choose all messages by selecting the check box in the table header and then click **Skip**.

Retrying Messages

In any message destination screen, clicking the check box to select a message from a single destination activates the **Retry** button. Click it to resend the message. To resend all retryable messages to a single destination, select them all before clicking **Retry**.

ClaimCenter distinguishes between retryable and failed messages. The **Retry** button is not available for a failed message.

Synchronizing Contacts with ContactManager

Note: This feature works only if you have integrated ContactManager with ClaimCenter. See “Integrating ContactManager with Guidewire Core Applications” on page 45 in the *Contact Management Guide*.

If you choose the **Contact Auto Sync Failure** destination and select one contact, a **Sync** button appears. Use it to copy all changes and additions made on that ClaimCenter contact to ContactManager. If you select the check box above all the new or changed ClaimCenter contacts, clicking the **Sync** button updates all contacts in ContactManager.

See also

- “Linking and Synchronizing Contacts” on page 191 in the *Contact Management Guide*

Managing Script Parameters

A *script parameter* is an application-wide global parameter that has a value that tends to change over time. For instance, script parameters can be used to set initial reserve values for auto glass damage, full body damage, or minor body damage. These initial reserve values can change from year to year.

You can modify script parameters values by navigating to **Administration tab** → **Utilities** → **Script Parameters**. You can also access this list of script parameters in Guidewire Studio by navigating in the Project window to **configuration** → **config** → **resources** and double-clicking **ScriptParameters.xml**. In the editor in Studio, you can edit and delete existing script parameters and create new ones.

See also

- “Script Parameters” on page 105 in the *Configuration Guide* for information on how to configure the list of script parameters
- “Administration Tab” on page 470

Changing a Script Parameter Value

After a script parameter has been added in Studio and the server has been restarted, you can edit its value by navigating to **Administration tab** → **Utilities** → **Script Parameters**. On the **Script Parameters** screen, you see the list of script parameters that have been added in Studio, as well as their **Value** and **Type**—`java.lang.boolean`, `java.lang.integer`, and so on.

To change a script parameter value:

1. Select the script parameter from the list.
2. Click **Edit**.
3. Change the script parameter **Value**.
4. Click **Update** to save your changes.

Managing Workflows

A workflow is a multistep process that manages a complex business practice that rules cannot define by themselves. You define a workflow in Studio and execute instances of it from buttons you add to PCF pages. Once invoked, a workflow handler executes the instance of the workflow, performs its steps, and controls its status. You can edit a workflow even when instances of it are running. Editing a workflow creates another version of the workflow with an incremented **Process Version**. New instances use the latest **Process Version**.

If you navigate to **Administration tab → Monitoring**, you can choose **Workflows** and **Workflow Statistics**.

- On the **Workflows** screen, you can search for workflows, see a list of workflow instances and their statuses, and manage them.
See the following topics that describe working with this screen:
 - “[Finding Workflows](#)” on page 484
 - “[Starting and Stopping Workflows](#)” on page 484
- On the **Workflow Statistics** screen, you can search for a workflow type and period during which its steps executed. You then see data about the workflow steps that executed during that period. See “[Viewing Workflow Statistics](#)” on page 484.

See also

- “[Using the Workflow Editor](#)” on page 387 in the *Configuration Guide*
- “[Guidewire Workflow](#)” on page 393 in the *Configuration Guide*
- “[Administration Tab](#)” on page 470

Finding Workflows

The upper part of the **Workflows** screen enables you to search either for all workflow instances, or for all instances of one **Workflow Type**, which is one workflow name. Filter your search by a version, a start date range, an update date range, a specific step it is executing, the handler type it uses, or its current status. The results reflect, for each workflow instance found, its **Workflow Type**, **Ver** (version), **Start Time**, **Update Time**, **Parent**, **Children**, **Handler**, **current Step Status**, **Active State**, **Work Item**, and **Timeout**. The last item indicates if the workflow has timed out instead of completing.

Starting and Stopping Workflows

Workflows proceed according to their internal schedules. They stop either on an error or if you suspend them in this screen. You can suspend only the instances that have **Active** status. To suspend an instance, select it and click the **Suspend** button. To restart an instance with suspended status, click **Resume**. The **Resume-All** button resumes all instances in the current list.

Viewing Workflow Statistics

Workflow statistics are collected periodically. You define the period you want to see. The statistics capture information on the workflow steps that have completed during the interval you specify. For each step that completed, the elapsed time and execution time is analyzed by extracting the min, max, mean, and std deviation. To see these statistics, navigate to the **Administration tab → Monitoring → Workflow Statistics** screen.

Managing Importing and Exporting Data

While users enter much of the administrative data directly into ClaimCenter, there are times when it is necessary or convenient to transfer this information in bulk. The **Import/Export Data** screen on the **Administration tab** provides a

convenient way of moving administrative data, question sets, role definitions, and so on as XML or zipped XML files.

You can also import or export other types of data, in either XML or CSV format, by using the API. Also, there is a command to import files in either format, but not to export them.

Method	Import? / Export?	Import / Export File Data Types	File Formats
user interface	yes / yes	admin.xml / admin.xml, questions.xml, roles.xml	XML, zipped XML
APIs	yes / yes	any / any	XML, CSV

See also

- “Administration Tab” on page 470

Importing Administrative and Other Data in the Administration Tab

To import administrative and other data,

1. Navigate to **Administration** tab → **Utilities** → **Import Data**.
2. Select a file of administrative data to import.

The **Browse** button can assist you in finding the file. For example, if you have created a file of modified question sets, called `newquestionset.xml`, select this file. This file must be either in XML or zipped XML format, with an XSD compatible with the XML files you can import. However, you need not import all administrative data. You can instead import any subset, such as users, regions, or security zones.

3. Click **Next**, and follow the commands on the screen to resolve differences between the data in the imported file and data already in the database.

Data not yet in the database is imported without question. After the imported data differs from what is already in the database, these commands enable you either to accept the imported data or to keep what is in the database.

4. Click **Finish** to complete the import.

See also

- “Exporting Data in the Administration Tab” on page 485
- “Importing Data From the User Interface” on page 116 in the *System Administration Guide*.

Exporting Data in the Administration Tab

Navigate to **Administration** tab → **Import/Export Data** → **Export** to export administrative data or the security dictionary.

Exporting Administrative Data

Exporting administrative data creates XML files. Each file contains all the data of a certain type in your installation. These export categories are:

- **Activity Patterns** – Exports all activity pattern data to `activitypattern.xml`, data of type `ActivityPattern`. If you choose **Admin** as the export type, the same activity patterns are exported with the other administrative data.

For more information, see “Managing Activity Patterns” on page 474.

- **Admin** – Exports all administrative data to `admin.xml`, including data of the following types:
 - `Attribute`
 - `AssignableQueue`
 - `AuthorityLimit`

- **Catastrophe**
- Contact objects, plus their associated Address and ContactIndividual objects
- **Credential**
- Group, and GroupRegion, GroupRuleSet, and GroupUser
- GroupAssignmentState and GroupUserAssignmentState
- InvalidCoverageForCause
- IncompatibleNewExposure
- IntegerClaimMetricLimit
- IntegerExposureMetricLimit
- LargeLossThreshold
- MoneyClaimMetricLimit
- Organization
- QuestionSet and Question, QuestionChoice, and QuestionFilter
- PolicyTypeMetricLimits
- Region
- ReinsuranceThreshold, and ReinsuranceCoverage and ReinsuranceLossCause
- Reviewtype and ReviewCategoryQuestionSet
- Role, Privileges, RolePrivilege, and Permission
- SecurityZone
- User, including AttributeUser, UserRole, and UserSettings
- UserPreference
- WCBenefitParameterSet and WCBenefitFactors and WCDenialPeriod
- **Authority Limit Profiles** – Exports all data on authority limit profiles to authoritylimitprofiles.xml, data of type AuthorityLimitProfile. If you choose Admin as the export type, the same authority limit profiles are exported with the other administrative data.
For more information, see “Managing Authority Limit Profiles” on page 476.
- **Business Weeks** – Exports all data you have defined on business weeks to businessweeks.xml. If you have not defined business weeks, no data is exported.
For more information, see “Managing Business Weeks” on page 504.
- **Catastrophes** – Exports all data you have defined on catastrophes to catastrophes.xml, data of type Catastrophe. If you choose Admin as the export type, the same catastrophe data is exported with the other administrative data.
For more information, see “Managing Catastrophes” on page 475.
- **Coverage Verifications** – Exports all data on coverage verification to coverageverification.xml. If you choose Admin as the export type, the same coverage verification data is exported with the other administrative data. The exported file has the following types of data:
 - InvalidCoverageForCause
 - IncompatibleNewExposure
 - InvalidCoverageForFaultFor more information, see “Verifying Coverage” on page 101.
- **Exchange Rates** – Exports all data on exchange rates to exchangerates.xml. You must choose this export type to export exchange rate data because it is not exported with the Admin data. The file contains the following types of data:
 - ExchangeRate
 - ExchangeRateSet

For more information, see “Exchange Rates” on page 342.

- **Holidays** – Exports all data you have defined on holidays to `holidays.xml`. If you have not defined holidays, no data is exported.

For more information, see “Managing Business Weeks” on page 504.

- **ICD Codes** – Exports all data on version 10 of the International Statistical Classification of Diseases and Related Health Problems (ICD), medical diagnosis codes that classify diseases, to `icd.xml`. You must choose this export type to export ICD data because it is not exported with the **Admin** data. The file contains data of type `ICDCode`.

For more information, see “Managing ICD Codes” on page 499.

- **Large Loss Thresholds** – Exports all data on large loss thresholds to `largelossthresholds.xml`. The file contains data of type `LargeLossThreshold`. If you choose **Admin** as the export type, the same large loss threshold data is exported with the other administrative data.

For more information, see “Managing Metrics and Thresholds” on page 500.

- **Metric Limits** – Exports all data on metric limits to `metriclimits.xml`. If you choose **Admin** as the export type, the same metric limit data is exported with the other administrative data. The file has data of the following types:

- `IntegerClaimMetricLimit`
- `IntegerExposureMetricLimit`
- `MoneyClaimMetricLimit`
- `PolicyTypeMetricLimits`

For more information, see “Managing Metrics and Thresholds” on page 500.

- **Questions** – Exports all data on question sets to `questions.xml`. By default, contains both the SIU (fraud) and Service Provider Management question sets. You can export question sets to modify them and create your own custom question sets. If you choose **Admin** as the export type, the same question set data is exported with the other administrative data. The file has data of the following types:

- `QuestionSet`
- `Question`
- `QuestionChoice`
- `QuestionFilter`
- `Reviewtype`
- `ReviewCategoryQuestionSet`

For more information, see “Question Sets” on page 269.

- **Regions** – Exports all data on regions to `regions.xml`. If you choose **Admin** as the export type, the same region data is exported with the other administrative data. The file has data of the following types:

- `Region`
- `RegionZones`
- `RegionZone`

For more information, see “Managing Regions” on page 479.

- **Reinsurance Thresholds** – Exports all data on reinsurance thresholds to `reinsurancethresholds.xml`. If you choose **Admin** as the export type, the same reinsurance threshold data is exported with the other administrative data. The file has data of the following types:

- `ReinsuranceThreshold`
- `ReinsuranceCoverage`
- `ReinsuranceLossCause`

For more information, see “Managing Reinsurance Thresholds” on page 498.

- **Roles** – Exports all data that maps system permissions to roles to the file `roles.xml`. If you choose **Admin** as the export type, the same role data is exported with the other administrative data. The file has data of the following types:

- `Role`
- `Privileges`
- `RolePrivilege`
- `Permission`

For more information, see “Managing Roles” on page 479.

- **Service Metric Limits** – Exports all limit data for service request metrics to `servicerequestmetriclimits.xml`. If you choose **Admin** as the export type, the same metric limit data is exported with the other administrative data. The export data set includes all instances of `ServiceRequestMetricLimit`.

Each instance includes:

- `ServiceRequestMetricType` – Type of metric.
- `CustomerServiceTier`
- `SpecialistService` – Service request type.
- `Currency`
- `LimitType` – Calculation method for the limit.
- `DecimalTargetValue`, `DecimalYellowValue`, and `DecimalRedValue` – Target, yellow, and red limit values.
- `MetricUnit` – The units for the limit values (currency, hours, days, and so on).

For more information, see “Managing Metrics and Thresholds” on page 500.

- **Special Handling** – Exports data for accounts and special handling of those accounts to `accountsandspecialhandling.xml`. You must choose this type to export this data because it is not exported with the **Admin** data. The data includes the following types:

- `Account`
- `AccountSpecialHandling`
- `Company`

For more information, see “Accounts and Service Tiers” on page 109.

- **Users and Groups** – Exports all data on users and groups to the file `usergroup.xml`. If you choose **Admin** as the export type, the same user and group data is exported with the other administrative data. The file has data of the following types:

- `User`
- `Users`
- `UserContact`
- `UserSettings`
- `Credential`
- `Organization`
- `Group`
- `SecurityZone`
- `AuthorityLimitProfile`
- `Address`
- `Role`

For more information, see “Managing Users and Groups” on page 472.

For more information, see “Managing Roles” on page 479.

- **Vendor Service Details** – Exports all data on vendor service details to the file `vendorservicedetails.xml`. Vendor service details associate each service with a compatible incident type and service request type. See “Vendor Service Details” on page 498 in the *Configuration Guide*.
- **Vendor Service Tree** – Exports the tree of vendor services to the file `vendorservicetree.xml`. Vendor services describe services performed by vendors. The file has data of the following types:
 - `SpecialistService`See “Vendor Service Tree” on page 496 in the *Configuration Guide*.
- **Workload Classifications** – Exports data on workload classifications to the file `workloadclassifications.xml`. Workload classifications support weighted workload balancing.
See “Weighted Workload Classifications” on page 209.

After you choose to export one of these types of data, ClaimCenter provides it with all relevant data formatted in XML. For example, the `questions.xml` file contains all the default question sets and all the question sets subsequently added.

To export administrative data:

1. Navigate to Administration tab → Import/Export Data → Export.
2. Select the data to export from the **Data to Export** text drop-down list. You can choose from one of the export types listed previously.
3. Click **Export**.

Note: There is no method in the user interface to export an XML file containing other kinds of data, or to export a CSV file or other file format.

See also

- “Question Sets” on page 269
- “Claim Fraud” on page 141
- “ClaimCenter Service Provider Performance Reviews” on page 215 in the *Contact Management Guide* for details of the supplied question sets and how to modify them
- “Exporting Data from the User Interface” on page 116 in the *System Administration Guide*

Exporting the Security Dictionary

You can export the ClaimCenter Security Dictionary from the **Export Data** screen. The Security Dictionary provides information on application permission keys, page configuration files, system permissions, and roles. You can export this data as HTML or XML.

To export the Security Dictionary:

1. Navigate to Administration tab → Import/Export Data → Export.
2. Under **Export Security Dictionary**, choose the output format, HTML or XML.
3. Click **Export**.

See also

- “Security Dictionary” on page 466

Importing and Exporting with APIs and from the Command Line

You might want to import or export other types of data or use files in formats other than XML. For example, if you receive new information from an external system, you might want to import this new data into ClaimCenter in a single step. APIs and the command-line functions are your two alternatives to the user interface described

previously. APIs enable you both to import and to export, but the command line commands support only importing, not exporting.

Importing and Exporting with APIs

Use the `IImportTool` and `IExportTool` APIs to create batch processes that move data in and out of ClaimCenter. These batch processes might be used to add current FNOL information periodically to ClaimCenter. These files can have either XML or CSV format. The topic “Importing and Exporting Administrative Data from ClaimCenter” on page 115 in the *System Administration Guide* covers how to use these APIs.

Importing from the Command Line

There are command-line commands for importing, but not exporting, XML and CSV files containing any kind of data, not just the types of data supported by the Administration tab. See “Importing and Exporting Administrative Data from ClaimCenter” on page 115 in the *System Administration Guide* for more details.

Managing Security Zones

Security zones are a way for ClaimCenter to provide security for a defined area larger than a group in your organization.

Every group must belong to a security zone. It is a good idea to have a strategy for how to use security zones. One strategy is to use zones that describe your lines of business (LOBs). Another is to describe zones that reflect your local or regional offices.

If you define just one security zone, there is no difference between global and related permission scopes. With just one security zone, both the owner of any claim and all users are members of the same security zone.

Security zones are just names. They are not defined as collections of geographical areas and are not regions. Claim center provides two default security zones, Workers’ Compensation and Auto and Property.

See also

- “Understanding Regions” on page 444
- “Security Zones” on page 464
- “Data-based Security and Claim Access Control” on page 451
- “Administration Tab” on page 470

Adding, Editing, and Renaming Security Zones

To perform add, edit, and delete operations on security zones, on the **Administration** tab, click **Users & Security** → **Security Zones** in the sidebar.

- To create a new security zone, click the **Add Security Zone** button and enter a name and description. Then click **Update**.
- To edit an existing security zone, in the list of zones, click the zone you want to edit and then click **Edit**. After editing the name or description or both, click **Update**.

Note: Changing the name of a security zone effectively deletes the old zone and assigns the zone with the new name to all groups that had used the old name.

Choosing or Changing a Group’s Security Zone

1. Select the group, either from the Organization tree or by searching for and selecting the group on the **Groups** screen.

To open the **Groups** screen so you can search, navigate to **Administration tab** → **Users & Security** → **Groups**.

2. On the screen for the group you selected, click **Edit**.
3. In the **Security Zone** field, select a security zone from the drop-down list.
4. Click **Update** to save your changes.

Creating and Managing Reference Tables

Reference tables are tables not connected to specific claims. Most entities in ClaimCenter are claim related. Main entities that are not related to specific claims and are used across claims are bulk invoices, aggregate limits, and reference tables.

ClaimCenter implements two varieties of reference tables: reference tables that define the Verifying Coverage feature and workers' compensation reference tables that enable rules to calculate benefits. You can view these reference tables by selecting one of the following sidebar menu links in the **Administration tab**:

- **Business Settings** → **Coverage Verification** – See “Managing Coverage Verification” on page 492.
- **Business Settings** → **WC Parameters** – See “Managing WC Parameters” on page 492.

You can also create your own sets of reference tables.

This topic includes:

- “Coverage Verification Reference Tables” on page 491
- “Configuring Reference Tables” on page 492

See also

- “Verifying Coverage” on page 101
- “Defining a Reference Entity” on page 222 in the *Configuration Guide*
- “Administration Tab” on page 470

Coverage Verification Reference Tables

The coverage verification feature uses the following tables to define allowed coverages for specific losses, users, and exposures. See “Verifying Coverage” on page 101 for more information.

- **Invalid Coverage For Cause** – A list of invalid loss cause and coverage pairs. ClaimCenter uses these pairs to warn if you are about to create an exposure with such an invalid combination, such as a personal auto comprehensive exposure due to a collision. The PCF files are `InvalidCoverageForCause.pcf` and `InvalidCoverageForCauseLV.pcf`. They use the entity `InvalidCoverageForCause.eti` to populate the table in the user interface and store changes.
- **Incompatible New Exposure** – A list of new exposures you try to create that are incompatible with other exposures that are already part of the claim. For example, it warns you if you try to create a comprehensive exposure when the claim already contains a collision exposure. The PCF files are `IncompatibleNewExposure.pcf` and `IncompatibleNewExposureLV.pcf`. They use the entity `IncompatibleNewExposure.eti` to populate the table in the user interface and store changes.
- **Possible Invalid Coverage due to Fault Rating** – A list of invalid coverage and fault rating pairs. ClaimCenter uses these pairs to warn if you are about to create an exposure with an invalid combination. An example is a personal auto liability exposure when the other party is at fault. The PCF files are `InvalidCoverageForCause.pcf` and `InvalidCoverageForCauseLV.pcf`. They use the entity `InvalidCoverageForCause.eti` to populate the table in the user interface and store changes.

Configuring Reference Tables

You can create new reference entities and the PCF files for them and add them either to the **Coverage Verification** or **WC Parameters** menu items in the **Administration** tab. Or you can create a new menu item for your new tables. Click **Edit** in the screens that show each table to edit values and remove table rows.

Once you have a correctly defined and populated reference table, you can write rules that read and use it. You can use Gosu functions in the rules to access the reference table.

ClaimCenter uses the Coverage Verification tables to help users avoid creating unreasonable exposures.

Managing Coverage Verification

Whenever you create a new exposure, ClaimCenter looks for inconsistencies between a policy's coverages and the loss party, loss cause, other existing exposures, and claimant's liability. The tables on each screen associate loss causes with appropriate exposures, loss party with appropriate exposures, and exposures on a claim incompatible with other existing exposures. In addition, you can edit and extend these tables.

On the **Administration** tab, click **Business Settings** → **Coverage Verification** in the sidebar. You see the following menu links:

- **Invalid Coverage for Cause** – You can edit or add the loss type, line of business code, policy type, loss cause, and invalid coverage for new exposure.
- **Incompatible New Exposure** – You can edit or add policy type, invalid coverage for a new exposure, and the coverage of existing exposure.
- **Possible Invalid Coverage due to Fault Rating** – You can edit or add the policy type, invalid coverage for a new exposure, and fault rating.

See also

- “Coverage Verification Reference Tables” on page 491
- “Verifying Coverage” on page 101
- “Administration Tab” on page 470

Managing WC Parameters

Note: See “Jurisdictional Benefit Calculation Management” on page 191 for an explanation of the various types of compensation.

ClaimCenter provides menu links under **Administration** tab → **Business Settings** → **WC Parameters** to administer and manage parameters associated with Workers’ Comp calculations. The screens that open from these menu links work in conjunction with business logic defined in Guidewire Studio. ClaimCenter bases this framework of business logic on conventions in use in the United States. However, it is possible for you to adapt the logic for use in other countries as well.

Using this functionality, it is possible to calculate multiple types of compensation, based on jurisdiction:

TPD	Temporary Partial Disability
TTD	Temporary Total Disability
PPD	Permanent Partial Disability
PTD	Permanent Total Disability

An important aspect of handling workers' compensation claims is calculating workers' compensation payments for lost time. For example, the following calculation is an example of a possible TPD calculation using AWW (Amount Weekly Wage):

$$\text{WeeklyCompRate} = \text{JurisdictionRate} \times (\text{Pre-injuryAWW} - \text{Post-injuryAWW})$$

It is possible for an individual state to calculate this value differently for each year. In the base configuration, ClaimCenter provides sample calculations for a few example states and more detailed sample PPD calculations for the state of California. The goal of these examples is to show you how you can calculate these amounts.

You enter, manage, and edit various workers' compensation-related parameters through the ClaimCenter interface. ClaimCenter then uses these parameters to perform the actual calculations in Gosu code, which you can configure through ClaimCenter Studio.

An adjuster can always override workers' comp amounts by entering a manual amount.

Navigate to **Administration tab** → **Business Settings** → **WC Parameters** to see the menu links for screens in which you can manage workers compensation parameters. The menu links and screens are:

Screen	Description	Topic
Benefit Parameters	Provides a list of jurisdictions. Clicking a jurisdiction opens the Benefit Parameters Detail screen showing the set of benefit parameters for that jurisdiction. You can view and edit these parameters.	"Using the Benefit Parameters Detail Screen" on page 493
PPD Min / Max	Provides data similar to the PPD area of the Benefit Parameter Detail screen, but with more detail.	"Entering Information in the PPD Min / Max Screen" on page 494
PPD Weeks	Entry screen in which you can define the limits of how long the injured worker can receive the workers' compensation benefits, based on the disability.	"Entering Information in the PPD Weeks Screen" on page 495
Denial Period	Shows a list of jurisdictions and the maximum time for each that the carrier has to make compensability decision, the denial period. Click a jurisdiction to open its Denial Period Detail page, where you can edit the settings.	"Entering Denial Period Information" on page 495

Using the Benefit Parameters Detail Screen

Use this screen to define a benefit parameters record, with a different jurisdictional state, start date, and end date for each record. For example, you can create several entries for a single state, with each entry based on a specific time period.

You access the **Benefit Parameter Detail** screen by navigating to **Administration tab** → **Business Settings** → **WC Parameters** → **Benefit Parameters** and then doing one of the following:

- Clicking **Add** in the **Benefit Parameters** screen. ClaimCenter opens the **Benefit Parameter Detail** screen in which you can create a new set of defined benefit parameters based on a new jurisdiction.
- Clicking a jurisdiction in the **Benefit Parameters** screen. ClaimCenter opens an existing set of benefit parameters, which you can then edit.

Use the **Benefit Parameter Detail** screen to define information on the following:

Area	Description
General	<p>You must set the following for each defined set of benefit parameters:</p> <ul style="list-style-type: none"> • Jurisdiction • Start date • End date <p>These parameters make this set of benefit parameters unique.</p>
Temporary Total Disability (TTD) Temporary Partial Disability (TPD) Permanent Total Disability (PTD) Permanent Partial Disability (PPD)	<p>ClaimCenter can calculate benefits, for example, as Average Weekly Wage (AWW) times Percent of Wages. If the result falls within the maximum and minimum, this calculated benefit amount becomes the benefit. Otherwise the value of the benefit is one of the following:</p> <ul style="list-style-type: none"> • The maximum if the result was more than the maximum weekly benefit. • The minimum if the result was less than the minimum weekly benefit. <p>If you set Minimum adjusted by Weekly Wage to Yes and the employee's AWW is less than the Minimum Weekly Benefit, the calculation changes. The minimum amount that the worker can receive becomes the AWW rather than the Minimum Weekly Benefit.</p>
Waiting Period	<p>In the Waiting Period section, you set the following:</p> <ul style="list-style-type: none"> • Number of days – Number of lost work days before the workers' compensation benefits will begin to be paid. For example, if the waiting period is three days, the worker is eligible to be paid on the fourth day of lost wages. • Retroactive Period – Number of lost work days at which point the worker is paid retroactively for the original waiting period days. For example, the waiting period is three days and the retroactive period is 14 days. In this case, the worker is eligible to be paid for the initial three days of lost wages on the 14th day of lost wages.
Other Jurisdictional Factors	<p>You can add additional factors for ClaimCenter to use in calculating workers' compensation benefits. The Other Jurisdictional Factors list view at the bottom of the screen can track information about special rules that apply to claims in this jurisdiction. Click Add under Other Jurisdictional Factors to define additional factors. Click the field for Category to add a category, and do the same for Detailed Factor. You can specify the units for the category and indicate if it applies to any combination of TTD, TPD, PTD, and PPD.</p> <p>In the default configuration, this list view informs adjusters working on claims of special conditions for various types of disabilities. The information could be leveraged in rules. The information is presented on the time loss exposures for claims in the appropriate jurisdictions. The expectation is that the adjuster can take this information into account and modify the benefits and manage the claim as appropriate.</p>

ClaimCenter renders the **Benefit Parameter Detail** screen by using the **WCBenefitParameterSetDV** PCF file.

ClaimCenter embeds **WCBenefitFactorsLV** in **WCBenefitParameterSetDV**. The **WCBenefitFactorsLV** PCF file defines the information to show in the **Other Jurisdictional Factors** section of the **Benefit Parameter Detail** screen. The entity **WCBenefitParameterSet** is used to retrieve and store the data used in these screens.

Entering Information in the PPD Min / Max Screen

Use the **PPD Min / Max** screen to define the extent to which an injured worker is disabled.

You access the **PPD Min / Max** screen by navigating to **Administration** tab → **Business Settings** → **WC Parameters** → **PPD Min / Max**. Click **Edit** to edit the screen.

The disability percentage minimum and maximum values on this screen refer to the degree to which the injured worker is disabled. The **PPD Min / Max** values are based on jurisdiction, with start and end dates, such as dates defining a calendar year. You must enter a jurisdiction, the start and end dates, a minimum and maximum disability percentage, and a minimum and maximum benefit dollar amount.

Note: If the data on the **Benefit Parameters** screen conflicts with the data on the **PPD Min / Max** screen, use the detailed data on the **PPD Min / Max** screen.

ClaimCenter renders the PPD Min / Max screen by using the WCPDBenefits and the WCPDBenefitsLV PCF files. The entity ref_WC_PD_Benefits is used to retrieve and store the data used in these screens.

Entering Information in the PPD Weeks Screen

Use this screen to define the length of time the injured worker can receive workers' compensation benefits, based on the disability.

You access the PPD Weeks screen by navigating to Administration tab → Business Settings → WC Parameters → PPD Weeks. Click **Edit** to edit the screen.

The PPD Weeks settings are based on jurisdiction, with start and end dates, such as dates defining a calendar year. You must enter a jurisdiction, the start and end dates, the disability percent, and the number of weeks that apply.

ClaimCenter renders the PPD Weeks screen by using the WCPDWeeksAndLimits and the WCPDWeeksAndLimitsLV PCF files. The entity ref_WC_PD_WeeksAndLimits is used to retrieve and store the data used in these screens.

Entering Denial Period Information

The denial period defines the maximum time the carrier has to make the compensability decision.

You access the Denial Period Detail screen by navigating to Administration tab → Business Settings → WC Parameters → Denial Period Detail and then doing one of the following:

- Clicking **Add** in the Denial Period screen. ClaimCenter opens the Denial Period Detail screen in which you can create a new denial period based on a new jurisdiction.
- Clicking a jurisdiction in the Denial Period screen. ClaimCenter opens an existing set of parameters in the Denial Period Detail screen. Click **Edit** to edit them.

If the compensability decision is not made by the time the denial period expires, the claim is automatically determined to be compensable. ClaimCenter uses the denial period data to determine due dates of the Determine Compensability activity. If ClaimCenter does not find a jurisdiction in the reference table, the system uses the Determine Compensability activity pattern. ClaimCenter creates the activity and sets the activity due date to five business days after the notice date.

The denial period is based on jurisdiction with effective and expiration dates. ClaimCenter also requires you to enter a due date formula that is based on either the loss or notice date. For example:

- Greater of x days after the loss date or y days after the notice date
- x days after the loss date
- y days after the notice date

Depending on your selected formula, you further define what Target Days from Loss (x) or Target Days from Notice (y) is. You must also select Target Include Days that can be based on calendar or business days.

You can optionally indicate documents to be used when accepting or denying compensability.

ClaimCenter renders the Denial Period screen by using the DenialPeriods and the DenialPeriodsLV PCF files. The entity WCDenialPeriod is used to retrieve and store the data used in these screens.

Creating Benefits Calculations in Gosu

ClaimCenter uses the benefit amounts and other information that you enter on the WC Benefit Parameters screens to calculate workers' compensation benefits programmatically. Guidewire calls the entire process the Workers' Comp Benefits Calculator. ClaimCenter stores the formulas used in these calculations in Gosu code that you can access and configure in Studio.

In Guidewire Studio, navigate in the Project window to Configuration → gsrc and then open the node gw.api.benefits to see the classes.

Guidewire provides the following classes to illustrate how to construct benefit calculations:

Gosu class	Description
PPDBenefitsCalculator	Benefits calculator for permanent partial disability (PPD). This example implementation illustrates how to vary the minimum compensation rate by state and also how a particular state, California, can use a separate calculator from the other states.
PPDBenefitsCalculatorForCA	Benefits calculator for permanent partial disability (PPD) in California. Guidewire has provided detailed information for the US state of California to serve as an example of the implementation.
PTDBenefitsCalculator	Benefits calculator for permanent total disability (PTD). The sample code includes a custom calculator for the U.S. state of Pennsylvania (PA), taking into account Pennsylvania's special minimum compensation rate.
TPDBenefitsCalculator	Benefits calculator for temporary partial disability (TPD). The sample code includes customized calculators for the U.S. states of Florida (FL), Pennsylvania (PA), and New Jersey (NJ).
TTDBenefitsCalculator	Benefits calculator for temporary total disability (TTD). The sample code includes customized calculators for the U.S. states of Illinois (IL) and Pennsylvania (PA).
WorkersCompBenefitsExceptions	Static utilities for workers' compensation benefit calculators. Utilities for a particular type of benefit, such as TTD or PPD, must go in the appropriate calculator class. However, utilities that will be shared across multiple benefit types do go in this class.

For each of the four benefit types (TTD, TPD, PPD, and PTD), the Gosu class for each type contains common getter properties that each class then overrides:

BaseRate	Typically, the weekly rate of pay for the worker before the injury occurred, except for Temporary Partial Disability (TPD). For Temporary Partial Disability, the base rate is typically the difference between: <ul style="list-style-type: none">• The weekly rate of pay for the worker pre-injury• The weekly rate of pay for the worker post-injury The calculation typically enforces the condition that the worker is earning less due to the disability.
PercentOfWages	The percentage of the BaseRate that is paid to injured workers as their benefit
MaxCompRate	The jurisdictional Maximum to pay the injured worker each week.
MinCompRate	The jurisdictional Minimum to pay the injured worker each week.
MinAwwAdjustment	A common exception to lower the Jurisdictional Minimum Comp Rate. If the BaseRate is lower than the mandated Minimum, states with this exception will lower the jurisdictional minimum to the BaseRate.

ClaimCenter uses these values to calculate the following:

CompRate	The weekly benefit for the injured worker based upon their BaseRate and the applicable jurisdictional parameters
MaxWeeksToPay	The maximum number of weeks to pay this benefit. ClaimCenter implements this calculation only in the sample code for PPD calculations. The other calculations return null in the ClaimCenter base configuration.

In addition to the previous properties, ClaimCenter uses an array of `WCBenefitFactorDetail` objects to track other notes, conditions, and exceptions related to the Jurisdictions benefit calculations. Some of the important fields on `WCBenefitFactorDetail` are:

<code>AppliesToPPD</code>	A flag that indicates to which of the four benefit types this entry belongs.
<code>AppliesToPTD</code>	
<code>AppliesToTPD</code>	
<code>AppliesToTTD</code>	
<code>FactorCategory</code>	Typekey to the <code>WCBenefitFactorCategory</code> typelist.
<code>DetailedFactor</code>	Typekey to the <code>WCBenefitFactorType</code> typelist, filtered by FactorCategory, the <code>WCBenefitFactorCategory</code> typelist.
<code>FactorValue</code>	Tracks a related value. For example, if <code>DetailedFactor</code> is set to age, the field indicates that a benefit is possibly reduced at a certain age. This value tracks the specific age, such as 70, at which the change in benefits occurs.
<code>FactorComment</code>	Available only if <code>WCBenefitFactorDetail.DetailedFactor == "other"</code> .

Viewing the Resultant Calculations

ClaimCenter displays the results of these calculations as benefits amounts in the **Time Loss → Benefits** card of a workers' compensation claim. This screen provides a view of any calculated values for each of the four benefit types. The screen shows any benefit factors relevant to the claim as well. It is possible to edit this screen and enter a weekly compensation rate manually.

In this screen:

- If there is no entry in `WCBenefitCalculations` appropriate for the claim, ClaimCenter sets the value of `Reference Data` for that benefit type to *Not available*.
- If ClaimCenter cannot calculate the Compensation Rate, meaning that `CompRate == null`, then ClaimCenter generates a *Not available* message.

Benefits Calculator and Multicurrency

The `WorkersCompBenefitCalculator` uses the `WCBenefitParameterSet` values to do the calculations. It does not contain information about the claim currency. ClaimCenter calculates everything based on the default currency of the system, configuration parameter `DefaultApplicationCurrency`.

If an adjuster is working on a workers' compensation claim and it is in Euros, but the default currency is in U.S. dollars, ClaimCenter shows both currencies. The benefits screens of the workers' compensation claim will be in Euros for claim-specific benefit amounts—the weekly wage, the weekly wage amount, and benefit periods. However, all the calculator-based benefit amounts will be in U.S. dollars.

For example, if there is a parameter of PPD maximum value of USD \$2000, you could set 1500 in Euros for a compensation rate. The calculator class interprets the 1500 Euros as \$1500 USD because you must do the currency conversion inside the calculator implementation.

Note: For benefit definitions refer to “Jurisdictional Benefit Calculation Management” on page 191.

Workers' Compensation Reference Tables

ClaimCenter uses the following administration entities to store reference data for workers' comp calculations. The tables, as seen in the **Benefit Parameters** screens, are:

ClaimCenter screen	Entity
Benefit Parameters	WCBenefitParameterSet
PPD Min / Max	ref_WC_PD_benefits
PPD Weeks	ref_WC_PD_WeeksAndLimits
Denial Period	WCDenialPeriod

Note: The administration tables `WCBenefitParameterSet`, `ref_WC_PD_benefits`, and `ref_WC_PD_WeeksAndLimits` do not contain any information about the currency of a claim.⁴

Workers' Compensation Permissions

In the base configuration, ClaimCenter provides the following permissions for use with workers' compensation:

Permission	Code	Description
View WC disability rates	wcrefview	Permission to create, edit, and delete values on Workers' Comp disability rate tables.
Manage WC disability rates	wcrefmanage	Permission to view the values on Workers' Comp disability rate tables.

Managing Reinsurance Thresholds

Reinsurance is insurance risk transferred to another insurance company for all or part of an assumed liability. Reinsurance can be thought of as insurance for insurance companies. When a company reinsures its liability with another company, it cedes business to that company. The amount an insurer keeps for its own account is its retention. When an insurance company or a reinsurance company accepts part of another company's business, it assumes risk. It thus becomes a reinsurer.

Note: The insurance company directly selling the policy is also known in the industry as the carrier, the reinsured, or the ceding company. This topic uses the term *carrier* to refer to this company. An insurance company accepting ceded risks is known as the *reinsurer*.

Agreements between insurers and reinsurers, called reinsurance treaties, are based on losses to insurers exceeding certain threshold amounts. Generally, insurers identify claims for possible reinsurance if the total incurred on a claim approaches the thresholds set out in the reinsurance treaty. ClaimCenter enables administrators and authorized reinsurance handlers set reinsurance thresholds. Setting these thresholds helps ClaimCenter automatically identify claims for reinsurance and assign review tasks to reinsurance managers.

For each policy type, ClaimCenter stores the following threshold information:

- Threshold value for gross total incurred, over which the reinsurance is triggered.
- Reporting threshold percentage, at which point the reinsurer is to be notified.
- Start and end dates, which set the life spans of thresholds.
- List of loss causes and coverages included in threshold calculations. An empty list is considered to include all loss causes and coverages.

See also

- “Reinsurance Management Concepts” on page 415

- “Reinsurance Management in ClaimCenter” on page 427
- “Administration Tab” on page 470

Administering Reinsurance Thresholds

The base configuration contains default threshold values that you must change to match the terms of your own reinsurance treaties.

1. Navigate to **Administration tab** → **Business Settings** → **Reinsurance Threshold** and click **Edit**.

The treaty types are mapped to policy types with a threshold value and reporting threshold percentage and optionally a start date and end date.

2. Make any changes and click **Update** when you are finished.

Managing ICD Codes

The International Statistical Classification of Diseases and Related Health Problems (ICD) are medical diagnosis codes that classify diseases. The ICD also classifies a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. Every health condition can be assigned to a unique category. Published by the World Health Organization, ICD is used for morbidity and mortality statistics, reimbursement systems, and automated decision support in medicine. Given a diagnosis code from a physician, the treatment codes for that injury or illness can be compared to the diagnosis code to ensure the treatments are valid and appropriate. Additionally, use these codes to adjust the claim as benchmarks of the claim characteristics. An example might be the amount of time off from work for the type of job for that diagnosis.

You manage ICD codes from the **Administration tab**, and you apply them in the **Medical Diagnosis** section of a claim in ClaimCenter. For information on permissions required to manage ICD codes, see “**ICD Permissions**” on page 500.

Note: **Medical Diagnosis** is located in different areas of the user interface depending on the line of business. For example, you would edit a **Medical Diagnosis** in a workers’ compensation claim by navigating to **Medical Details** screen and clicking **Edit**. You would then click the **Medical Case Mgmt** card and make your edits on the **Medical Diagnosis** section. In a personal auto claim, you would navigate to **Loss Details** screen and click the name of a person in the **Injuries** section. Then, on the **Injury Incident** screen, you would click **Edit** and make your edits on the **Medical Diagnosis** section.

Guidewire provides ICD-10 codes as reference data, which can be imported through either the command line or the user interface. In the user interface, use the **Utilities** → **Import Data** tool in the **Administration tab**. ClaimCenter stores each code in an **ICDCode** entity. Once stored, you can use it immediately without doing additional configuration. Each year the administrator must either add or expire codes.

ClaimCenter additionally stores classifications of ICD codes used for categorization in the typelist **ICDBodySystem**.

Note: Guidewire does not provide ICD-9 codes in the base configuration, and the link to the external web site does not work for ICD-9.

See also

- “Administration Tab” on page 470
- “Medical Details Screens” on page 187

Working with ICD Codes

You can view, edit, or add new codes. The following steps explain how to do this.

To view ICD codes

1. To see a code in ClaimCenter, navigate to **Administration tab** → **Business Settings** → **ICD Codes**.
2. Optionally enter a code or select a body system from the drop-down list, and then click **Search**.
3. Select a code by clicking its link in the **ICD Code** column.
4. In the **ICD Code Details** screen, you can obtain additional information about that code. Click the code identifier in the **ICD Code** field to see the code on the external ICD web site.

To edit ICD codes

1. Navigate to **Administration tab** → **Business Settings** → **ICD Codes**.
2. Optionally enter a code or select a body system from the drop-down list, and then click **Search**.
3. Select a code by clicking its link in the **ICD Code** column.
4. Click **Edit**. You can:
 - Edit the code number.
 - Edit the description.
 - Edit the body system.
 - Mark it as chronic, or clear the check box to remove the chronic setting.
 - Enter availability and expiration dates.Typically, you might edit the dates to activate or retire a code, because you cannot delete them.
5. When you are finished, to save your edits, click **Update**.

To add new ICD codes

The following steps describe how to add codes through the **Administration tab**. You can also import codes by using **Administration tab** → **Utilities** → **Import Data** or the command line. See “Managing Importing and Exporting Data” on page 484.

- **To add a new code**

1. Navigate to **Administration tab** → **Business Settings** → **ICD Codes**.
2. Click **Add new code**. The **New ICD Code** screen opens.
3. Enter the code and description, and associate it with a body system.
4. Optionally mark the code as chronic.
5. Optionally add the available date or the expiration date or both.
6. Click **Update**.

ICD Permissions

You need the following permissions to work with administration reference data:

- **viewrefdata** – Enables you to view administration reference data.
- **editrefdata** – Enables you to edit administration reference data.

Managing Metrics and Thresholds

You can define metric targets by policy type in ClaimCenter by navigating to **Administration tab** → **Business Settings** → **Metrics & Thresholds**. You can define metric targets for different tiers. When a tier is not defined, you are setting up the metric targets for the default tier.

Selecting a policy type displays all the metric limits that apply to that policy type. Every metric subtype has default limits. For money based metric targets, there are multiple defaults, one for each currency in the **Currency** typelist. Because these default limits are added automatically by the system, you cannot delete them, but you can edit them.

You add new metric limits by using the menu items on the default limits. You can add new limits for each claim tier that applies to the policy type. The claim tier typelist is filtered by the policy type typelist. You can add only one limit per tier.

This topic includes:

- “Editing Metric Limits” on page 501
- “Using Tiers to Add Granularity” on page 502
- “Claim Metric Limits” on page 502
- “Claim Metric Limits and Currency” on page 503
- “Exposure Metric Limits” on page 503
- “Large Loss Threshold” on page 504
- “Claim Metrics Batch Processes” on page 504

See also

- “Claim Health Metrics” on page 392
- “Administration Tab” on page 470

Editing Metric Limits

You need the Manage Metric Limits permission `metriclimitmanage` to edit claim health metric target values. Navigate to **Administration** tab → **Business Settings** → **Metrics & Thresholds**. There are separate cards for **Claim Metric Limits**, **Exposure Metric Limits**, and **Large Loss Thresholds**, which is visible on the high-risk indicators section of the claim summary.

To edit, you must first select the policy type. In the following example, the policy type is Personal Auto.

Metrics & Thresholds					
Edit		Policy Type *	Personal Auto		
		Claim Metric Limits	Exposure Metric Limits	Large Loss Threshold	
	Attribute	Units		Target/Service Level	!
Overall Claim Metrics					
	Days Open	Days	30	25	60
	Low Severity	Days	10	8	20
	High Severity	Days	150	140	180
	Initial Contact with Insur...	Days	1	1	2
Claim Activity					
	Days Since Last View - Ad...	Days	10	8	15
	High Severity	Days	20	18	30
	Days Since Last View - Su...	Days	20	16	40
	High Severity	Days	30	25	50

Metric values can be assigned for the target service green level, yellow status, and red status. The red level is used for highlighting claims that need immediate attention. The yellow level is for warnings and indicates that supervisors or adjusters need to take action before the claim becomes problematic. You can have yellow values be either above or below the target values, either warning that you are slightly above the target, or warning that you are approaching the target.

You first assign metric target values by policy type. While all policy types have the same metrics, there can be different target values associated with them. For example, you decide that the **Days Open** target value for the red level can be at a higher threshold number for one policy type than for the others.

Using Tiers to Add Granularity

You can use tiers to provide different target values for a particular metric with a specific policy type. Tiers are a way to add further granularity within the policy type and help in identifying type, complexity, and size of the claim. For example, in the previous example, the **Days Open** metric on the Personal Auto policy type has default values of 30/25/60. For Low Severity claims the values are 10/8/20. For the High Severity claims, the values are 150/140/180. In this example, the Medium Severity tier was not defined.

To add a tier

1. Navigate to **Administration tab** → **Business Settings** → **Metrics & Thresholds**.
2. Click the **Edit** button.
3. In the **Attribute** column, click the down arrow next to the claim metric to which you want to add a tier.
4. ClaimCenter shows the available tiers. Click one to add it to the metric.
When you add a tier, the initial values are the same as the base values for the metric.
5. Enter values for the tier and click **Update** to save.

To remove a tier

You cannot remove a metric on the **Administration tab**, but you can remove a tier from a metric.

1. Navigate to **Administration tab** → **Business Settings** → **Metrics & Thresholds**.
2. Click the **Edit** button.
3. Click the check box for the tier you want to remove.
The **Remove** button is now enabled.
4. Click **Remove** to delete the tier.
5. Click **Update** to save your changes.

Claim Metric Limits

In the base configuration, you can administer the targets for the following claim metrics. To see these limits, navigate to **Administration tab** → **Business Settings** → **Metrics & Thresholds**.

Metric Name	Description
Overall Claim Metrics	
• Days Open	Average days open.
• Initial Contact with Insured (Days)	Average time to initial contact.
Claim Activity	
• Days Since Last View - Adjuster	Number of days since the adjuster last viewed the claim.
• Days Since Last View - Supervisor	Number of days since the supervisor last viewed the claim.

Metric Name	Description
• Activities Past Due Date	Indicates that activities are past their due date.
• Open Escalated Activities	Number of how many escalated activities are still open.
• Number of Escalated Activities	Number of escalated activities associated with the claim.
• % of Escalated Activities	Number of escalated activities divided by total activities.
Claim Financials	
• Net Total Incurred	Total Incurred Net financial calculation, the Open Reserves plus Total Payments minus Total Recoveries. This metric can be in more than one currency.
• Total Paid	The amount that has been paid on the claim. This metric can be in more than one currency. The Total Payments financial calculation is the sum of all submitted and awaiting submission payments whose scheduled send date is today or earlier.
• Incurred Loss Costs as % of Net Total Incurred	Net Total Incurred for Cost Type of claim cost divided by Net Total Incurred.
• Paid Loss Costs as % of Total Paid	Payments for Cost Type of claim cost divided by Total Payments.
• Time to First Loss Payment (Days)	The number of days until the first loss payment occurs.
• Number of Reserve Changes	The number of reserve changes.
• % Reserve Change from Initial Reserve	Change in Total Reserve Amount from Initial Reserve Amount divided by Initial Reserve Amount calculation.

Claim Metric Limits and Currency

If ClaimCenter is configured to use a single currency, all money based metrics use the default currency type. However, if multicurrency is configured, all money based metrics such as Net Total Incurred or Total Paid, have an entry for every currency defined. In the base configuration, USD and CAD currencies are included in the `metriclimit` type filter.

To change the type of currency that you see in the user interface, see “Setting the Default Application Currency” on page 91 in the *Globalization Guide*.

Exposure Metric Limits

In the base configuration, you can administer the exposure metrics listed in the following table. To see these limits, navigate to **Administration tab** → **Business Settings** → **Metrics & Thresholds** and click **Exposure Metric Limits**.

Tiering is based on the policy type. For example, for the Personal Auto policy type, available exposure tiers include rental, towing, first party medical, first party physical damage, third party medical, and so forth.

Metric Name	Description
Exposures	
• Days Open	Average days open.
• Initial Contact with Claimant (Days)	Average time to initial contact.
• Net Total Incurred	Total Incurred Net financial calculation, the Open Reserves plus Total Payments minus Total Recoveries. This metric can be in more than one currency.
• Total Paid	The amount that has been paid on the claim. This metric can be in more than one currency. The Total Payments financial calculation is the sum of all submitted and awaiting submission payments whose scheduled send date is today or earlier.
• % of Escalated Activities	Number of escalated activities divided by total activities.

Metric Name	Description
• Paid Loss Costs as % of Total Paid	Payments for Cost Type of claim cost divided by Total Payments.
• Time to First Loss Payment (Days)	The number of days until the first loss payment occurs.

Large Loss Threshold

You can set large loss thresholds in the **Metrics & Thresholds** screen, based on policy type. To see these limits, navigate to **Administration tab** → **Business Settings** → **Metrics & Thresholds**, select a **Policy Type**, and click **Large Loss Thresholds**.

Click **Edit** to set the **Large Loss Indicator** amount. Claim amounts that are over your defined limit trigger the large loss indicator.

If PolicyCenter has been integrated with ClaimCenter, you can also define the large loss threshold for PolicyCenter, the **Policy System Notification**. When that number is reached, then PolicyCenter is notified. This number does not need to match the large loss indicator number in ClaimCenter.

See also

- To learn more about large loss thresholds sent to a policy administration system, see “Large Loss Notifications” on page 511.

Claim Metrics Batch Processes

To run your existing claims against newly set claim health metrics, you must run the Claim Health Calculations batch process. Press ALT+SHIFT+T to open the **Server Tools** screen, and then click **Batch Processes** in the sidebar menu. You must be logged in as a user with a role that has the `toolsBatchProcessview` permission to be able to see this screen.

ClaimCenter provides the following batch processes to calculate claim metrics:

- **Claim Health Calculations** – Calculates health indicators and metrics for all claims that do not have any metrics calculated.
- **Recalculate Claim Metrics** – Recalculates claim metrics for claims whose metric update time has passed. For example, this batch process is used for overdue activities.

See also

- “Batch Processes and Work Queues” on page 123 in the *System Administration Guide* to learn more about batch processes.

Managing Business Weeks

To define one or more business weeks, navigate to **Administration tab** → **Business Settings** → **Business Week**. For information on this feature, see:

- “Working with Holidays, Weekends, and Business Weeks” on page 260
- “Business Weeks and Business Hours” on page 261

See also

- “Administration Tab” on page 470

External System Integration

ClaimCenter Integration Points

ClaimCenter can integrate with many applications and services. These integration points need to be considered as you configure the application. Some are mandatory while others are optional, depending on your business needs.

ClaimCenter integrates with external systems by using a set of services and APIs that can link ClaimCenter with custom code and external systems. The code or mechanism used to exchange information with an external system is known as an *integration point*. ClaimCenter can be integrated with any system that can make information available externally through a commonly established technology. The following list shows the most common types of external systems that might need to be integrated.

- **Authentication system** – Enables a person to access ClaimCenter.
- **Policy Administration System** – ClaimCenter pulls related policy information during the claim process from a policy administration system, such as Guidewire PolicyCenter. To learn more how ClaimCenter integrates with a policy administration system, see “Policy Administration System Integration” on page 509.
- **Billing System** – When a user creates a policy, the policy administration system can export billing information to a billing system, such as Guidewire BillingCenter. ClaimCenter can communicate with the billing system as needed.
- **Contact Management or Address Book application** – A separate application for contact information. It is often necessary to store and maintain contact information separately from ClaimCenter to make the information available both to different claims and to users outside ClaimCenter. For details on integrating with the Guidewire contact management system, see “Integrating ContactManager with Guidewire Core Applications” on page 45 in the *Contact Management Guide*.
- **Document Production System and Document Storage System** – ClaimCenter creates and manages claim-associated documents. These documents can be online documents existing in or created in ClaimCenter as well as hard copy, printed documents stored in a file cabinet. It is common to integrate your document management system with ClaimCenter to store electronic versions of your claim-associated documents. See “Document Management” on page 525 for details.
- **Metropolitan Reporting Bureau** – A nationwide police accident and incident reports service in the United States. Many insurance carriers use this system to obtain police accident and incident reports, which can improve record-keeping and reduce fraud. ClaimCenter built-in support for this service makes it easier to deploy Metropolitan Reporting Bureau integration projects. See “Metropolitan Reports Overview” on

page 533 for details.

- **General Ledger, Check Processing System, and Financial Institution** – ClaimCenter passes financial information to downstream systems for tasks such as check processing. See “Claim Financials” on page 287 for more information.
- **ISO** – In the United States, ClaimCenter integrates with ISO, formerly known as the Insurance Services Office. ISO provides a service called ClaimSearch that helps detect duplicate and fraudulent insurance claims. After a claim is created, the carrier can send details to the ISO ClaimSearch service and subsequently get reports of potentially similar claims from other companies. See “ISO and Claims” on page 539 for details.
- **Geocoding Service** – The Geocoding service works with Microsoft Bing Maps Geocode Service to geocode contacts. One use is to help users find services within a given location. See “Using the Geocoding Feature” on page 19 in the *System Administration Guide* for details.

Policy Administration System Integration

In the base configuration, ClaimCenter provides integration points to use for a functional integration with Guidewire PolicyCenter. You can also integrate ClaimCenter with the policy system of your choice. This topic describes how ClaimCenter integrates with a policy system in general and with PolicyCenter in particular.

This topic includes:

- “Policy Administration System Integration Overview” on page 509
- “Retrieving a Policy in ClaimCenter” on page 510
- “Viewing Policies in a Policy Administration System (PAS)” on page 510
- “Large Loss Notifications” on page 511
- “Permissions for Working with Policies” on page 513
- “Coverage Term Mapping Between ClaimCenter and PolicyCenter” on page 513

See also

- “Enabling Integration between ClaimCenter and PolicyCenter” on page 97 in the *Installation Guide*
- “Claim and Policy Integration” on page 511 in the *Integration Guide*

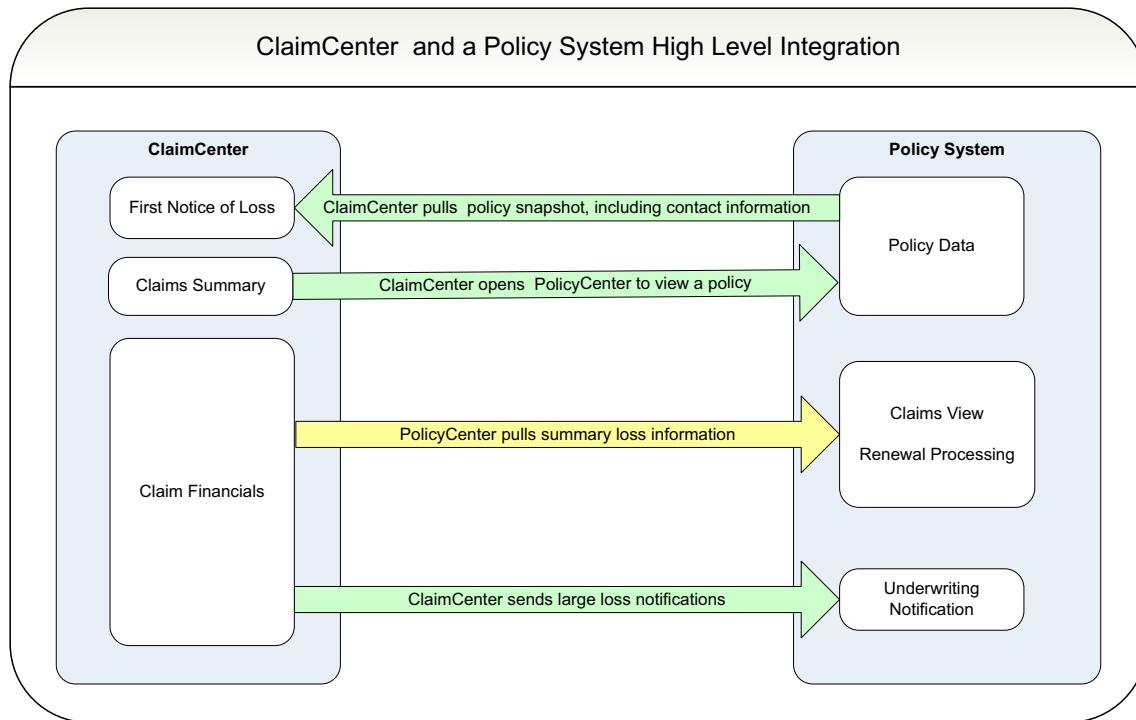
Policy Administration System Integration Overview

In the ClaimCenter base configuration, you can do the following:

- **Retrieve a policy snapshot in the process of gathering claim information** – It is necessary for ClaimCenter to have a verified policy to ultimately be able pay on a claim. For example, in the **New Claim** wizard when starting a new claim, you must either find a policy or generate an unverified policy.
- **View a policy in PolicyCenter** – The integration opens an instance of PolicyCenter or any policy administration system that has a web interface.

- **ClaimCenter sends large loss notifications to PolicyCenter** – Sending notifications to the policy's underwriter helps in determining risk and ultimately granting a policy renewal.

The following diagram shows the integration between ClaimCenter and a policy administration system at a high level.



See also

- For information about the parts of the integration that originate in PolicyCenter, see the *PolicyCenter Application Guide* topic “Claim System Integration”.

Retrieving a Policy in ClaimCenter

In the base configuration, ClaimCenter defines a plugin interface called `IPolicySearchAdapter`. The default implementation of this plugin, `PolicySearchPCPlugin`, pulls policies from a policy administration system into ClaimCenter.

See also

- For information on how to do the integration, see “Enabling Integration between ClaimCenter and PolicyCenter” on page 97 in the *Installation Guide*.
- For information on the plugin, see “Policy Search Plugin” on page 517 in the *Integration Guide*.

Viewing Policies in a Policy Administration System (PAS)

If enabled, from the **Policy** screen you can open a web browser window of the policy administration system. This policy administration system can be Guidewire PolicyCenter or another system if it has a web interface.

The following instructions apply to installations that contain integrated versions of Guidewire ClaimCenter and Guidewire PolicyCenter.

Viewing a Policy in PolicyCenter

The ClaimCenter Policy screen has a **View Policy in Policy System** button. This button appears if the PolicyCenter integration is enabled and you have the permissions to view policies in the system. You must also have set the `PolicySystemURL` configuration parameter in `config.xml` to the URL for the policy system.

The button opens PolicyCenter in a web browser window. You must have a user account in PolicyCenter to use this functionality. If you are not logged in, the login screen appears. If you are logged in, PolicyCenter displays the policy. If you have single sign-on, PolicyCenter opens directly with the policy summary screen.

To view a policy in PolicyCenter

1. Open a claim and then click the **Policy** menu link in the sidebar.

ClaimCenter opens the **Policy: General** screen.

2. Click **View Policy in Policy System**.

A new instance of PolicyCenter opens. You must log into it. If the policy system finds the policy, it shows the information. If it does not find the policy, you can search for it in PolicyCenter.

3. Click the policy link.

PolicyCenter opens the **Policy Summary** screen, in which you can view the policy information.

Note: Based on your business requirements, you can integrate ClaimCenter with several policy administration systems. These integrations are seamless in the user interface.

Large Loss Notifications

Sometimes a claim has a large loss associated with it. You determine the large loss amount based on your business practices. The amount can vary depending on the line of business, or policy type. For example, a personal auto large loss notification might have a lesser amount than a large loss notification for a homeowners policy. Large loss information is critical to an underwriter who uses that information in determining risk and ultimately granting a renewal policy. ClaimCenter can send large loss information to a policy administration system if the two systems are integrated.

Policy System Notification Framework

Guidewire supplies a policy system notification framework that enables ClaimCenter to send messages to policy administration systems, including Guidewire PolicyCenter. Large loss notifications use this framework. Notifications are created as events, which generate messages in the Guidewire messaging system. A messaging transport then delivers the messages to the policy system.

In the base configuration, ClaimCenter does not send large loss notifications to the policy system. To configure this integration, see “Enabling Large Loss Notification Integration” on page 99 in the *Installation Guide*.

See also

- “Policy System Notifications” on page 512 in the *Integration Guide*.

Administering Large Loss Notifications

You define and map threshold amounts by using the **Large Loss Threshold** card. Navigate to **Administration** → **Business Settings** → **Metrics & Thresholds** → **Large Loss Threshold** to see that card, shown in the following figure:

To edit the threshold levels for large losses

1. Log in to ClaimCenter as an administrator.
2. Click the **Administration** tab.
3. In the sidebar, click **Business Settings** → **Metrics & Thresholds**.
4. Click the **Large Loss Threshold** card.
5. From the **Policy Type** drop-down list, select the policy type for which you want to set the threshold amount.
6. Click the **Edit** button.
7. Edit the value in the **Large Loss Indicator** field.
8. Click **Update**.
9. If you want to change additional thresholds, select another policy type and repeat these steps.

You must configure one threshold per line of business (policy type). The following table lists the ClaimCenter policy type defaults and the corresponding PolicyCenter base configuration line of business, if any.

ClaimCenter Policy Type	PolicyCenter Line of Business	Default Large Loss Total Reserve Threshold in US Dollars
Businessowners	Businessowners	25,000
Commercial auto	Commercial Auto	50,000
Commercial package	Commercial Package	no default
Commercial property	Commercial Property	100,000
Farmowners	not applicable	10,000
General liability	General Liability	50,000
Homeowners	not applicable	10,000
Inland marine	Inland Marine	25,000
Personal auto	Personal Auto	20,000
Personal travel	not applicable	no default
Professional liability	not applicable	100,000
Workers' compensation	Workers' Compensation	50,000

In the base configuration, ClaimCenter maps the workers' compensation and personal auto lines of business to their equivalent PolicyCenter lines of business for policy search and large losses.

See also

- “Policy System Notifications” on page 512 in the *Integration Guide*

Permissions for Working with Policies

There are two permissions that allow the user to view policies in PolicyCenter:

- **View claim Policy page** – This permission controls the policy screens in ClaimCenter. The code for this permission is `viewpolicy`.
- **View policy system** – You can select the **View Policy** button in the user interface, which opens PolicyCenter so you can view a policy. The code for this permission is `viewpolicysystem`.

Coverage Term Mapping Between ClaimCenter and PolicyCenter

A coverage term is a value that specifies the extent, degree, or attribute of a coverage. Using a coverage term, you can:

- Specify the limits or deductibles of a coverage
- Specify the scope of a coverage
- Specify a selection or an exclusion that is specific to a particular coverage

A coverage can have zero, one, or many coverage terms.

In the base configuration, ClaimCenter provides a `CovTerm` entity, along with multiple `CovTerm` subtypes, all of which end in `CovTerm`. You use these coverage terms to map to the equivalent coverage terms in the policy administration system.

The following table lists the ClaimCenter coverage term entities.

Entity	Important fields	Description
<code>CovTerm</code>	<ul style="list-style-type: none">• <code>PolicySystemId</code>• <code>Coverage</code>• <code>CovTermPattern</code>• <code>ModelAggregation</code>• <code>ModelRestriction</code>• <code>CovTermOrder</code>	<p>Specifies the extent, degree, or attribute of a coverage. As the supertype, fields on the <code>CovTerm</code> entity are common to all its subtypes:</p> <ul style="list-style-type: none">• <code>PolicySystemID</code> – The identifier for the coverage term in an external policy system• <code>Coverage</code> – Foreign key to the coverage to which the coverage term belongs.• <code>CovTermPattern</code> – Typekey to the <code>CovTermPattern</code> typelist.• <code>ModelAggregation</code> – Typekey to the <code>CovTermModelAgg</code> typelist. This value indicates that the <code>CovTerm</code> applies to a subset or a subtype of the coverage.• <code>ModelRestriction</code> – Typekey to the <code>CovTermModelRest</code> typelist. This value indicates to what level of an event the <code>CovTerm</code> applies, for example, to a single claimant or to a single accident.• <code>CovTermOrder</code> – Provides a way to place the coverage terms in a particular order. This field is set in Guidewire PolicyCenter. Its primary purpose is to sort data in the user interface.
<code>ClassificationCovTerm</code>	<ul style="list-style-type: none">• <code>Code</code>• <code>Description</code>	<p>Specifies a class code. Policy systems often use classification codes to segment or categorize a large set of items. For example, there are jurisdictional class codes that divide a geographical region into smaller areas, each with a specific code. There are also medical class codes that assign every conceivable medical condition a specific code.</p> <p>IMPORTANT The <code>Code</code> field on a Classification coverage term must map to a valid classification code in PolicyCenter.</p>

Entity	Important fields	Description
FinancialCovTerm	• FinancialAmount	Specifies a non-negative currency amount.
NumericCovTerm	• NumericValue • Units	Specifies a decimal value, along with its units. The CovTermMode1Val typelist populates the drop-down list for the Units field.

You enter coverage and coverage term information in ClaimCenter in the **Policy** screen. To access this screen, open a specific claim, and then choose **Policy** from the sidebar menu on the left. After you choose a policy, you can add coverage terms to that coverage, if any are available.

See also

- “Adding Coverages to a Policy” on page 98

TypeList Mapping

ClaimCenter uses the following typelists in working with coverage terms. Most of these typelists exist in PolicyCenter as well. If you make a change to a typelist that is common to both ClaimCenter and PolicyCenter, you must duplicate that work in both applications.

TypeList	PolicyCenter	Comments
CovTermMode1Agg	Yes	Used to populate the Per field drop-down list of the Coverage Term screen.
CovTermMode1Rest	Yes	Used to populate the Applicable To field drop-down list of the Coverage Term screen.
CovTermMode1Val	Yes	Used to populate the Units field drop-down list on a Numeric type Coverage Term screen.
CovTermPattern	No	Used to populate the Subject field drop-down list of the Coverage Term screen.

ClaimCenter Contacts

Contacts are external people, companies, or locations that you connect with a claim. A contact can be the insured party, the reporting party, a witness, attorney, doctor, repair shop, legal venue, and so on. The people who process the claim, such as claims adjusters, are not contacts. They are *users*, and are typically employees of the insurance company.

In ClaimCenter, you define and maintain contacts at the claim level. For example, you can define contacts in the **New Claim** wizard when processing a new claim or in the **Parties Involved → Contacts** screen for an existing claim. In these screens, you can view contacts and their data, like address, phone number, and so on. You can also create new contacts for the claim, edit existing contacts, and delete them.

If ClaimCenter is not integrated with a contact management system, contacts stored with one claim have no connection to contacts stored with another claim. Additionally, you cannot search for contacts in the Address Book. For example, you can add a new witness, Samantha Andrews, separately to two claims. The contact information for Samantha Andrews is stored separately with each claim and does not have to be the same. If an adjuster changes the address for Samantha Andrews in one of the claims, the updated address is stored only with that claim. The address for the Samantha Andrews contact in the other claim is not updated.

If ClaimCenter is integrated with a contact management system, like ContactManager, you have the option of storing contacts in the contact management system and maintaining them centrally. Contacts stored in the contact management system can be added to claims, and they are then stored with claims, as are any claim contacts. However, ClaimCenter tracks claim contacts that are stored in the contact management system and keeps their data in sync. For example, Samantha Andrews is a contact in the contact management system. You add her as an existing contact, a contact retrieved from the contact management system, to two separate claims. The two copies of the contact, one stored with each claim, are kept in sync by ClaimCenter.

This topic includes:

- “Types of Contacts” on page 516
- “ContactManager Integration” on page 519
- “Working with Contacts in ClaimCenter and ContactManager” on page 519

Types of Contacts

Contacts have a data model, a set of tags, and a set of services that can be associated with contacts in ContactManager, all of which define the contact. Contact tags define two major types of contacts, client contacts and vendor contacts. In ClaimCenter, a contact can be a third type of contact, also defined by a tag, a claim party.

- **Vendor Contact** – A person or company that provides services for claims. In ClaimCenter, a vendor contact can be a person like a doctor or attorney. Additionally, a vendor contact can be a company, such as a repair shop, a bank, or a hospital. A vendor can also be a client and a claim party. See “Vendor Data Management” on page 35 in the *Contact Management Guide*.
- **Claim Party** – A person or company who has been added to a claim. For example, a witness can be just a claim party and nothing else. A vendor is often both a vendor and a claim party, because vendors are added to claims to provide services for the claim. A client, such as the insured party on a claim, can be both a claim party and a client contact.
- **Client Contact** – A person or company that is a customer of a carrier, such as the owner of a policy. A client can be both a vendor and a client. For example, a doctor who has a policy with the carrier also provides medical services on claims. Client contact access requires that you license Client Data Management. See “Client Data Management” on page 33 in the *Contact Management Guide*.

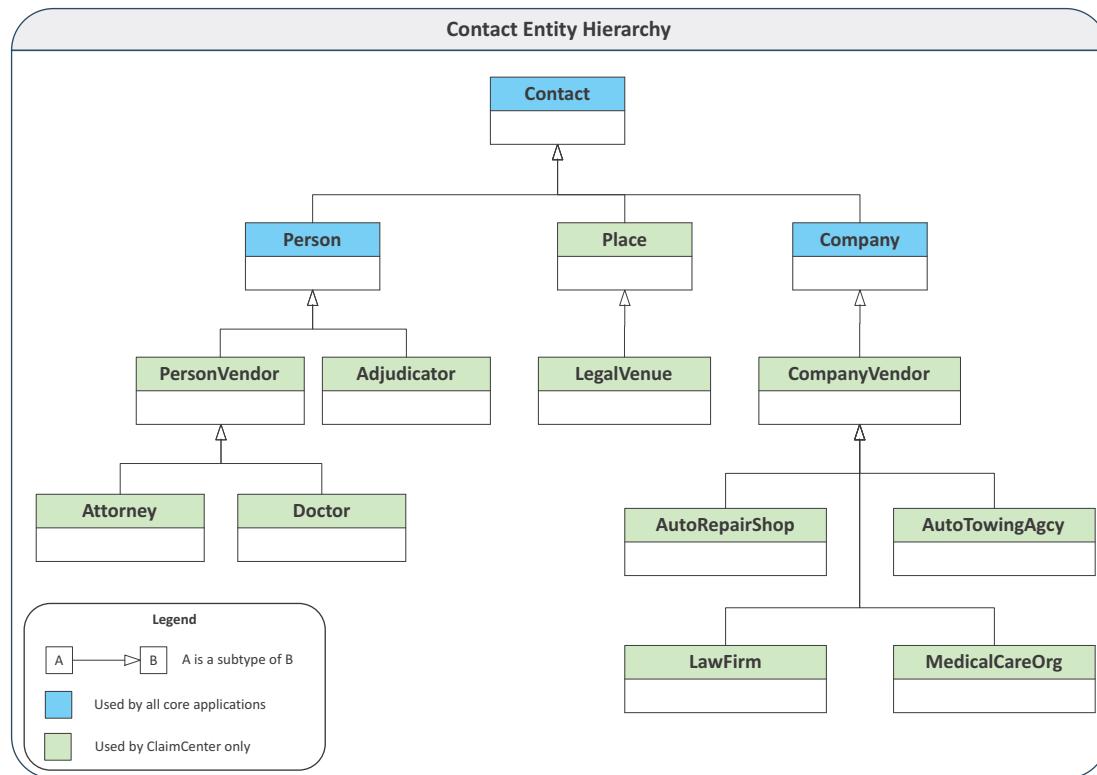
A **Contact** is the ClaimCenter data model entity used in both client and vendor data management. In the base configuration, this entity is the core application equivalent of the ContactManager entity ABContact, described in “ABContact Data Model” on page 134 in the *Contact Management Guide*.

The **Contact** entity has subtypes for various types of contacts, like **Person**, **Company**, and **Place**.

In ClaimCenter, these subtypes have additional subtypes, like **Adjudicator**, **CompanyVendor**, **LegalVenue**, and so on. The following figure shows the **Contact** entity hierarchy. This entity hierarchy has a parallel in the ABContact entity hierarchy in ContactManager. See “Guidewire Core Application and ContactManager Contact

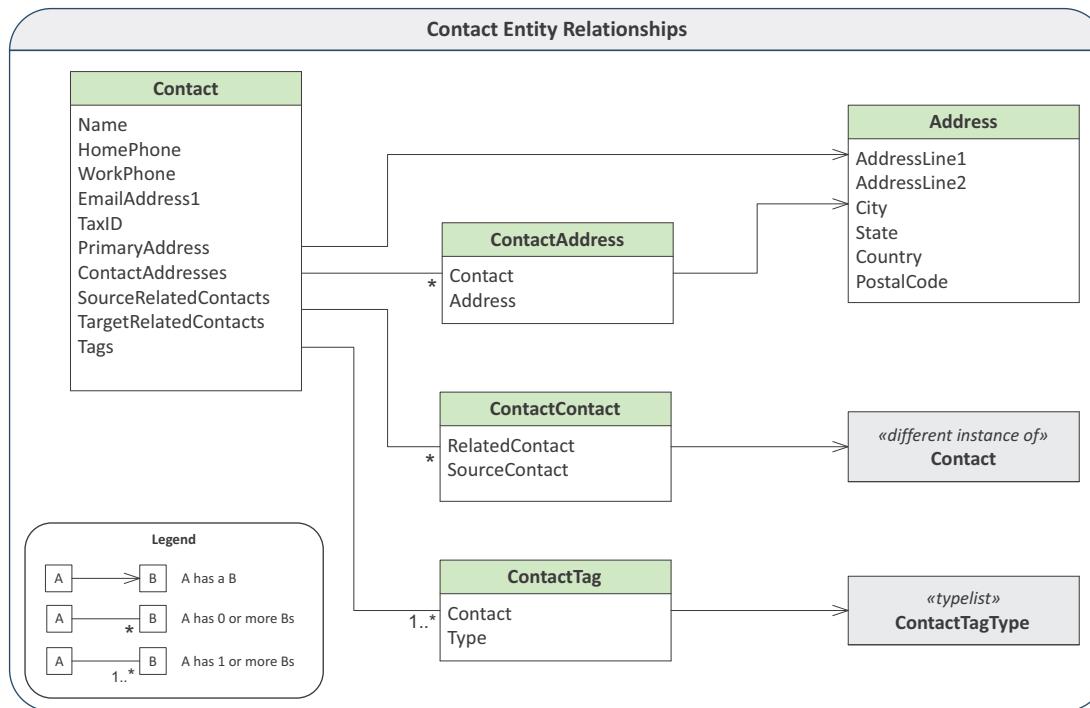
Entity Hierarchy” on page 137 in the *Contact Management Guide*.

Note: The following figure does not include the Contact subtype UserContact. This entity is used by the User entity, which represents a user of the application, such as a claims adjuster. The User entity has a foreign key to UserContact so it can store data like the user’s address and phone number. However, UserContact entities are not intended to be used as either vendor contacts or client contacts, and in the base configuration they cannot be stored in ContactManager.



The Contact entity is associated with other entities as well. A contact can have multiple addresses, related contacts, and tags. A Contact entity that is stored in ContactManager must have at least one tag. Except for the

primary address, references to those entities are handled with arrays of join entities. For example, there is `ContactAddress` for addresses and `ContactContact` for related contacts, as shown in the following figure:



The mailing address of a `Contact` is stored in the `Address` entity. A `Contact` can reference a primary address and, through the `ContactAddress` entity, other secondary addresses.

Contacts can have relationships with other contacts. For example, a `Person` might be employed by a particular `Company`. The `ContactContact` entity maintains data about the relationships a contact can have with other contacts.

Note: For simplicity, the diagram shows `ContactContact` connecting to a different instance of `Contact`. However, `ContactContact` can also point back to the original contact. For example, you can be your own primary contact.

Contacts can have tags, like Client and Vendor. A `Contact` entity references its tags by using the `ContactTag` entity.

A contact that has the Vendor tag can provide specialist services, like carpentry or independent appraisal. The relationship between a contact and its services is maintained by `ContactManager`, which is why there is no `Contact` property accessing services in the entity relationship model.

See also

- “`ContactManager Integration`” on page 519
- “`Working with Contacts in ClaimCenter and ContactManager`” on page 519
- “`Contact Tags`” on page 177 in the *Contact Management Guide*
- “`Services`” on page 375
- “`Vendor Services`” on page 181 in the *Contact Management Guide*

ContactManager Integration

ContactManager is a Guidewire application that serves as a central address book—a contact management system—for ClaimCenter and the other Guidewire core applications. Most aspects of using ClaimCenter with ContactManager are covered in the *Guidewire Contact Management Guide*.

There are several reasons for having a separate contact management application:

- Sharing contact information with other applications, like PolicyCenter and BillingCenter
- Using a common administrative interface for creating, editing, deleting, and resolving duplicate address book contacts
- Managing data for a contact across all claims

Before you can work with ContactManager, you must install it as described at “Installing ContactManager” on page 39 in the *Contact Management Guide*.

You can set up ClaimCenter and ContactManager to work together as described at “Integrating ContactManager with Guidewire Core Applications” on page 45 in the *Contact Management Guide*.

See also

- “Types of Contacts” on page 516
- “Working with Contacts in ClaimCenter and ContactManager” on page 519

Working with Contacts in ClaimCenter and ContactManager

After you set up ClaimCenter and ContactManager to work together and then start both applications, you can work directly in ClaimCenter with contacts stored in ContactManager. These contacts are called *linked contacts*. For example, you can use the **Address Book** tab to search for contacts stored in ContactManager. You can open the **Address Book Search** screen by clicking the **Address Book** tab. This screen also opens when you choose in a claim to add an existing contact, such as in the **Parties Involved** → **Contacts** screen.

Note: To search in ClaimCenter for contacts stored in ContactManager and see the results, log in as a user with a role that has `abviewsearch`, `abview`, and `anytagview` permissions. See “ClaimCenter Contact Subtype and Tag Permissions” on page 123 in the *Contact Management Guide*.

You cannot create or edit contacts in the **Address Book** tab. However, you can open ContactManager for that purpose from the **Address Book Search** screen by clicking either the **Open ContactManager** button or the **Edit in ContactManager** button. If you are not already running ContactManager, you must log in when ContactManager opens. To log in, you need a ContactManager user name with a role that has the permissions to work with contacts.

You can also create and edit ContactManager contacts associated with claims by using the **New Claim** wizard or the **Parties Involved** → **Contacts** screen of an open claim. See “Contacts Screen” on page 36.

Note: To be able to create, edit, and delete local-only, unlinked contacts in ClaimCenter, your role must include the following permissions: `anytagedit`, `ctccreate`, `ctcedit`, and `ctcview`.

This topic includes:

- “Pending Changes” on page 520
- “Contact Permissions and Contacts” on page 522
- “Changing the Subtype of a Contact” on page 524

See also

- “Types of Contacts” on page 516
- “ContactManager Integration” on page 519

- “Working Directly in ContactManager” on page 237 in the *Contact Management Guide*.
- “Extending the Contact Data Model” on page 133 in the *Contact Management Guide*.

Pending Changes

Changes made in ClaimCenter to linked vendor contacts can be sent to ContactManager as pending changes, which require approval in ContactManager.

How ClaimCenter handles creating and editing vendor contacts depends on the permissions of the user making the changes. If a user does not have permission to create a new vendor contact or edit a vendor contact, ClaimCenter sends the create or update to ContactManager as a pending change. If the user does have the needed permissions, the changes are simply sent to ContactManager, where they take effect. For information on these permissions, see “Contact Permissions and Contacts” on page 522.

In the base configuration, pending changes are created only when a user with insufficient permissions is working with vendor contacts. The changes remain pending until a ContactManager user logs in to ContactManager and reviews the pending changes. The reviewer either approves or rejects the pending contact creates and updates.

- If a pending change is approved, the contact becomes linked and in sync, meaning that the data for the contact in ClaimCenter and in ContactManager is the same.
- If a pending change is not approved, the behavior depends on the type of change. A pending change can be a pending create of a new vendor contact or a pending update of an existing vendor contact.
 - **Pending create** – When a pending create is rejected, ContactManager retires the pending contact object and notifies ClaimCenter. ClaimCenter updates the status of the contact as a broken link and creates a Pending Create Rejected activity for the user that created the vendor contact.
 - **Pending update** – When a pending update is rejected, ContactManager discards the pending updated data and notifies ClaimCenter of the rejected update. ClaimCenter overwrites the data for the contact with the existing data from ContactManager, making the contact in sync again. Additionally, ClaimCenter creates a Pending Update Rejected activity for the user who made the update and associates a note with the activity that retains the rejected change data.

Note

This ClaimCenter behavior with vendor contacts is defined in the Gosu class `gw.plugin.contact.ab800.ContactSystemApprovalUtil`. You can edit this class and change how ClaimCenter determines the following:

- If a contact created in ClaimCenter will be created in ContactManager
- If a contact created or updated in ClaimCenter will be applied immediately, or if it requires approval in ContactManager before being applied

Pending Create Example

1. A user with the Clerical role opens a claim and navigates to **Parties Involved** → **Contacts**.

Note: The Clerical role does not have permissions that allow creating or editing a linked vendor contact.

2. On the **Contacts** screen, the user creates a new vendor contact. The vendor contact has the minimum required data, including a name and a tax ID.

3. The ClaimCenter user re-selects the new vendor contact to refresh the **Basics** card for that contact.

After the pending contact creation request is sent to ContactManager and a return message comes back, the **Basics** card displays the following message:

The contact is linked to the Address Book and is in sync but the remote contact is pending approval.

4. A user who can review pending changes logs in to ContactManager and rejects the pending create.

The ContactManager user indicates on the rejection notice that more information is needed on the contact. Additionally, the user specifies in the note for the rejection why the create was rejected and what needs to be done to correct it.

5. After ClaimCenter gets the message from ContactManager that the pending create was not approved and the user refreshes the contact screen, the **Basics** card shows the following message:
This contact has been removed in ContactManager
6. The user then navigates to **Desktop tab → Activities** and chooses the **All open** filter to see if there is more information on the rejected contact.
The **Activity Detail** worksheet indicates that more information is needed on the contact.
7. The user edits the contact and adds more information to the contact.
8. After saving the contact change, the user clicks **Relink** in the **Basics** card.
9. After the pending contact creation request is sent to ContactManager and a return message comes back, the ClaimCenter user refreshes the contact. The **Basics** card displays the following message:
The contact is linked to the Address Book and is in sync but the remote contact is pending approval.
10. A user who can review pending changes logs in to ContactManager and approves the pending create.
11. In ClaimCenter, the user refreshes the **Contacts** screen and selects the vendor contact. The **Basics** card now shows the following message:
The contact is linked to the Address Book and is in sync

Pending Update Example

1. A user with the Clerical role opens a claim and navigates to **Parties Involved → Contacts**.
Note: The Clerical role does not have permissions that allow creating or editing a linked vendor contact.
2. On the **Contacts** screen, the user edits an existing, linked vendor contact that is in sync.
3. The user clicks **Update** to save the contact, and the **Basics** card shows the contact status as:
The contact is linked to the Address Book but is out of sync
This message appears because ClaimCenter has not yet received notification from ContactManager that the pending update was received.
4. The user clicks another contact and then clicks the edited one to refresh the message on the **Basics** card.
The pending contact creation request has been sent to ContactManager and has been acknowledged, so the **Basics** card displays the following message:
The contact is linked to the Address Book and is in sync but the remote contact has pending updates.
5. A user who can review pending changes logs in to ContactManager and rejects the pending update.
The ContactManager user indicates on the rejection notice that more information is needed on the contact. Additionally, the user specifies in the note for the rejection why the update was rejected and what needs to be done to correct it.
6. After ClaimCenter gets the message from ContactManager that the pending update was not approved, the user refreshes the contact screen.
The **Basics** card shows the following message:
This contact is linked to the Address Book and is in sync
This message appears because the update has been discarded and the contact data has been overwritten with the current data in ContactManager.
7. The ClaimCenter user navigates to **Desktop tab → Activities** and chooses the **All open** filter to see if there is an activity providing more information on the rejected update.

The **Activity Detail** worksheet for the rejected update indicates that more information is needed on the contact and specifies what information was incorrect.

8. The ClaimCenter user clicks **View Notes** on the **Activity Detail** worksheet. The note shows the original data that the user entered for the contact.
9. The ClaimCenter user edits the contact and corrects the information for the contact.
10. The user clicks **Update** to save the contact, and the **Basics** card shows the contact status as:
The contact is linked to the Address Book but is out of sync
This message appears because ClaimCenter has not yet received notification from ContactManager that the pending update was received.
11. The user clicks another contact and then clicks the edited one to refresh the message on the **Basics** card.
After the pending contact creation request is sent to ContactManager and a return message comes back, the **Basics** card displays the following message:
The contact is linked to the Address Book but is out of sync and the remote contact has pending updates.
12. A user who can review pending changes logs in to ContactManager and approves the pending update.
13. In ClaimCenter, the user refreshes the **Contacts** screen and selects the vendor contact. The **Basics** card now shows the following message:
The contact is linked to the Address Book and is in sync

See also

- “Reviewing Pending Changes to Contacts” on page 252 in the *Contact Management Guide*.

Contact Permissions and Contacts

ClaimCenter contact and tag permissions are described in “ClaimCenter Contact Subtype and Tag Permissions” on page 123 in the *Contact Management Guide*. These contact permissions permit a user to make changes to contacts, with varying effects.

Following are some examples of actions you can perform with various groups of permissions.

Permissions required to save contacts locally only in ClaimCenter

In the base configuration, to be able to work with contacts stored only in ClaimCenter with claims, and not in ContactManager, you must have at least the following permissions:

Code	Enables a User to
anytagview	See a contact that has any contact tag.
ctccreate	Create a new, local contact.
ctcedit	Edit local contacts.
ctcview	View and search local contacts.

Permissions required to view ContactManager contacts in ClaimCenter, save locally, and make pending changes and creates in ContactManager

In the base configuration, to be able to view, create, and edit contacts stored in ContactManager, you must have at least the following permissions. In the base configuration, these permissions are in the role Clerical. These permissions enable you to save pending creates and updates to vendor contacts in ContactManager.

Code	Enables a User to
abview	View the details of contact entries retrieved from ContactManager.
abviewsearch	Search for contact entries in ContactManager.

anytagview	See a contact that has any contact tag.
ctccreate	Create a new, local contact.
ctcedit	Edit local contacts.
ctcview	View and search local contacts.

For example, with these permissions, you can do the following:

- Create or edit a contact that is stored only locally, an unlinked contact.
- Create or edit a non-vendor contact that is stored in ContactManager and have your changes saved in ContactManager.
- Create or edit a vendor contact that is stored in ContactManager and have your changes saved as pending creates or pending updates in ContactManager. Pending changes must be reviewed and either approved or rejected by a ContactManager user. See “Reviewing Pending Changes to Contacts” on page 252 in the *Contact Management Guide*.

Permissions required to view ContactManager contacts in ClaimCenter, save locally, and save changes in ContactManager

In the base configuration, the following permissions give you all the capabilities described in the previous topic. Additionally, you can create and edit vendor contacts and have your changes saved in ContactManager without requiring approval. Unless you have preferred vendors defined in your system, these permissions give you everything you need to work with contacts.

Note: If you are working in ClaimCenter, you cannot delete a contact in ContactManager. You can remove a contact from a claim, but that removal does not delete the contact stored in ContactManager. You must log in to ContactManager to delete contacts.

Code	Enables a User to
abcreate	Create a new vendor contact in ContactManager. In the base configuration, this permission enables a ClaimCenter user to create a vendor contact and have it saved in ContactManager. Without this permission, a ClaimCenter user can create and save non-vendor contacts in ContactManager. Any vendor contacts created by a user without this permission are created in ContactManager with pending status and must be approved by a ContactManager user.
abedit	Edit an existing vendor contact stored in ContactManager. In the base configuration, this permission enables a ClaimCenter user to edit a vendor contact and have it saved in ContactManager. Without this permission, a ClaimCenter user can edit and save non-vendor contacts in ContactManager. Any vendor contact changes by a user without this permission become pending changes in ContactManager and must be approved by a ContactManager user.
abview	View the details of contact entries retrieved from ContactManager.
abviewsearch	Search for contact entries in ContactManager.
anytagview	See a contact that has any contact tag.
anytagcreate	Create a new contact regardless of which contact tag it requires.
anytagedit	Edit a contact that has any contact tag.
ctccreate	Create a new, local contact.
ctcedit	Edit local contacts.
ctcview	View and search local contacts.

Changing the Subtype of a Contact

If you have a contact that has the wrong subtype, you can change the contact's subtype under certain conditions by using a command-line tool. See “Changing the Subtype of a Contact Instance” on page 172 in the *Contact Management Guide*.

Document Management

ClaimCenter creates and manages claim-associated documents. These documents can either be online—existing in or created in ClaimCenter—or printed documents. For example, you can write and send the insured a letter to acknowledge the claim, or the claimant can email you a map of the loss location. There can also be a copy of a written police report. Use ClaimCenter to manage all these varieties of documents.

Use the Document feature in ClaimCenter to:

- Create new documents from templates.
- Have another user approve a document you wrote before it is sent.
- Store documents, both those you create and those received from other sources.
- Search for documents associated with a claim, and categorize them to simplify the searches.
- Link to external documents.
- Indicate the existence of hardcopy, printed documents.
- Remove documents.
- Associate a document with a single claim, exposure or matter.
- Associate the creation of a document with an activity.
- Create and send a document to perform a task for an activity.
- Create and send a document from rules or workflows.
- Extend these default capabilities by integrating to an external document management system (DMS).

By default, ClaimCenter stores documents as files in your local file system. You manage these files with directory and file commands. You can also integrate documents with an external document management system. For more information, see “Configuring Document Management” on page 530.

Note: All documents must either be ASCII or use the UTF-8 character set.

This topic includes:

- “Document Security” on page 526
- “Working with Documents” on page 527
- “Configuring Document Management” on page 530

- “Document Management Integration” on page 531

See also

- “Localizing Templates” on page 57 in the *Globalization Guide*
- “Document Creation” on page 145 in the *Rules Guide*
- “Document Management” on page 199 in the *Integration Guide*

Document Security

ClaimCenter provides a set of system permissions to provide security for all documents as seen in the following table. You can also use these permissions to define different security types for documents and assign permissions to users that relate to these security types.

Note: See “Access Control for Documents and Notes” on page 456 for more information.

Permissions Related to Documents

The following system permissions provide security for documents.

Name	Purpose of permission	Also needed
viewdocs	See the Claim Documents page.	-
doccreate	Add documents to a claim.	-
docdelete	Remove documents from any claim.	-
docedit	Edit documents.	-
doccreateclsd	Add documents to a closed claim.	doccreate
docdeleteclsd	Remove documents from a closed claim.	docdelete
docmodifyall	Modify any document, regardless of security type (ACL).	-
docview	View the documents on a claim.	viewdocs
docviewall	View any document, regardless of its security type (ACL).	-

Hidden Documents

Hiding documents is a way to remove obsolete documents from your list of documents without deleting them. When you hide a document, you no longer see it listed in the **Documents** screen unless you indicate that want to see hidden documents.

You can hide a document in a number of ways:

- With a claim open, click **Documents** in the left sidebar, select a listed document, and click **Hide Document**.
- In the **Documents** screen, click a document name to open its **Document Details** screen, click **Edit**, and then set **Hidden** to Yes.

Hiding a document in either of these ways sets the **Obsolete** flag on the **Document** entity and does not retire the document in the database. You can view hidden documents by setting **Include Hidden Documents** to Yes on the **Documents** screen.

Hiding a document is not the same as deleting it. The **docdelete** permission is necessary to fully delete documents. Only users who have that permission can delete. Since document deletion is at least semi-permanent, you can delete only one document at a time through the user interface.

Working with Documents

This topic describes the various ways you can work with documents and includes:

- “Viewing Claim Documents” on page 527
- “Searching for Documents” on page 527
- “Adding a New Document” on page 528
- “Linking to an Existing Document” on page 528
- “Creating a New Document” on page 528
- “Indicating the Existence of a Hard-copy Document” on page 528
- “Editing a Document” on page 529
- “Removing a Document” on page 529
- “Using an Activity to Create a Document” on page 529
- “Creating a Document with a Rule or in a Workflow” on page 529
- “Relating a Document to a ClaimCenter Entity” on page 529
- “Linking a Document to Another Entity” on page 529
- “Creating a Document Template” on page 530

You can perform any of these actions on existing documents from any claim screen, or from the New Claim wizard, by selecting the **Documents** link in the left sidebar. To work with a new document, select any of the **New Document** menu choices from the **Actions** menu while in any claim screen.

Viewing Claim Documents

The **Documents** screen shows the documents for a claim. To open this screen, click the **Documents** link, located on the left sidebar of all claim and New Claim wizard screens.

The bottom of the **Documents** screen initially contains the unfiltered list of all documents related to the claim. Use the search pane at the top of the screen to filter the list of documents.

You can view all documents for which you have permission. Click any document name to view its details.

The **RestrictSearchesToPermittedItems** search parameter in the **config.xml** file determines whether you can see a document in the list that you do not have permission to view.

Searching for Documents

Use the **Search** pane of the **Documents** screen to search for documents. This pane includes the search attributes that follow. You can use the following search parameter values for a document after you create the document or link to it:

- **Related To** – A document created in an exposure, activity or matter is related to that entity. This filter finds only documents related to a specific exposure, activity, or matter. A document can be related to just one entity.
- **Section** – The part or section of a document, from the **DocumentSection** typelist.
- **Name or Identifier** – Especially useful for locating hard-copy documents.
- **Status** – From the **DocumentStatusType** typelist. Status can be set in the user interface, but its main use is to track the approval process of a document in rules.
- **Author** – Can be the name of the creator or sender, or can have any other value.
- **Include Hidden Documents** – Whether to include documents that have been hidden in the search. See “**Hidden Documents**” on page 526.

See also

- “Configuring ClaimCenter Database Search” on page 348 in the *Configuration Guide*

Adding a New Document

Navigate to the **New Document** section of the **Actions** menu while in any claim screen to see the following choices for adding documents to the current claim:

- **Create from template** – See “Creating a New Document” on page 528.
- **Attach an existing document** – See “Linking to an Existing Document” on page 528.
- **Indicate existence of a document** – See “Indicating the Existence of a Hard-copy Document” on page 528.

Linking to an Existing Document

1. Select **Actions** → **New Document** → **Attach an existing document**.
2. Browse to the location of your document.
3. Click **Update** to create the link.

Creating a New Document

1. Select **Actions** → **New Document** → **Create from template**.
2. In the **New Document** panel, select the template to use. Initially, leave the field empty and click the **Select Template** search icon. You cannot create a document without specifying an existing template.
After clicking the search icon, a second screen opens, enabling you to search for document templates as follows:
 - a. The pane displays a list of document templates at the bottom. Find the one you want and click **Select**.
 - b. If there are too many to choose from, limit the list by using the search pane.

For example, choose a document type from the **Type** picker and click **Search**. The list of document templates displays again with a list showing only that document type. After you find your choice, click **Select**.

After you select a template, ClaimCenter displays numbered steps along the left side of the screen.

Note: The base configuration Sample Acrobat document, `SampleAcrobat.pdf`, uses Helvetica font. If you intend to create a document that uses Unicode characters, such as one that uses an East Asian language, the document template must support a Unicode font. Otherwise, the document does not display Unicode characters correctly.

3. Follow the steps on the screen. You can also add additional criteria from the right side of the screen.
The file attributes, used by your document management system, need not be the same as the comparable object values that appear in the document.
The document appears in its native editor. If you edit the document, remember to save it.
4. Click **Update** to save your work.

After you create the document, you can take additional steps, such as sending this document as an email attachment. You can also print it and send it through the mail. Additionally, you can use any features provided by your document management system.

Indicating the Existence of a Hard-copy Document

If you keep claim documents as hard copies instead of scanning them into your document management system, use this option to describe the document in ClaimCenter. This description becomes searchable. However, you have to go to your file cabinet or other storage location to retrieve it. This option gives you all the document attri-

bute fields that you have for electronic documents. The description appears in searches as if it were in the document management system.

Click **Action** and choose **Indicate existence of a document**. The screen that appears is the same as the screen that links an existing document to a claim, except that there is no **Attachment** text box. Enter attributes as if you were linking to an existing document in your document management system. Clicking **Update** adds this document without contents, your hard-copy document, to the document management system.

Editing a Document

You can edit a file in the **Documents** screen of a claim.

You can edit documents if you have sufficient permissions or if the document does not have a status of **Final**. To edit a document, click **Edit** in the **Actions** column for the document. ClaimCenter enables the **Upload** and **Cancel** buttons in this column. Clicking **Edit** downloads a copy of the file to your local drive and opens it in its appropriate editor. Clicking **Upload** returns the document to your document management system. Clicking **Cancel** discards your local edits.

Removing a Document

After locating the document in the **Documents** list, click **Delete**. If no button is visible in the **Delete** column, you do not have the authority to delete that file. See “Document Security” on page 526.

Using an Activity to Create a Document

If a document template is specified in the activity pattern of an activity, all activities created from that pattern have a **Create Document** button visible after the activity opens. Clicking this button displays a popup window identical to the **Create New Document** version of a **New Document** screen. You can create the document. Since an activity pattern can indicate only one template, any activity creates only one type of document.

For the **New Document** screen, see the example in “Adding a New Document” on page 528.

Creating a Document with a Rule or in a Workflow

To learn how to automatically create documents by using rules, see “Generating Documents from Gosu” on page 230 in the *Integration Guide*. Use similar rules to create a document in a workflow.

Relating a Document to a ClaimCenter Entity

You can relate a document to a single exposure, matter, or contact.

If you are creating a document, specify the entity in the **Related To** text box. If the document already exists, you create this relationship by using the same **Related To** field after linking the document to a claim. The **Related To** relationship can only have one value for any given document.

Linking a Document to Another Entity

Documents can be linked to other entities such as activities, or certain financial objects, such as a reserve. This linking is different from a document’s being **Related To** a single exposure, matter, or contact.

To link a document to an entity, open the details page of that entity. Click **Link to Document**. Find and select the document in the document search popup screen.

Clicking **Link Document** opens a document search page that is similar to the **Documents** list page. Only one document can be linked at a time, and only existing documents can be linked.

Note: You can see **View** only in a list of linked documents. You can edit a document only by clicking **Edit** in the Document list pages.

Creating a Document Template

A document template consists of two files. One file is a document template descriptor file, which contains the metadata, such as its name, ID, and MIME type. The other file is the document template itself, which contains the document contents.

You can view and edit the document templates and descriptors by navigating to **configuration** → **config** → **resources** → **doctemplates** in Studio.

Document template files are in the following directory:

`ClaimCenter/modules/configuration/config/resources/doctemplates`

- There are several example files in that directory. The best way to create a new template is to generate this pair of files from copies of these examples. The descriptor file is in XML format. Studio does not contain a special editor to help generate new templates.
- For details about document management, document templates, and related integration points, see “Document Management” on page 199 in the *Integration Guide*.

Configuring Document Management

The following configuration parameters in the `config.xml` file control the display and editing of files in a document management system. The suggested values assume that you are using the file system on the application server.

IMPORTANT Guidewire strongly suggests integrating with an external document management system rather than using this default system. The default system does not support versioning, sending documents, providing security, and so on.

Parameter	Description
<code>AllowDocumentAssistant</code> <code>UseDocumentAssistantToDisplayDocuments</code>	Set both to <code>true</code> so that the Document Assistant ActiveX control displays document contents. These settings are necessary to display and edit documents. See “Guidewire Document Assistant Configuration Parameters” on page 154 in the <i>System Administration Guide</i> .
<code>DisplayDocumentEditUploadButtons</code>	Set to <code>true</code> to display Edit and Upload buttons, which enable editing and returning edited files to the document management system. <code>AllowDocumentAssistant</code> must also be <code>true</code> , and <code>IDocumentContentSource</code> must support editing.
<code>DocumentContentDispositionMode</code>	How to display a retrieved document. Set to <code>inline</code> to have it appear in a browser. Set to <code>attachment</code> to have it opened by its editor, as determined by its MIME type. If <code>inline</code> , the <code>AllowDocumentAssistant</code> parameter must be <code>false</code> .
<code>DocumentTemplateDescriptorXSDLocation</code>	The location of the XSD file that validates document template descriptor files, usually <code>document-template.xsd</code> . See “DocumentTemplateDescriptorXSDLocation” on page 52 in the <i>Configuration Guide</i> for a description of how to set this location.

Parameter	Description
MaximumFileUploadSize	Because documents either reside on the application server or are uploaded to the document management system by the server, this value can protect the server. The default is 20 MB.
MaxDocTemplateSearchResults	The maximum number of template search results to show before showing a warning in the user interface. The default is 50. The warning appears if the limit is exceeded.

Another section of the `config.xml` file maps document MIME types to file extensions and icons in the user interface:

```
<mimetypemapping>
  <mimetype name="application/msword"
    extensions=".doc"
    icon="word.gif"
    description="Microsoft Word Document"/>
  <!-- more mappings -->
</mimetypemapping>
```

See also

- To configure search parameters for documents, see “Searching for Documents” on page 527.
- For details about document management and related integration points, see “Document Management” on page 199 in the *Integration Guide*.

Document Management Integration

The following are the main plugin interfaces used to integrate with a document management system. Each plugin interface has a default plugin implementation class.

Interface	Description
IDocumentMetadataSource	ClaimCenter passes search parameters—metadata—to this interface, which searches its metadata and returns a list of documents found. You can use it to interface with a system for storing document metadata—name, id, status, author, and so on. If the system specifies none, then the ClaimCenter database stores the metadata. This interface is separate from <code>IDocumentContentSource</code> because of different architectural requirements. In the base configuration, this interface is implemented by the class <code>gw.plugin.document.impl.LocalDocumentMetadataSource</code> .
IDocumentContentSource	ClaimCenter passes this interface metadata for one file, which returns its content. This interface: <ul style="list-style-type: none"> • Interfaces with a document storage system. • Contains methods for creating, updating, and retrieving document contents. • Supports the following document retrieval modes: <ul style="list-style-type: none"> • Document contents. • Web page containing an ActiveX control (see “Working with Documents” on page 527). • Gosu executed by client rules. • URL to a local content store. In the base configuration, this interface is implemented by the class <code>gw.plugin.document.impl.AsyncDocumentContentSource</code> .

Interface	Description
<code>IDocumentProduction</code>	<ul style="list-style-type: none">• Interface to a document creation system.• Document creation process can involve extended workflow and/or asynchronous processes.• Can depend on or set document fields. <p>In the base configuration, this interface is implemented by the class <code>gw.plugin.document.impl.LocalDocumentProductionDispatcher</code>.</p>
<code>IDocumentTemplateSource</code> and <code>IDocumentTemplateDescriptor</code>	<ul style="list-style-type: none">• Basic interfaces for searching for and retrieving templates describing the document to be created.• Include basic metadata (name, MIME type, and so on) and a pointer to the template content.• Specifically, the <code>IDocumentTemplateDescriptor</code> plugin describes the templates used to create documents and the <code>IDocumentTemplateSource</code> plugin actually lists and retrieves the document templates.

For more information about document management and related integration points, see “Document Management” on page 199 in the *Integration Guide*.

Metropolitan Reports

Metropolitan Reporting Bureau (MRB) provides a nationwide police accident and incident reports service in the United States. Many insurance carriers use this system to obtain police accident and incident reports to improve record-keeping and to reduce fraud. ClaimCenter built-in support for this service reduces the amount of time it takes to develop and deploy projects that integrate with the MRB. This topic describes how to use MRB reports.

See also

- “Metropolitan Reporting Bureau Integration” on page 487 in the *Integration Guide*.
- The Metropolitan Reporting Bureau web site at <http://www.metroreporting.com>.

This topic includes:

- “Metropolitan Reports Overview” on page 533
- “Working with Metropolitan Reports” on page 534
- “Configuring Metropolitan Reports” on page 536
- “Metropolitan Report Workflow” on page 538

Metropolitan Reports Overview

ClaimCenter integrates with the Metropolitan Reporting Bureau to enable you to request police accident and incident reports that might be associated with a claim. You enter all the pertinent data in ClaimCenter and, through the integration, send the data and request a report.

There are many report types. Metropolitan has approximately 30 report types, and ClaimCenter supports most of the current report types. Some examples of the types of reports that MRB provides are:

- Police Accident and Incident Reports
- Fire Reports
- Insurance Check
- Title History Check
- Driver History

- Disposition of Charges
- Weather Reports
- Coroner and Death Certificate
- OSHA Reports
- Property and Judgment Search

MRB also offers additional services such as:

- People Search
- Financial Asset Checks
- Vehicle History Reports
- Vehicle Registration Information
- Court Records Search
- Locate Defendant/Witness

You can attach a report to a claim file as a document. After adjusters request reports, the reports are retrieved later, asynchronously. After Metropolitan returns the report, ClaimCenter matches it to a specific claim and attaches it as a document in the claim file. You can view or print the report as with any other document.

For a full list of report types and request codes supported by ClaimCenter, see “Overview of ClaimCenter-Metropolitan Integration” on page 487 in the *Integration Guide*.

Reasons to Order a Report

- **Ordering a report during claim intake** – An adjuster or customer service representative is on the phone with an insured customer taking in a First Notice of Loss (FNOL) report through the ClaimCenter **New Claim** wizard. The adjuster or CSR can order a report during the claims intake process.
- **Ordering a report on an established claim** – If a police report was not requested originally during claim intake (FNOL), the adjuster can order one later from the claim screens.
- **Multiple reports on the same claim** – Sometimes an adjuster requests a police report for a claim but has some data incorrect, such as the police department details. An adjuster can change the appropriate information and submit a request for another, new report.

Working with Metropolitan Reports

You can view a report and order a report.

This topic includes:

- “Viewing a Report” on page 534
- “Ordering a Report” on page 535

Viewing a Report

To view the **Metropolitan Reports** detail screen, open a claim and click **Loss Details** in the left sidebar, and then scroll down to the **Metropolitan Reports** section.

- If there are no reports, click **Edit** at the top of the screen and then scroll back down to the **Metropolitan Reports** section and click **Add** to add a report.
- If there are reports, click the **Type** field of a report to open its detail screen.

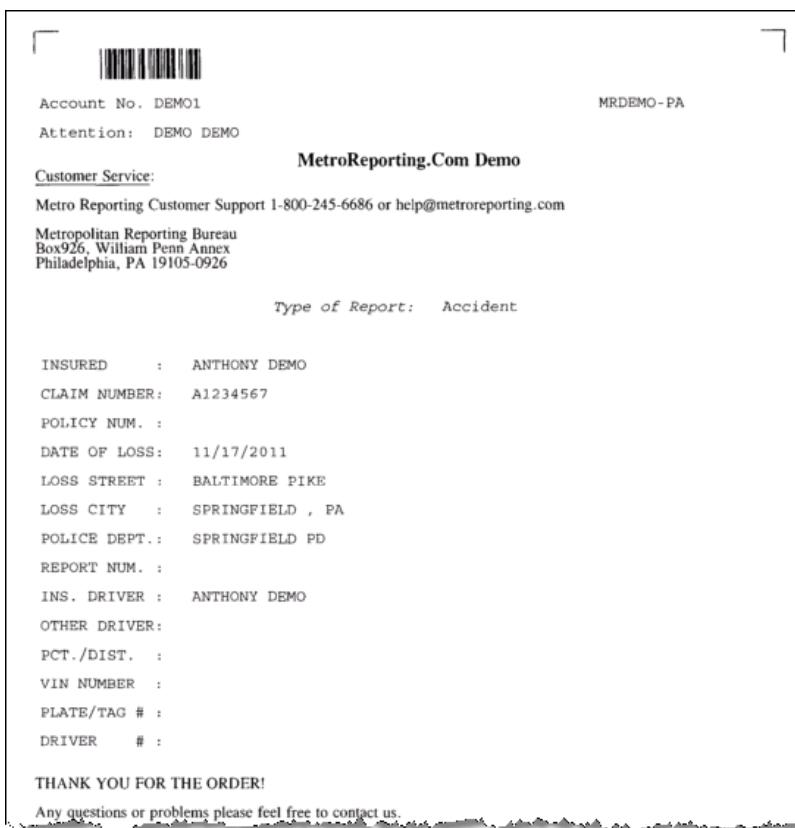
The list of reports on the **Loss Details** screen has the following columns:

- **Type** – The type of the report request. The list of types is in the **MetroReportType** typelist, visible in Guidewire Studio.
- **Status** – The current status of the report request. See “Metropolitan Report Status and How It Changes” on page 495 in the *Integration Guide*.
- **Order Date** – The date that the report request was sent to the Metropolitan Reporting Bureau. The order date is empty if the report has a status of Insufficient Data.
- **Document** – The document column shows the name of the document if the report status is Received. The user can view the document by clicking the **View Document** button in the **Actions** column.
- **Actions** – The last column is for buttons that enable you to view a document or to resubmit the report request. If the original report request has insufficient data, you can update the claim with all the required properties. You can then return to the **Loss Details** screen and click the **Resubmit** button to re-run pre-update rules. ClaimCenter can send a new report request if the report passes preupdate rules.

See “Preupdate Rules and Metropolitan Reports” on page 537.

If you click the type name link in the **Type** column, such as **Auto Accident**, the **Metropolitan Report Details** screen opens, showing the data for the report.

If the report status is Received and you click the **View Document** button, ClaimCenter opens the actual report, as seen in the figure that follows. Use **View Document** if you need to print the report.



Ordering a Report

Perform the following steps to order a report.

1. Create a new claim by using the **New Claim** wizard.
2. In the **Loss Details** step of the wizard, navigate to the **At the Scene** section.

3. In the **Metropolitan Reports** section, click **Add**.

Note: The name of this section depends on the type of claim. For example, for a personal auto claim, the section is **Police Reports**.

4. The **Metropolitan Report Details** screen opens where you can add details. When finished, click **OK**.

The type of report ordered shows on the **Loss Details** screen.

You can also order a report by navigating to a claim's **Loss Details** screen, clicking **Edit**, and then clicking **Add** in the **Metropolitan Reports** section. You must click **Update** to complete this process.

Configuring Metropolitan Reports

The topics that follow give a quick overview of some ways to configure the Metropolitan Reports feature. The primary discussion of this topic is in “Metropolitan Reporting Bureau Integration” on page 487 in the *Integration Guide*.

This topic includes:

- “Metropolitan Reports Configuration Parameters” on page 536
- “ClaimCenter Display Keys for Metropolitan Reports” on page 536
- “Preupdate Rules and Metropolitan Reports” on page 537
- “Activity Patterns and Metropolitan Reports” on page 537
- “Metropolitan Report Templates and Report Types” on page 537
- “Metropolitan Report Data Types, Typelists, and Properties” on page 537

Metropolitan Reports Configuration Parameters

You enable or disable Metropolitan Reports by setting the `EnableMetroIntegration` configuration parameter in the `config.xml` file. The default setting is `true`.

There is another configuration parameter in the `config.xml` file that affects the Metropolitan Reports feature, the `MetroPropertiesFileName` feature. This parameter sets the name of the Metropolitan Reports properties file in the `ClaimCenter/modules/configuration/config/metro` configuration directory. In the base configuration, this file is `Metro.properties`. ClaimCenter uses this file to set up fields in the XML messages sent to the Metropolitan Reporting Bureau. See “Metropolitan Properties File” on page 490 in the *Integration Guide*.

ClaimCenter Display Keys for Metropolitan Reports

In ClaimCenter Studio, you can set display keys to define your own error messages, property names, and other text to display for metropolitan reports.

To modify metropolitan reports display keys for US English

1. Open Guidewire Studio, and then navigate in the Project window to `configuration` → `config` → `Localizations` → `en_US`.
2. Double-click `display.properties` to open this file in the editor
3. In the `display.properties` file, search for `metro`.

For more information, see “ClaimCenter Display Keys for Metropolitan Reports” on page 491 in the *Integration Guide*.

Preupdate Rules and Metropolitan Reports

ClaimCenter sends the metropolitan report request only if the claim contains all the required data. The claim preupdate rule **CPU08000 - Metro Report Request** makes this determination. It checks, one at a time, the type of each report requested and determines whether the claim contains the data required to request each of the requested reports.

If there are any missing fields, an activity called **Metropolitan Report Request Failed** is created and assigned to the person that created the request.

If the required data is added to the claim and the claim update completes successfully, the report status changes. After the report status is validated, ClaimCenter starts a workflow that then changes the Metropolitan report status to **Sending Order**.

Activity Patterns and Metropolitan Reports

The Metropolitan Reports feature includes a set of *activity patterns*, which are a type of template for a user activity notification. If you log in to ClaimCenter as an administrator, you can modify these activity patterns by navigating to **Administration tab → Business Settings → Activity Patterns**.

For example, when a report request fails as **InsufficientData**, the **Metropolitan Report Request Failed** pattern creates a **metropolitan_request_failed** activity and assigns it to the person that created the request.

See also

- “Understanding Activity Patterns” on page 225
- “Configuring Activity Patterns” on page 491 in the *Integration Guide*

Metropolitan Report Templates and Report Types

ClaimCenter report requests to Metropolitan must be formatted in the XML format required by the report type. To generate this request, ClaimCenter runs a specific a Gosu template, which is a text file with embedded Gosu code. This template generates the necessary XML-formatted text. ClaimCenter includes templates for all report types, and these report types are auto-configured to correspond to the standard loss types in the ClaimCenter reference configuration.

You can configure these templates and match them to loss types as described at “Metropolitan Report Templates and Report Types” on page 492 in the *Integration Guide*.

Metropolitan Report Data Types, Typelists, and Properties

The entity representing a metropolitan report is the **MetroReport** entity. See “**MetroReport Entity**” on page 494 in the *Integration Guide*.

The **MetroReport** entity also references a **Document**, which represents the report returned from MRB. See “**Document Entity**” on page 495 in the *Integration Guide*.

There are several typelists used by the Metropolitan Reports feature:

- **MetroReportType** – Defines a type of report that adjusters can request, such as Auto Accident or Coroner Reports and Title History. There is also a mapping defined between loss detail type and **MetroReportType**. See “**MetroReportType Typelist**” on page 494 in the *Integration Guide*.
- **MetroAgencyType** – The investigating agency type for each report. See “**MetroAgencyType Typelist**” on page 495 in the *Integration Guide*.
- **MetroReportStatus** – Indicates the current status of the report request, such as Accepted or Pending. See “**Metropolitan Report Status and How It Changes**” on page 495 in the *Integration Guide*.

See also

- “Adding New Report Types” on page 494 in the *Integration Guide*

Metropolitan Report Workflow

Interacting with the Metropolitan Reporting Bureau is an example of how ClaimCenter uses a workflow process to implement a complex set of interactions. You can either modify this existing workflow or generate new ones to model other business processes.

Workflows do not replace rules. If you can model a business practice with a rule set, a workflow is unnecessary. But workflows are more powerful and flexible than rules in many ways. One of their most important advantages is that workflows can wait for a defined time before checking to see if a condition has changed, or before performing a specific action. This means that a process can go to the next step without manual intervention.

For more information, see the Metropolitan Reports workflow diagram at “Metropolitan Report Status and How It Changes” on page 495 in the *Integration Guide*. Additionally, for information on setting workflow timing, see “Customizing Metropolitan Timeouts” on page 498 in the *Integration Guide*.

See also

- “Guidewire Workflow” on page 393 in the *Configuration Guide* to learn more about workflows.

ISO and Claims

In the United States, ClaimCenter integrates with ISO, formerly known as the Insurance Services Office. ISO provides a service called ClaimSearch that helps detect duplicate and fraudulent insurance claims. After a claim is created, a carrier can send details to the ISO ClaimSearch service and subsequently get reports of potentially similar claims from other companies.

The base configuration of ClaimCenter includes integration with this service. In the base configuration, you can configure ClaimCenter for claim-level messaging. You can optionally configure ClaimCenter to integrate with ISO on the exposure level.

Note: Both Guidewire and ISO recommend that you configure ClaimCenter to send ClaimCenter claims, not exposures, to ISO. For compatibility with older versions of ClaimCenter, ClaimCenter supports optionally sending exposures to ISO. See “Claim-based Messaging, Legacy Support for Exposures” on page 448 in the *Integration Guide*.

ClaimCenter provides a special validation level for ISO that enables ClaimCenter to verify that all the required data is entered into the system during the intake process. Once verified, ClaimCenter sends the claim to ISO and records any ISO match reports associated with the claim or exposure. This topic introduces working with ISO and describes its general processes.

This topic includes:

- “How ISO Interacts with Claims and Exposures” on page 540
- “How ISO Works with ClaimCenter” on page 540
- “ISO Permissions” on page 543

See also

- “Insurance Services Office (ISO) Integration” on page 447 in the *Integration Guide*
- “Enabling ISO Integration” on page 453 in the *Integration Guide*

How ISO Interacts with Claims and Exposures

If you integrate ClaimCenter with ISO, you must determine whether to send messages to ISO at the exposure or the claim level. If you integrate with ISO at the exposure level, the base configuration supports several exposure types such as:

- Vehicle damage
- Property damage
- Injury damage in workers' compensation line of business

These exposure types are commonly used with personal auto, homeowners, or workers' compensation claims.

Benefits of Claim-level Integration

- Other carriers can receive a more complete picture of what happened on a certain claim, aiding in fraud detection.
- Claim-level data includes additional fields that are not available at the exposure level.
- Support for ISO ClaimDirector integration, a service used for fraud scoring that you must configure.

Benefits of Exposure-level Integration

- You can configure certain lines of business, such as personal auto, to send data to ISO at the exposure level.

How ISO Works with ClaimCenter

This topic describes how ClaimCenter interacts with ISO.

A triggering event occurs on a claim or one of its exposures that is at the Valid for ISO validation level. Triggering events can include:

- An exposure or claim was added, made valid, or changed.
- The policy changed.
- The claim contact changed.
- Important field information changed.

Note: You can send data to ISO automatically after completing the **New Claim** wizard if the claim has all the required ISO information and passes validation.

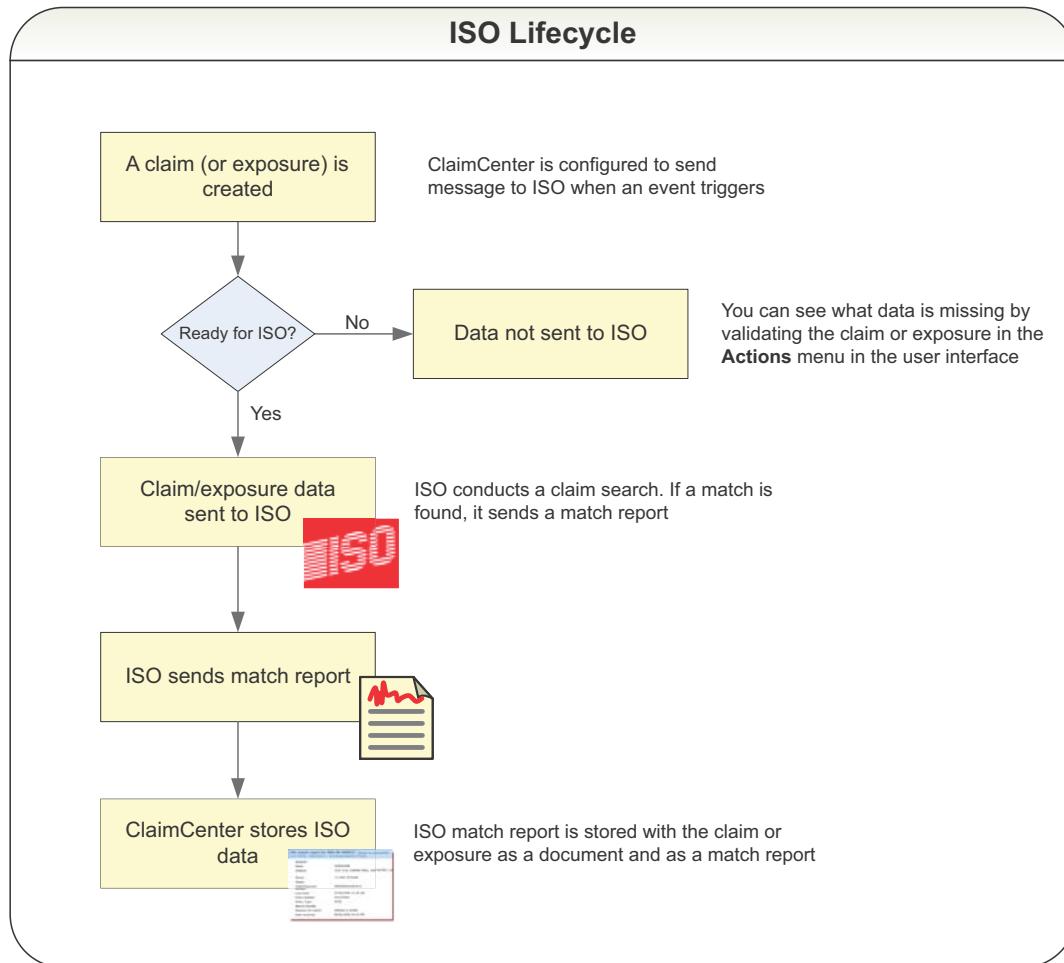
The event triggers the Event Message rule set category, which in turn triggers the Event Fired rule set. The system creates a message containing the required data and sends that payload generation request to ISO.

There are different payloads depending on the type of claim or exposure type. For example, a payload for an auto claim can include items such as VIN, make, model, and year of the damaged vehicle. A payload for WaterCraft/Boat might require data on per boat property loss: boat year, boat make, and HIN—serial ID number. A large part of configuration involves defining what data is to be captured and sent to ISO.

ISO sends a reply back to ClaimCenter indicating if there were any matches to the criteria it received. These matches are useful in detecting fraud because the majority of carriers in the United States integrate with ISO. The system updates the claim or exposure with the new response and match report. ClaimCenter stores the match reports as documents. See “Viewing ISO Information” on page 541.

If, at a later date, certain data changes again, you can send that change to ISO by clicking the **Send to ISO** button located on the **ISO** tab.

ISO Lifecycle



Viewing ISO Information

Depending on your configuration, you can see ISO information at two locations for an open claim:

- The **Documents** menu link in the sidebar.
- The **ISO** card, which can be in several locations:
 - If ClaimCenter has been integrated with ISO at the claim level, you can see the ISO card on the **Loss Details** → **General** screen.
 - If ClaimCenter has been integrated with ISO at the exposure level, for claims other than workers' compensation, you can see the ISO card on the **Exposure Details** screen.
 - If ClaimCenter has been integrated with ISO at the exposure level, for workers' compensation claims, you can see the ISO card on the **Medical Details** screen.

The following commercial auto claim example shows data that ISO has sent to ClaimCenter. If you click the link under the Claim/Exposure Number column, you can see the details.

Loss Details

[Edit](#) [Send To ISO](#) [Refresh Responses](#)

[Details](#) [ISO](#)

Status

Status	Sent
Date sent to ISO	10/10/2013 4:05 PM
Last response from ISO	10/10/2013 4:06 PM
Known to ISO	Yes

« ‹ | Page 1 of 2 › »

Insurer	Insurer Phone	Claim/Exposure Num
GUIDEWIRE...		34553343195EXP14
GUIDEWIRE...		34553343195EXP18
GUIDEWIRE...		34553343195EXP14
GUIDEWIRE...		34553343195EXP14
GUIDEWIRE ...	+1-650-3579100	34553343195EXP111
GUIDEWIRE ...	+1-650-3579100	34553343195EXP111
GUIDEWIRE ...	+1-650-3579100	0000000250EXP111
GUIDEWIRE ...	+1-650-3579100	0000000285EXP111
GUIDEWIRE ...	+1-650-3579100	00000000805EXP1112
GUIDEWIRE...		34553343195EXP16C

ISO match report for 345-53-343195 [Return to Loss Details](#)

INSURER	
Name	GUIDEWIRE-XML
Address	2121 SEL CAMINO REAL, SAN MATEO, CA, 94403
Phone	
CLAIM	
Claim/Exposure Number	34553343195EXP14
Loss Date	05/30/2005 12:00 AM
Policy Number	643187654
Policy Type	CAPP
Match Details	
Reasons for match	Vehicle identification number is identical
Date received	10/10/2013 4:06 PM

If you prefer to see detailed information, click **Documents** in the sidebar and then click **View** for that report to see additional details. The following figure shows an example of the ISO report:

Documents

Related To: * Claim

Section: Any

Name or Identifier:

Status: Any

Author:

Include Hidden Documents: Yes No

Actions

	Name	Actions	Type
<input type="checkbox"/>	ISOMatchReport-2013-10-10-16-06-01.xml	View	ISO
<input type="checkbox"/>	ISOMatchReport-2013-10-10-15-51-03.xml	View	ISO
<input type="checkbox"/>	ISOMatchReport-2013-10-10-15-50-03.xml	View	ISO

ISO ClaimSearch
The information system for claims professionals

ISO CLAIMSEARCH MATCH REPORT SUMMARY

A claim report identified by ClaimSearch identification number SH000468981 was received by ISO ClaimSearch on 10/10/2013 as a Replacement of a previously submitted claim. Submission of this replacement claim initiated a search of the ClaimSearch database. The claim(s) listed below appears to be similar to the claim submitted. Reasonable procedures have been adopted to maximize the accuracy of this report. Independent investigations should be performed to evaluate the relevant data provided.

If you have any questions concerning your report, please contact Customer Support at (800) 888-4476.

INITIATING CLAIM INFORMATION

Claim Number:	3455334319514184B74728	Date of Loss:	10/03/2013
Policy Number:	6431876514184B74728	ISO File Number:	SH000468981

SUMMARY FOR EACH SEARCHABLE PARTY

PRY-WAY TRUCKING COMPANY_14184B74728, BOTH CLAIMANT & INSURED
Coverage: COLLISION Loss Type: COLLISION

# of Matches	NAME	LOSS TYPE	SIU INVOLVEMENT	NAME	ADDRESS	SSN	PHONE	DRIVER'S LICENSE	VIN	LICENSE PLATE	KEY INDICATORS FOR THIS PARTY
19		3							21	9	Prior Claims History
0Y000445677	X							X	X		
1H000416366	X							X			

ISO Permissions

If you have the permissions to view the claim or exposure, you can view the ISO match reports. You can also edit the claim or exposure and click the **Send to ISO** button to send the message to ISO.

Additionally, the Administer Integration permission `integadmin` can be added to a role such as Claims Supervisor or Adjuster. Use this permission to see and edit information that is not of interest to most users, but that can help in rare cases. For example, you can edit information if the ISO state of the exposure or claim is no longer in sync with the ISO server.

