ClaimCenter Application Guide

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Guidewire

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About This Document

This application guide describes the functions and processes of Guidewire ClaimCenter. It provides conceptual overviews as well as complete details of how the default application works before configuration.

This topic includes:

Intended Audience

This guide is meant as an introduction to ClaimCenter. It is a good starting point for

- Implementation team members or IT staff who seek a better understanding of how ClaimCenter works and what is contained in the default application
- Business analysts who define the business logic
- Anyone who has a vested interest in understanding ClaimCenter

Assumed Knowledge

This guide is your starting point in the ClaimCenter documentation and introduces you to concepts that are the basis of the application. Prior knowledge of ClaimCenter is not required. See the following topic to see which documents to use for implementing and configuring ClaimCenter.

Related Documents

For details on the various aspects of ClaimCenter, see the following:

ClaimCenter Installation Guide – Describes how to install a new copy of ClaimCenter into Windows or UNIX environments. This guide is intended for system administrators and developers who need to install ClaimCenter.

ClaimCenter System Administration Guide – Provides guidance for the ongoing management of a ClaimCenter system. This document is intended to help system administrators monitor ClaimCenter, manage its security, and take care of routine tasks such as system backups, logging, and importing files.

ClaimCenter Configuration Guide – Describes how to configure ClaimCenter and includes basic steps and examples for implementing such configurations. This guide is intended for IT staff and system integrators who configure ClaimCenter for an initial implementation or create custom enhancements. This guide is intended as a reference, not to be read cover-to-cover.

ClaimCenter Rules Guide – Describes the business rule methodology, rule categories for ClaimCenter, and rule syntax for Guidewire Studio. This book is intended for programmers who write Gosu business rules and analysts who define the business rule logic.

Gosu Reference Guide – Describes the syntax of expressions and statements within ClaimCenter. This document also provides examples of how the syntax is used when creating rules. This document is intended for rule writers who create and maintain rules in Guidewire Studio.

ClaimCenter Integration Guide – Provides an architectural overview and examples of how to integrate ClaimCenter with external systems and custom code. This document is a learning tool for explanations and examples with links to the *Java API Reference Javadoc* and *SOAP API Javadoc* for further details. This document is written for integration programmers and consultants.

ClaimCenter Contact Management Guide – Describes how to install and configure ContactCenter and how to integrate it with *ClaimCenter.* Includes basic steps and examples. This guide is intended for IT staff and system integrators who configure ContactCenter for an initial integration or create custom enhancements. This guide is intended as a reference, not to be read cover-to-cover.

Guidewire Glossary – Defines terms used in the documentation.

ClaimCenter Data Dictionary – Describes the ClaimCenter data model, including your custom data model extensions. To generate the dictionary, go to the `ClaimCenter/bin` directory and run the `gwcc regen-dictionary` command. To view the dictionary, open the `ClaimCenter/build/dictionary/data/index.html` file. For more information about generating and using the *Data Dictionary*, see the *ClaimCenter Configuration Guide*.

ClaimCenter Security Dictionary – Documents security permissions, roles, and the relationships between them. Generate the dictionary by going to the `ClaimCenter/bin` directory and running the `gwcc regen-dictionary` command. To view the dictionary, open the `ClaimCenter/build/dictionary/security/index.html` file. For more information about generating the *Security Dictionary*, see the *ClaimCenter Configuration Guide*.

This entire documentation suite is available as both PDF files and an HTML-based help system, featuring a multi-book search capability.

Conventions In This Document

Text style	Meaning	Examples
italic	Emphasis, special terminology, or a book title.	A *destination* 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**.
`monospaced`	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.	Get the field from the `Address` object.
`monospaced italic`	Parameter names or other variable placeholder text within URLs or other code snippets.	Use `getName(first, last)`. `http://SERVERNAME/a.html`.

Support

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

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

Introduction

chapter 1

Introduction to ClaimCenter

ClaimCenter is a web-based enterprise software application designed to manage the process of reporting, veri-
fying, 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**. This allows for 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.** Manage the finances that surround a claim. This includes 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 Contact objects to be shared across multiple claims. Guidewire provides
  an address book application called ContactCenter that can be integrated with ClaimCenter.

This topic includes:

- "ClaimCenter Benefits" on page 23
- "The Claims Management Process" on page 24
- "ClaimCenter Users" on page 25

ClaimCenter Benefits

Use ClaimCenter to:

- **Improve adjuster efficiency**. 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 auto-
  mated, enabling higher productivity.
- **Reduce leakage**. Use ClaimCenter to reduce adjustment expenses and eliminates unexpected processing fees.

- **Distribute collaboration**. Use ClaimCenter to manage distributed participants such as fraud investigation units, auto repair shops, and claimants.

- **Coordinate activities.** Using ClaimCenter, adjusters and supervisors manage activities on hundreds of open claims being managed by a group of adjusters at any given time. ClaimCenter tracks critical activities. It coordinates the distribution of work on a claim across people inside and outside the organization. Lower cost employees can handle routine activities and experts are freed to handle only the most difficult issues.

- **Provide guidance**. ClaimCenter embeds best practice guidance for adjusters and supervisors through automatic workplan generation and suggestions to guide discretionary additions to a claim's workplan.

- **Manage workers and claims**. ClaimCenter ensures that supervisors are aware of claims and activities within their group in real time, instead of relying on reports that are dated. Supervisors can identify problem claims quickly and intervene before issues become problems.

- **Measure and improve performance.** ClaimCenter provides executives with better information about claims handling within the organization, allowing best practices to be tuned to provide continuous process improvement over time.

The Claims Management Process

ClaimCenter guides you through these types of activities:

- **First Notice of Loss (FNOL).** Enter initial claim information either directly into ClaimCenter through the New Claim wizard, or import from an external system. 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 workplan 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 claims management process. Adjusters can record their investigative notes, collaborate with other adjusters and internal experts, and view high priority or overdue claims quickly before they become problem claims.

- **Payment and Recovery.** Use ClaimCenter to track claims 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 has several mechanisms that help you identify potential fraud.

- **Litigation and Negotiation.** Use the Plan of Action section of a claim to identify strategies in negotiating a claim.

- **Property and Vehicle Assessment.** ClaimCenter has 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	• Create and work on claims, bulk invoices, and new exposures. • Typically collect basic information prior to establishing that coverage exists.
Adjusters	There can be several adjusters, and several 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 or both, and another adjuster can have the role of subrogation owner. Adjuster activities can include: • 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	• Managers are members of a group who are responsible for occasionally knowing about or doing work that is assigned to another member of the group. • They access any object that any member of the group can access. • View summary information on **Team** tab about objects assigned to users in a group. • A group can have zero, one, or many managers.
Supervisors	• Supervisors are assigned to one or more groups. They are responsible for ensuring that the group's work is completed as efficiently as possible. To be a supervisor, a user must have the *supervisor* role. The role contains the permissions appropriate to doing the work of a supervisor. In addition, they are 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. This permission makes the **Pending Assignment** link in the left sidebar 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 matters.
Subrogation specialists	• 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.

Users	Typical activities
Salvage specialists	• Assist insureds in processing their total loss claim, including the mailing or collecting of all necessary paperwork and issuing any necessary payments. • Issue settlements to lien holders and insureds. • Monitor the sale of salvage, and posting 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

Every claim is a collection of these sections:

- A Summary of the Claim screen, listing the most salient information about the claim.
- A Workplan of initial Activities, which grows to include all activities created for the claim.
- A description of the types of losses (including vehicles, properties and injuries), and causes of the losses, or Loss Details. These screens also include Claim Associations, damage Assessments, Subrogation, Catastrophes, and Fraud detection information.
- Exposures, or screens correlating policy coverages with claimants.
- All Parties Involved with the claim, which is all people, companies, and legal venues.
- An auditable record of all Financials. This record includes Checks and Transactions, including reserves, payments, recoveries, and recovery reserves.
- All Notes made about the claim.
- An electronic record of all the collected physical Documents that relate to the claim.
- A Plan of Action, which details plans for Evaluations and Negotiations.
- A list of related Matters and pending Litigation.
- A History of all non-financial claim events.
- A Calendar of upcoming Activities and Litigation.
- An FNOL Snapshot (First Notice of Loss) and a New Claim wizard that facilitates entering this information into ClaimCenter.

Selecting any menu item on the left of the **Claim** screen, takes you to the **Summary** screen.

Other Aspects of Claims

ClaimCenter uses the following associated concepts to create and use claims:

- ClaimCenter tracks its users, how they work together in groups and queues, and how they receive work as seen in *Assigning Work*. This is useful as a claim is seldom handled by only one person
- *Assigning Work*: ClaimCenter creates owners for claims, exposures, and other parts of a claim. It can use attributes, such a location, proximity information, and user characteristics, to make these assignments.
- *New Claim Wizard* facilitates collection all information when a claim is first reported.
- 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*.
- You can rate and select vendors based on their ratings by using the *Service Provider Performance Reviews* feature.
- Use the *Archiving* feature to keep the active claims database manageable.
- ClaimCenter provides strong security for contacts and many aspects of the claim information it contains. See *Security: Roles, Permissions, and Access Controls* for more information.
- Use *Business Rules* and *Workflows* to define your own business model.
- ClaimCenter maintains a set of statistics for each user that include 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 329.
- If you have administrative permissions, you can perform functions such as finding users, editing permissions, setting claim metrics, creating catastrophes, and so forth.

- ClaimCenter has its own address book to store contact information of users, parties involved in claims, companies and vendors, and legal venues.

Summary of the Claim

The default view of a claim is the **Summary** screen. You see this screen when you open a claim.

The **Summary** screen contains common information that applies to all exposures in the claim. All work to verify policy coverage and the basic facts of the incident is centralized with a single adjuster prior to dividing the work for investigating separate exposures among specialists. It contains the facts of the incident and the related policy information, including limits that apply across all payments for a single incident.

The claim **Summary** screen contains these sections:

- **Claim Headline**: This section provides basic, financial, and high risk indicators that apply to the claim.
- **Financials**: A summary: totals of all remaining reserves, payments made, and future scheduled payments.
- **Exposures**: The type, coverage, claimant, adjuster, status, and financial summary information of each exposure.
- **Parties Involved**: A list of both the Users and Contacts related to the claim.
- **Planned Activities**: From the Workplan, the most urgently due claim activities.
- **Litigation**: A list of all legal actions related to the claim.
- **Associated Claims**: Other claims that have the same insured, claimant, or damaged property or vehicle.
- **Latest Notes**: Notes most recently entered about the claim.

Besides the **Summary** detail view, there are **Claim Status** and **Claim Health Metrics** detail views that enable you to surmise the condition of the claim. See "Claim Headline" on page 29 in this section.

Working With the Summary screen

To view details of each of the previous sections, click the menu item of the same name on the left pane of the screen. (Use the **Workplan** menu item to see Planned Activities, and the **Loss Details** menu item to see Associated Claims.)

- **Claimant**: The claimant's name (not necessarily the insured).
- **External**: Whether the activity is completed by someone employed by the carrier or not.
- **Ext Owner**: The name of the outside owner of the activity.
- **Assigned By**: The ClaimCenter user who assigned the work.
- **Assigned To**: The ClaimCenter user who must complete the work.

The **Workplan** also has a button bar containing these buttons:

- **Filter**: Show a subset of all activities, such as activities, activities due within 7, 14, or 30 days, overdue activities, or all open activities. The filter allows you to see all claim activities or just the ones you own.
- **Assign**: Assign an activity, either by manually selecting a user or group or by using automated assignment.
- **Skip**: Change the status of the activity to skip, which is possible only for non-mandatory activities.
- **Complete**: Change the status of the activity to **Closed** and mark the completion date as today.
- **Approve**: If the activity is to approve another user's activity, approve it.
- **Reject**: If the activity is to approve another user's activity, reject it.

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 such as:

- **Basic**: How long the claim has been open. If this time is within an acceptable range. What has been done so far.
- **Financials**: The total incurred amount of this claim. How much the carrier has paid. If applicable, whether the deductible for the claim been paid.
- **Risk Indicators**: Any risks associated with this claim, such as 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. To learn more, refer to "Claim Performance Monitoring" on page 315.

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. Examples include claims with many overdue or escalated activities. See "Working with Activities" on page 219 for details.

Workplan

The Workplan includes all activities, including those not completed and not assigned to a specific user. The Workplan view shows what remains to be done and a history of what has been done with a date. The entries on this view are activities identical to those on the adjuster's Activities List, except that they are grouped to show all activities specific to a given claim.

From the **Workplan** menu item, you can view and manage activities. To view or edit the details of an activity, exposure or involved party, select the corresponding subject, which is underlined.

Similar to the **Activities** list on the **Desktop**, the following columns can appear on a claim's workplan:

- **New**: Indicates if the assigned activity has been changed by someone else since the last time you opened it. A changed activity could be:
  - A new activity in the workplan.
  - An activity that was reassigned to you from someone else.
  - A activity that was recently edited by someone else.
- **Escalated**: Indicates whether the activity is past its escalation date. Activities have escalation dates assigned either automatically by ClaimCenter or by the adjuster. This is not the same as the activity being past its due date.
- **Due**: Indicates the activity's targeted completion date. The due date is shown in red if the activity is past due.
- **Priority**: Indicates the importance of the activity, typically Urgent, High, Normal, or Low. You usually work first on high priority, overdue, or new activities.
- **Status**: Indicates the status of the activity, such as open or closed.
- **Subject**: Indicates the name of the activity.
- **Exposures**: Shows the list of all exposures into which the claim has been divided,

Loss Details

The *Loss Details* section of ClaimCenter displays all 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** screens contain medical information that is relevant to the claim.

Besides the main Loss Details section, this screen contains the following subtabs:

- **Assessments**
- **Claim Associations**
- **Subrogation**
- **Fraud (Special Investigation Details)**

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. Usually, other systems, often from vendors, manage this process. Therefore, 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. The goal of assessment in ClaimCenter is to provide a framework in which to manage the assessment information so that customers can configure it to match their business needs. For more information, see "Assessments" on page 109.

Catastrophes

The term *catastrophe* refers to a single incident or a series of closely related incidents that cause a significant amount of losses. Carriers often group claims by the catastrophes that caused them. For more information, see "Catastrophes" on page 115.

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**. 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 (and/or third person) damage claims.
- **Multiple claims from the same claimant could represent fraud**. A Special Investigations Unit (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 both a parent claim and child claims.** An insured can have both an auto and an 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.

Navigate from **Claims** → **Loss Details** to use the **Associations** section to associate one claim with others. The section displays a table of all claims associated with each other. For each claim, it shows:

- **Association**: A unique name that you give to a group of associated claims. If your association is for all claims involving one particular vehicle, the **Association** could be the vehicle name.
- **Claims**: The list of all claims having the name of that association.
- **Type**: The kind of association, from the `ClaimAssocType` typelist, where you can add your own. Examples include:
  - **Event-related**: One event, such as a catastrophe or a 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 claim**s: An association of all claims, either by the same claimant or concerning the same vehicle.
  - **General**: A placeholder for your own category of association.
- **Description**: A free-form text entry box.
- **Primary**: The main claim in the association. ClaimCenter does not further use this information.

The **Associations** section contains a button bar. You can select 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 association by name.

Working With Claim Associations

To create a new association for the current claim
- Navigate to **Claim → Loss Details → Associations → New Association → Add**. Use the search icon to locate the claim. Enter a new or existing **Title** (Association name) and **Type** and **Description**, and optionally check **Primary** and click **Update**.

To delete a claim from an association, but not the entire association
- Navigate to **Claim → Loss Details → Associations**. Select an association → **Edit** → click the claim's check box under **Remove**, and 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 as **Primary** to enable the delete.

To delete an entire association, not just a file from the association
- Navigate to **Claim → Loss Details → Associations** → check the desired association → **Delete**.

To find an association
- Navigate to **Claim → Loss Details → Associations → Find Association**, and then search by claim number, insured name, loss data, or Title (Association name).

To write Gosu rules to set up associations
- In Studio, search for `Claim.Associations` to display the methods available for creating and modifying associations.

Subrogation

Carriers sometimes settle claims, knowing that another party can be liable for the costs. After that occurs, the carrier tries to recover those costs from the other party on behalf of their insured. The fine print of most insurance policies cedes the insured's recovery rights to their carriers. For more information about how ClaimCenter helps you manage subrogation, see "Subrogation" on page 273.

Fraud (Special Investigation Details)

Fraudulent claims are a continuing problem for all who handle claims, and identifying suspicious claims can be difficult. Too often, flagging a suspicious claim is left to be done manually, a process that might be different for each adjuster. ClaimCenter, recognizing the importance of uncovering fraudulent claims, provides a mechanism to help you determine when to further investigate a claim. See "Claim Fraud" on page 101 for details.

Incidents in ClaimCenter

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

- One of your insured clients is in an automobile accident and has filed a claim with your insurance company.
- Someone slips and falls at a store owned by one of your insured clients, but has not yet filed a claim. The store owner contacts your insurance company to ensure that the incident is recorded with you.

Incidents are explained in the section called "Incidents" on page 235.

Exposures

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

Each claim's exposure 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 claimant and coverage association 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 by subsets of exposures by using cost type and cost category.

This section also provides a workspace for you to **Add**, **Edit**, and **Close** exposures.

The following columns can be enabled in the Exposures section:

- **#**: Unique number identifying the exposure within the claim.
- **Type**: Type of exposure, such as Vehicle or Bodily Injury
- **Coverage**: Related coverage type for the exposure, such as Collision, Medical payments, or Auto physical damage.
- **Claimant**: Name of the claimant for the exposure. This is not necessarily the same claimant for the overall claim.
- **Adjuster**: The adjuster in charge of processing the exposure. This adjuster is not necessarily the same as the adjuster for the overall claim because individual exposures in a claim can be assigned to different people. While there is always one main adjuster in charge of the whole claim, that adjuster can have different individuals managing individual exposures of the claim.
- **Status**: Status of the exposure, such as Draft, Open, or Closed.
- **Remaining Reserves**: Related reserve liability amount allocated for the exposure.
- **Paid**: Amount already paid out for the exposure.

The Exposures section also has a button bar containing the following buttons for processing exposures:

- **Filter**: Filter the exposure list by 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.

Parties Involved

The **Claim → Parties Involved** section of a claim lists all the people and organizations associated with the claim. Involved parties can be divided into two categories, users and contacts. You can see them by clicking one of these subtabs:

- **Contacts**: People, companies, vendors, or legal venues associated with the claim. The people do not directly use ClaimCenter.
- **User**: Anyone interacting with ClaimCenter. Claim users either have work on the claim assigned to them or have a user role on the claim.

Contacts

The **Contacts** screen that opens when you navigate to **Claim → Parties Involved**, lists all the contacts associated with the claim. The contacts include the insured, the claimant, the people involved in the accident, the vendors associated with the accident, experts, and witnesses. To associate a contact with a claim, each contact must have at least one role on the claim.

This screen's upper section is a filtered list of contacts, while the lower part of the screen provides a detailed view of one selected contact.

These columns appear on the upper part of this screen:

- **Name**: The name of the person related to the claim.
- **Roles**: The relationship of the person to the claim, such as claimant or witness (in the `ContactRoles` typelist).
- **Contact Prohibited**: A Boolean field noting whether you can communicate with the contact.
- **Phone and Address**: Include Street **Address**, **City**, **State** and **ZIP**.

The lower part of this screen contains the details of one contact spread over these three tabs:

- **Basic**: A summary of the most important details.
- **Addresses**: The contact can have multiple ways to be contacted. This tab 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. After agents work with branch offices to receive claims and with headquarters offices to receive checks, this area can relate the branch office to headquarters.

The upper part of this screen also has a button bar containing the following buttons for managing contacts:

- **Filter**: Instead of all contacts, show only those with a former role, or primary contacts, secondary contacts, litigation contacts, vendors, or contacts related to an exposure of the claim.
- **New Contact**: Create a new contact. Submenus enable creation of a person, vendor, or legal venue.
- **Add Existing Contact**: Search the Address Book for a contact to add to the claim.
- **Delete**: Remove a contact from the claim, including all its contact roles. This removal does not affect the Address Book.
- **Merge Roles**: Delete a contact after transferring its contact roles to another contact.

Users

Users are people who have access to ClaimCenter. 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 contains the following:

- **Name**: The name of the ClaimCenter user related to the claim.
- **Group**: The ClaimCenter business group to which the person belongs.
- **Roles**: The relationship of the person to the claim, such as adjuster.
- **Exposures**: The exposures to which the relationship applies, if it does not apply to the entire claim.

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

- **Add User/Group**: Add a new user relationship.
- **Remove User/Group**: Remove the selected relationship.

Working With Contacts and Users

You can work with contact information in the address book or in a particular claim. If you create a new contact or edit the contact inside a claim, the contact is not correctly linked to the Address Book. ClaimCenter generates an warning message for contacts that are not linked or whose information is not in sync with the Address Book.

To select a contact or user

You can select a contact directly from a claim:

- Navigate to **Claim** → **Parties Involved** menu item → **Contacts** tab and click the small Page icon next to the name.

You can select a user assigned to the claim:

- Navigate to **Claim** → **Parties Involved** menu item → **Users** tab and click the small Page icon next to the name.

Alternatively, if ContactCenter is integrated with ClaimCenter, you can select a contact by searching the Address Book. You can filter the type of contact to narrow your search. After identifying an Address Book contact, you can add it to the claim. Access the **Address Book** tab and enter filter and search criteria for searching. Then click **Search**, select the contact, and click **Update**.

To add a new contact to a claim

You can add a new contact in the following ways:

- Create a new contact directly in the Address Book and select it in the claim, as previously described.
- Define a new contact directly in the claim.

    1. Navigate to **Claim** → **Parties Involved** → **Contacts**.

    2. Click **New Contact** and select the type in drop down menu.

    3. Enter your information and click **Update**.

A contact must have at least one contact **Role** to be added to the claim.

To add a new user to a claim

You must add users from the claim, as follows:

1. Navigate to: **Claim** → **Parties Involved** → **Users** tab→ **Add User**.

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

After work is assigned to a user, that user becomes a part of the claim and is added to this screen.

To modify a contact in the address book

If ContactCenter is integrated with ClaimCenter, you can change the Address Book information for a contact. Doing so does not change any current use of the contact in a claim. ClaimCenter maintains this link to the address book and lets you know if the contact information changes in the Address Book.

1. Navigate to the **Address Book** tab.

2. Enter your search criteria and click **Search**.

3. Select your contact.

4. Click **Edit** to make your changes

5. Click **Update** to save the changes.

To modify a contact in a claim

You can change the information for a contact directly in the claim. You can then either update the Address Book with the new information or save the changes in the claim and synchronize it with the Address Book later.

1. Select **Claim → Parties Involved** menu item → **Contacts** tab.

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

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

4. If the contact is linked to the Address Book, you can save your changes in the claim and also modify the Address Book entry. To do so, click **Save to Claim and Address Book**.

To delete a contact or user

If a contact is no longer connected with a claim, such as a contact with the role of nursing supervisor when medical treatment is complete, you can delete the contact. Deleting a contact does not affect information in the Address Book.

1. In the Address Book navigate to **Claim → Parties Involved → Contacts** tab.

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

To delete a user you must reassign all the user's work on the claim, and then remove all user roles from the user with the **Edit** button.

To merge contact roles

Often the data on a claim regarding who is involved and how they are involved comes from different sources at different times or from different systems. The claim might show two Mike Smiths as contacts. The first one is listed as the insured and driver, and the second Mike Smith contact has the role of lienholder. At first, you might not be positive that these names are the same person. Perhaps the lienholder's full name was Mike Smith, Senior, and the other was Mike Smith, Junior, and they are different people. If they are not different people, you can consolidate the two records to make a single contact with all the roles.

You can merge several contacts into a single contact, keeping all contact roles while deleting all other contact information that belonged to the merged contacts.

1. Navigate to **Claim → Parties Involved → Contacts**.

2. Select a contact, check one or more other contacts, and click **Merge Roles**.

The roles of the checked contacts are added to the selected contact, and the checked contacts are deleted from the claim, but not the Address Book.

Policies

ClaimCenter retrieves policy information from an external policy system. It can also retrieve that information from 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, although if there is additional information on the Policy section that is not part of the verified policy, that part is editable.

If you enter policy information manually into ClaimCenter, it is considered *unverified* and there are limitations to what you can do.

See Also

- For a description of what ClaimCenter does with policies, see "Working with Policies in Claims" on page 71.
- For a discussion on how ClaimCenter can integrate with PolicyCenter, see "Getting a Policy into ClaimCenter" on page 336.

Financials

Financials provide views of all the financial transactions that are related to the claim. This view can be a read-only view of transactional information imported from an external financial system, or it can be editable information managed in ClaimCenter.

See Also

- "Claim Financials" on page 131 for an overview of how ClaimCenter uses financials.
- "Multiple Currencies" on page 171 to learn how ClaimCenter handles multiple currencies.
- "Bulk Invoices" on page 189 to learn how to use bulk invoices in ClaimCenter.
- "Deductible Handling" on page 183 to learn how ClaimCenter handles deductibles.

Summary

The **Financials Summary** screen shows an overview of reserves, payments, recoveries, and total amount incurred for the claim. You can subtotal the amounts grouped by exposure, claimant, coverage, and other criteria.

This screen contains the following columns:

- **Remaining Reserves**: The remaining estimate for what the insurance company will still have to pay out for the claim.
- **Future Payments**: Amount that is scheduled to be paid at a future date.
- **Payments**: Amount already paid out for the claim.
- **Recoveries**: Amount of money collected to offset the claim payments, such as from salvage or subrogation.
- **Total Incurred**: Amount of money the company currently expects to pay for the claim.

Clicking various sections of this screen drills down into more financial details.

Transactions

This screen lists all the individual financial transactions for the claim and includes the following columns:

- **Type**: Type of transaction, such as reserve, payment, or recovery.
- **Exposure**: Exposure that is associated with the payment.
- **Coverage**: Insurance coverage related to the transaction.
- **Cost Type**: Cost type associated with the transaction.

- **Cost Category**: Cost category associated with the transaction.
- **Status**: Status of the transaction, such as **Submitted** or **Pending Approval**.

Checks

This screen lists the checks that have been generated for the claim and includes the following columns:

- **Gross Amount**: Amount of the check.
- **Issue Date**: Date on which the check was issued.
- **Scheduled Send Date:** Date on which the check has been or is scheduled to be sent to the payee.
- **Status**: Status of the check, such as Issued or Pending Approval.

New Claim Wizard

To open new claims, use the New Claim wizard. The screens 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 screens.

Working With the New Claim Wizard

To access the New Claim wizard, navigate in either of the following ways:

- **Actions** menu → **Claim Actions** → **New Claim**
- **Claim** tab → **New Claim**

A brief overview of what the wizard does:

- It models the natural flow of collecting FNOL information.
- It uses fewer and more logically ordered steps, or screens.
- Many peripherally useful screens, like Parties Involved and Documents, are not in the main wizard flow.
- You can jump between steps and non-step screens.
- In its default mode, it is optimized for both personal auto and workers' compensation, but can be configured for any line of business.
- It uses incidents to organize Loss Details data by vehicle, property, and injury.
- It enables you to pick subflows, such as first-and-final or auto glass, to further optimize the wizard's flow.
- Its flow is easy to follow for naive users.
- It provides quick navigation and data entry for experienced users.

For details, see "Overview of the New Claim Wizard" on page 60.

Notes

The Notes screen is an important place where claim information is stored. This screen contains both a set of controls on the left for filtering notes and a section on the right showing the notes related to the claim. See "Notes in ClaimCenter" on page 249.

Documents

ClaimCenter manages documents associated with claims. These documents can be either online documents created in 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 within ClaimCenter.

Use the document management system 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 345.

Calendar

ClaimCenter contains a variety of calendars to help organize activities. The calendars display activities in monthly and weekly views. Access calendars from either the **Desktop** or **Claim** tab. Additionally, filter the activities and view activities from multiple users if you have supervisor permissions. See "Activity Calendars" on page 228.

Plan of Action

The Plan of Action section of a claim tries to help you settle complex claims without resorting to legal action. It has two tabs:

- **Evaluations**: This screen 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 in both negotiating a settlement and planning your response to any litigation.
- **Negotiations**: This screen 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. Open a **Claim** (use **Search** or **Claim** tab).
2. Select **Plan Of Action** → **Evaluations** tab.
3. Select an **Evaluation** from the list.

To start a new Evaluation

1. Open a **Claim** (use **Search** or **Claim** tab).
2. Select **Plan Of Action** → **Evaluations** tab.
3. Select **New Evaluation**.

Alternatively, you can:

1. Open a **Claim**.

2. Select **Action** → **New Other** → **New Evaluation**.

Negotiations

To see a Negotiation

1. Open a **Claim**.

2. Select **Plan Of Action** → **Negotiation** tab.

3. Select a **Negotiation** from the list.

To start a new Negotiation

1. Open a **Claim**.

2. Select **Plan Of Action** → **Negotiation**s tab → **New Negotiation**.

Alternatively, you can:

1. Open a **Claim**.

2. Select **Action** → **New Other** → **New Negotiation**.

Litigation

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 241.

History

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 that track whenever a claim is viewed. See "Claim History" on page 83 for a complete description of this feature.

The History tracks the following for each event:

- **Type**: Indicates what happened to the claim, such as being viewed, an exposure's being closed, an exposure's being reopened, a flagged indicator's being set, and so on. Viewing events record every user that opens a particular claim. These event records are helpful in tracking if an adjuster is doing enough work on a claim or if 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 on 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**: Filters the history list by the type of event.
- **Refresh**: Shows the latest list of history events.

See "Claim History" on page 83.

FNOL Snapshot

You can create a claim in ClaimCenter or import a claim as a First Notice of Loss (FNOL) 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.

The FNOL Snapshot screen, which you can open from the navigation panel, shows the snapshot data if you have enabled this feature. The `EnableClaimSnapshot` parameter in the `Misc. Parameters` section of `config.xml` determines whether these snapshots are visible in ClaimCenter.

Administration

Both users and administrators can perform administrative tasks. There are few things a user can do, and those things cannot affect other users. See "The Administration Tab" on page 399 for details.

User Tasks in the Administration Tab

Use the **Action** button of the **Desktop** tab to perform these administrative functions:

- **Statistics**: You can see an overview of how many claims and activities you have. The number of claims reflects all claims, including those that are incidents only. As an administrator, this screen also displays statistics for your team.

- **Preference**; You can change your **Startup View**, the first screen you see when you log in to ClaimCenter, or your password. In the base configuration, the default opening screen shows your current activities. You can change it to instead open the New Claim wizard, show a list of your current claims or exposures, or show a claim search screen. If you are an administrator, you have other options, such as the **Dashboard** and your team's **Statistics**. For information on changing your password, "User Login and Passwords" on page 395.

- **Vacation Status**: You can change your vacation status from **At Work** to either **On Vacation** or **On Vacation (Inactive)**. You can also specify a backup to accept new work assigned to you. See "Vacation Status" on page 261 for more details.

Administrative Tasks

With administrator privileges, you have access to the **Administration** tab. For details, see "The Administration Tab" on page 399.

ClaimCenter Management

A manager or supervisor can access certain tabs to monitor workloads.

The Dashboard Tab

The **Dashboard** provides an executive summary of ClaimCenter data. It gives managers a high level 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. See "Dashboard" on page 329.

The Team Tab

The Team tab is for managers and supervisors managing a group—a *team*—of adjusters. This area shows the team's current workload and the statistics for each adjuster's claims, exposures, and activities. It also highlights any flagged claims that need immediate attention within the group. See "Team Management" on page 325.

High-Level User Interface

chapter 3

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

Before you log in to ClaimCenter, you need:

- **The Internet Explorer web browser**. Guidewire currently supports Internet Explorer version 7.0 and higher.
- **The URL (web address) for connecting to ClaimCenter.** See the *ClaimCenter Installation Guide* for details on installation and the web address to use. You can set up a **Favorite** link to the URL or a create a shortcut on your computer desktop that starts Internet Explorer with that URL.
- **A user name and password**.

To log in to ClaimCenter

1. Launch ClaimCenter by opening up an instance of Internet Explorer using the appropriate web address, such as:

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

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

If successful, ClaimCenter displays your startup view (or landing page).

Note: Since ClaimCenter generates screens dynamically:
- You cannot create Favorites to screens other than the login screen.
- The Back button is not supported.

Changing Your Preferences, Startup View, and Entries

You can change your preferences which include your password, startup view, and entries in recent claims list. In the base configuration, you do not have password. ClaimCenter opens to the Activities screen on the Desktop tab. This screen 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. This can be useful, for example, if you are a supervisor and prefer to see the Team screen first.

1. Change your startup view by selecting the Actions menu on the left pane and click Preferences. The Preferences worksheet appears below the main work area.

2. Select a different Startup Screen.

3. In the base configuration, the Entries in recent claims list is empty but you can optionally enter a number. If you leave this field empty, it defaults to 10 claims.

   Note: You can also change your vacation status. See "Vacation Status" on page 261.

Viewing Statistics

You can always see the status of your activities and claims by navigating to the Action menu and selecting Statistics.

Common Areas in the ClaimCenter User Interface

This section explains some of the common areas in a claim's user interface.
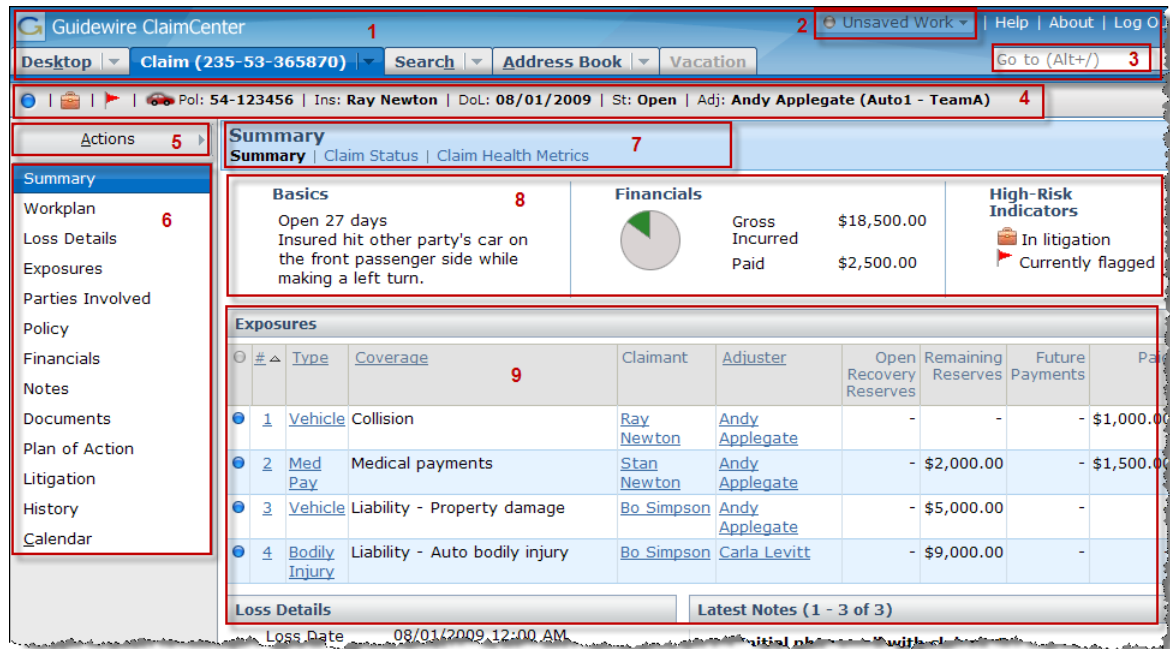
The ClaimCenter main user interface contains the following areas:

Area	Description
1, 2, 3	The **Tab Bar** (**see #1**) contains: • Tabs. The number of tabs depends on the user's permissions. For example, a supervisor sees the **Team** tab. If you are a coworker's back up, then you see the **Vacation** tab. If ClaimCenter is integrated with reporting, then you see **Reports**, and so forth. • **Unsaved Work** menu (**see #2**). ClaimCenter automatically saves your work to the database in wizards and through the **Unsaved Work** menu in the user interface. You can access your unsaved work from the **Unsaved Work** menu in the **Info bar**. ClaimCenter automatically saves your work whether you are in the **Claim** or **Administration** tabs. If you leave one of those screens with unsaved changes, and navigate to another section of ClaimCenter, the server keeps your information in memory. The database does not store your information. You are able to retrieve your work from the **Unsaved Work** menu. Selecting it returns you to that screen with your unsaved data. You can finish your work and save it by clicking **Update**. This is useful if you must navigate away from a screen but need to return to it later. After you complete and save your work, ClaimCenter removes that item from the **Unsaved Work** menu. However, 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 using the **Unsaved Work** menu. • **QuickJump** box (**see #3**). The white text box that displays **Go to** (ALT+ /), **QuickJump** is a fast way for you to navigate elsewhere in ClaimCenter or search for information in specific categories. Type the name of a command and press `Enter` to jump to that location in the application. Guidewire provides you with a number of already defined commands. You can also configure the **QuickJump Box** in Guidewire Studio and define often used commands, search parameters, and permissions. This feature checks permissions and blocks unpermitted jumps. For the **QuickJump Box** to be enabled, there must be at least one configured command. • Links to **Help**, **About**, and **Log Out**.

Area	Description
4	The **Info bar** contains relevant information that pertains to your immediate task as seen in the main screen area (#4). Using a combination of icons and text, you can quickly see where you are and what exactly you are looking at. Looking at the previous example explains the following. • The blue circular button means the claim is open and/or has exposures that are open. • The suitcase 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 321. • The car icon indicates that this is a personal auto claim. • Ray Newton is the insured. • 8/1/2009 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.
5	The **Actions** menu displays choices based on the screen you are on. For example, if you navigate to **Desktop** → **Actions**, you can only select **Statistics**, **Preferences**, and **Vacation Status**. However, if you are on the **Summary** screen of a claim and you select the **Actions** menu, then you can choose many actions that relate to the claim. Examples include validating a claim or adding a note as seen in the following example.
6	The **Sidebar** contains menu links. Use it to navigate to different screens. The items in the **Sidebar** are contextual and some can change depending on the claim object.
7	This section contains second level navigation tabs.
8	The Claim Headline provides basic and financial information. If there are any issues pertaining to the claim, then ClaimCenter displays the high risk indicator icons. See "Claim Headline" on page 319 for details.
9	The **Screen Area** displays most of the business information that you interact with.
	The **Workspace Area** (not shown in the example) can display information separately from the **Screen Area**.

The Actions Menu

The **Actions** button is on the left side of the screen. It opens a set of cascading menu actions that are based on the current screen. The following example displays the actions available when you are in a claim screen:
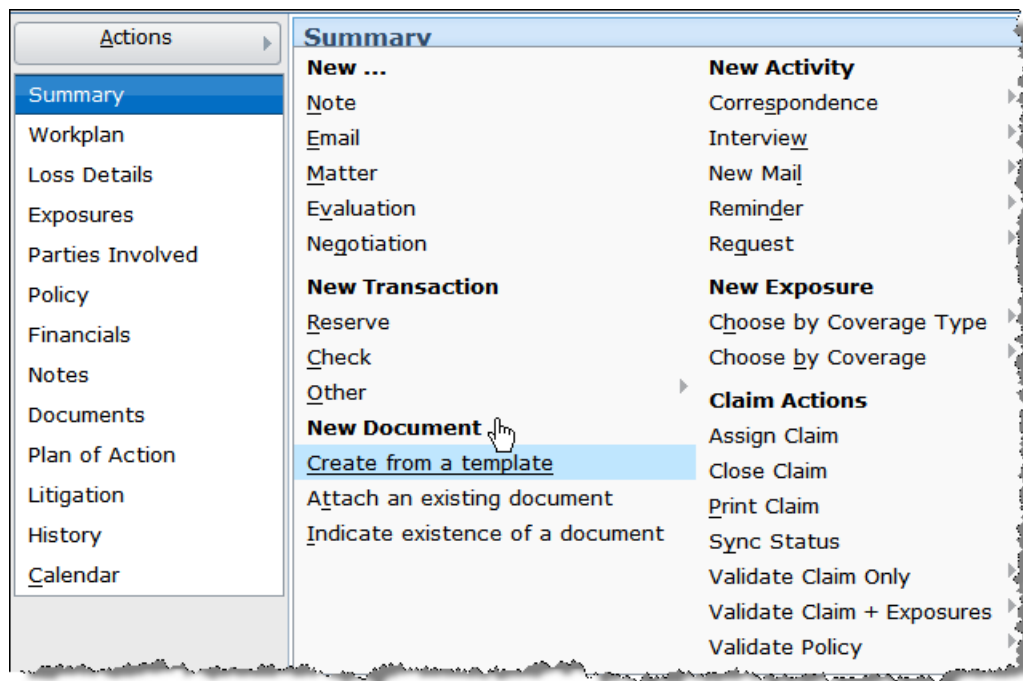
Performing Searches

Use the search tab to perform searches for claims, activities, checks, recoveries, and bulk invoices.

Some fields on search screens 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 entered *Ray* into the first name field, then the search returns all first names that start with *Ray*. This would include: *Ray*, or *Raymond*. However, you must enter an exact match in the **Claim Number** and **Policy Number** fields.

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

ClaimCenter requires you to enter at least one search criteria from the left side as seen in the following example. The secondary search criteria (**Optional parameters** section) is just that, optional.

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

Claim Search

You can search for claims using simple or advanced search parameters.

Simple Search

Simple searches include searching by claim or policy number, type of person (for example, claimant, insured, any party involved, or additional insured), by name, or tax ID.

Advanced Search

Advanced search has additional parameters that might be useful in finding your claim.

For example:
- If archiving has been set up, then you can search either the archive database or any archived databases.
- You can search by catastrophe, loss dates, or flagged or high risk indicators.

If multicurrency is enabled, you can search for the currency, type, and amounts. The search returns claims in that currency. Note that ClaimCenter searches for claim currencies.

Activity Search

Searching for activities means that the parameters include:
- assigned group
- overdue or late
- pending assignment
- by subject (derived from activity patterns)

Check Search

Your search for checks can include the following criteria:
- check number
- invoice number
- payee information
- check total
- status

- dates

If multicurrency is enabled, then you can search for check totals that are based *only* on transactional currency. This limits the search to checks in the selected currency. If you specify a currency but no amount range, then the search results look for results with that selected currency but it does not search on 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, then 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, then the search results look for results with that selected currency but it does not search on amount.

Bulk Invoice Search

Your search for specific bulk invoices can include the following criteria:

- claim number
- invoice number
- payee information
- check number
- pay to
- dates

If multicurrency is enabled, 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.

Note: You might notice the **Desktop** view of the **Bulk Invoice** link. Because you can use the **Search** tab to search for bulk invoices, the **Desktop** view is used for bulk invoices that are currently being worked on or processed.

chapter 4

Localizing ClaimCenter

You can localize your ClaimCenter interface so that it displays information in a language other than US English. If ClaimCenter has multiple locales defined, a language selector appears along the top of the ClaimCenter interface.

You can change the date, time, number, and currency formats for values that appear in ClaimCenter. You can also localize the product model.

For more information, see "Localizing Guidewire ClaimCenter" on page 463 in the *Configuration Guide*.

This topic includes:

- "Localizing Documents, Email, and Notes" on page 51
- "Localizing Activities" on page 51
- "Localizing Workflows" on page 52

Localizing Documents, Email, and Notes

A system configurator can create localized versions of document, email, and note templates. Then, within ClaimCenter, someone can use these templates to create a document, note, or email in the language of their locale.

For more information, see "Localizing Templates" on page 517 in the *Configuration Guide*.

Localizing Activities

A ClaimCenter administrator can localize the subject and description of an activity pattern (from the Administration tab.) Then, within ClaimCenter, a user sees the subject and description of the activity in the language of their locale.

For more information, see "Localizing Shared Administration Data" on page 501 in the *Configuration Guide*.

Localizing Workflows

Before advancing a workflow, the Workflow engine determines the locale in which to execute the workflow. This is the locale that ClaimCenter uses for display keys, dates, numbers, and other similar items generated during the execution of the workflow. At the start of the workflow execution, the Workflow engine evaluates the workflow locale and uses that locale for notes, documents, activities, and similar items. PolicyCenter workflows are executed in the preferred language of the policy being processed. Within ClaimCenter, an administrator can also see localized versions of workflow logs and workflow step names in Studio.

For more information, see "Localizing Guidewire Workflow" on page 497 in the *Configuration Guide*.

The QuickJump Box

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 screen.

ClaimCenter is a web-based application, its complex screen structure navigable with mouse clicks in specific places. It replaces 'green-screen' applications on a mainframe, which typically used keyboard shortcuts for navigation. The QuickJump feature provides this same ability to ClaimCenter users who prefer typing navigation commands.

This topic includes:

QuickJump Features:

- **Omnipresence**: QuickJump is always present, in the same place on every application screen.
- **Availability**: You reach it quickly, 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 screen.
- **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 what you type to make them happen.
- **Expandability**: You can add jumps to all the new screens you create in the application.
- **Intelligence:** QuickJump is context specific. Jumping to New Note within a claim associates any note that you write with that claim.

Accessing QuickJump

To jump the cursor into the QuickJump text box, type the QuickJump shortcut command (ALT / until you change it) while in any ClaimCenter screen. Until you jump there, the box contains the previous named shortcut. You can also use your mouse. You can change this jump shortcut, if you do not like the one ClaimCenter provides.

QuickJump to a Specific Screen

You can use absolute QuickJump commands to reach certain ClaimCenter screens. 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) which does not require an argument to specify it, for example, the **Quick Check** wizard.

QuickJump to a Specific Entity

Use entity QuickJump commands to reach any specific entity. The only entity-based QuickJump command provided by ClaimCenter is claim. You can add others.

Claim: entering the word claim, and a **claim number** as its argument, takes you to that claim's **Summary** screen.

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

QuickJump to a Claim-Related Screen

After QuickJump recognizes the name (context) of a claim, it jumps directly to a subentity or other screen related to that claim. After you are in any screen related to a specific claim, you can QuickJump to many other screens of the claim by typing that screen name in the QuickJump box. The following screens 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 between the many claim-related screens.

Chain QuickJump Destinations Together

You can enter both an entity and a 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 latter two do not work because there are multiple exposure types and check wizards.

QuickJump is Localized

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

Data Model for QuickJump

ClaimCenter provides a `QuickJump-config.xml` file. This file contains both the commands that execute the jumps and a reference to `display.properties` for the localized command names.

Working With Claims

chapter 6

Claim Creation

One of the ways that ClaimCenter gathers claim information is through the use of wizards. Wizards are designed to be flexible in how you gather data based on:

- The line of business.
- Your best business practices.

For example, 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. This New Claim wizard offers many advantages:

- It models the natural flow of collecting FNOL information.
- It uses fewer and more logically ordered steps.
- It captures high-level details, such as the reporter, relevant parties, and loss details in an organized way.
- Many peripherally useful screens, like **Parties Involved** and **Documents**, are accessible at any time, outside of the main wizard flow.
- You can jump between steps and non-step screens.
- In the default mode, it is optimized for both personal auto and workers' compensation, but can be configured for any line of business.
- It uses incidents to organize **Loss Details** data by vehicle, property, and injury.
- You can pick subflows (such as first-and-final or auto glass) to further optimize the wizard's flow.

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

This topic includes:

Overview of the New Claim Wizard

The **New Claim** wizard screen 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 has 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 example. The Wizard Step 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. This specification also affects the flow, and thus the steps shown in the Wizard Step navigation panel. See "Steps of the New Claim Wizard" on page 62.

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 screens that you reach from the Claim Action navigation panel. These screens 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 grayed-out choices. For example, you can always enter a new note, but you can attach **Documents** only after completing step one. See "Optional New Claim Wizard Screens" on page 68 for more details.

Claim Info Bar

The **Claim Info bar** contains the information about the claim. It shows whether the claim is open or closed, the selected policy, the insured, the 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 remembers your work and returns you to work that you have started but not yet saved. The **Unsaved Work** link shows a drop-down menu of all step and claim action panels into which you have entered data, but which you have not saved.

Step one of the wizard is always to select a policy. To pay the claim, there must be 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 a claim action screen by using **Next**, you save the information on that screen 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 screens. Use the **Unsaved Work** link to return to any screen 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 select **Next**, never when you select **Back**.

Delaying Creation of a Draft Claim

To delay creating a draft claim until a later wizard step, set the `autosaveable` attribute of the first screen of the `fnolwizard.pcf` PCF file to `false`. Set 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 screen of the New Claim wizard, you cannot exit the wizard and re-enter it to create another claim. After you re-enter the wizard, it displays your current draft. However, this feature is configurable.

Allowing Multiple Draft Claims

To allow multiple draft claims, change the `autosaveable` attribute to `false` in all screens of `fnolwizard.pcf`.

You can exit the wizard at any time after creating a draft claim. After you re-enter the wizard, you can begin entering a new claim, instead of returning to your previous draft claim.

To re-enter the wizard 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 choose to create an unverified policy, you must enter a **Policy #**, **Policy Type**, and **Type of Claim** before you exit step one. These entries enable the New Claim wizard to determine which flow to use. After you then 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. 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. Therefore, the CSR merely gathers any available information during the first notice of loss.

However, you can also create incidents after a claim is created. Navigate in the claim's **Loss Details** screen, and then click **Edit** and make your selection. Available incidents are located on the right side of the screen.

> **Note:** In the base configuration, there is a **Incident Only** radio button in step three of the wizard. This radio button is actually a boolean property on the `IncidentReport` entity. ClaimCenter provides this 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. It *does not* create an incident.

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

Steps of the New Claim Wizard

This section describes in detail the flow of an auto claim. The screens for personal auto and commercial auto are similar to the screens for personal and property claims. Differences are noted.

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, then the wizard's `setPolicy` method does nothing.

You can customize how the wizard determines whether two policies are the same based on fields in the policy summaries. 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 determines 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 71 describes the reasons and consequences of using each type of policy, especially as they affect claim validation.

Creating an Unverified Policy

After you select **Create Unverified Policy,** you enter a **Loss date**, besides 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 the flow to use. This section describes the main auto flow, and assumes you have chosen the Auto claim type.

Completing a Claim With an Unverified Policy

For 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 box.

Selecting a Verified Policy

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

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	

Policy search criterion	If searching for a name, you can also specify:
Auto VIN (vehicle ID #)	

After you click **Search**, the results appear in a table at the bottom of the screen. Use **Select** to display the correct policy. If the search finds just one result, the New Claim wizard selects it for you. Use the **Unselect** button to override this choice and try again. For example, the next figure shows all personal auto policies in California with a policyholder's last name beginning with the letter R:

Selecting a policy displays 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, since there are many claims against such policies. After the claimant's name becomes known, ContactCenter displays a claim history for the current claimant. You must enter additional information to complete this step.

- **Date of Loss**: Required so that the New Claim wizard can determine if the policy is valid for the claim. You can optionally enter the **Loss Time**, which defaults to midnight.
- **Type of Claim**: If the policy type can have more than one flow (see "Flows of the New Claim Wizard" on page 61), you must select the targeted flow.

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

Step Two: Basic Information

The **Basic Info** screen captures information about the main contact for the claim. This pane is designed only for information about the people involved in the claim:

- Who the claim was Reported By.
- Who is the Insured.
- Who is the Main Contact is.
- What are the Involved Vehicles.

Capture information about all other relevant contacts (people, organizations, and companies) by navigating to the **Parties Involved** claim action screen 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** (default), **Fax**, **Mail**, **Internet**, **Walk-in**, and **None**

- **Name:** A picker icon next to this field must find the contact name you need. After you have chosen, the screen displays contact information, some of which, like phone numbers but not addresses, is 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. To select the contact yourself, choose the **New Person** option on the picker.

- **Relation to the insured:** A drop-down box aids your selection.

- **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. However if you click the name, the **Contacts** screen 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 information is set to the reporter by default. To choose another main contact, select **Different Person**. This selection shows **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 same text box in the **Reported By** area of this step.

Involved Vehicles

This section, which contains the names of all vehicles listed on the policy, comes from the policy. Selecting the checkbox next to any vehicle shows 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 selecting a checkbox, you are choosing 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: Loss Details

Loss Details is the central step 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. By collecting incident information rather than exposure information, the New Claim wizard is usable by call center operators with no insurance background.

For more information on incidents, see "Incidents" on page 235.

The separate sections of **Loss Details** capture:

- **Basic Claim Information.**
- Incident information on **Vehicles**, **People and Property.**
- Contact information about others **At the Scene** of the loss or accident.
- A **Categorization** of the loss.

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.
- **Loss Cause:** ContactCenter does not take any action based on this field. The choices come from the `Losscause` typelist.

- **Incident Only**: ContactCenter does not take any action on this field. Configure a rule to decide what to do with the draft claim already opened by the New Claim wizard.
- **Location**: This is actually a number of text boxes for address, city, and so on. Defaulting to a new address, its Location drop-down box lists all the addresses obtained from the policy; selecting one fills in the other address fields.

Vehicles, People and Property

This section initially contains only the vehicles selected by the previous step. It contains three buttons to add other incidents, based on another vehicle, a property loss, or 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 Button**
- **Add Pedestrian Button**
- **Add Property Damage Button**

   Note: If the claim is a property claim, this section shows selected properties.

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 it is not known, or if the **Third Party** button is selected, the fields in the previous screen shot appear, to help describe the vehicle. If you click **Stolen** or **Parked** in this section, the **Other Details** and **Damage** sections disappear from the screen.

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

Use the damage section to describe the vehicle damage. It 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 screen. They are identical to the **Services** described in "Step Four: Allocate Services" on page 66.

Add Pedestrian Button

Use this button to add a person to the claim, but only someone not inside a vehicle. They are part of a vehicle incident as previously described. After clicking this button, you see the **Pedestrian Details** screen.

The **Injuries** fields appear only when you select the **Injured** (**Yes**) button. After you save this screen, a new entry appears in the **Vehicles, People & Properties** table of the main Step Three screen. 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** screen each time you click it. Each time you save this screen, a new row appears in the **Vehicles, People & Properties** table of the main Step Three screen. 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's **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, clicking the **Add** button for **Police Report?** opens the **Metropolitan Report Details** screen. Enter details of the report.

> **Note:** If ContactCenter is integrated with Metropolitan Police Reports, this screen shows data when ContactCenter receives its accident report.

Categorization

This section of Step Three contains:

- **Fault rating**: This is used by the subrogation feature; see "Working With Subrogation" on page 273.
- **Weather**: The weather at the accident, from the `Weather` typelist.
- **Catastrophe**: Entering a name associates the claim with that catastrophe. See "Catastrophes" on page 115.
- **Special Claim Permission**: Entering a name places the claim on that ACL. See "Data-based Security - Claim Access Control" on page 383.

Step Four: Allocate 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 to the insured, claimant, or another party reporting the claim. You can determine what services are needed.

- Select a service provider and create an activity to involve that provider in the claim.
- Give information about the preferred service provider to use directly to the claim reporter.
- Do both. Create an activity to assign an adjuster, and tell the caller who to expect and when.

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

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

The screen for each service includes the related coverage and limit. For example, the **Auto Body Repair Shop** service section includes 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 the step four screen of the **New Claim** wizard. Details of each service appear only when the service's checkbox is selected.

The picker can be configured to search based on proximity to the loss, which is already part of the claim. Use the picker to select only **Preferred Vendors**, or vendors meeting a certain minimum standard, as determined by a ranking score. See "Service Provider Performance Reviews" on page 121.

Step Five: Save and Assign the Claim

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

Step five:

- Adds a new **Note** on the claim with a topic of "First Notice of Loss".
- **Assigns** the claim, either to the logged-in user filling out the wizard, or 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.
- Creates **Exposures** by using 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, like a pedestrian, or as part of a vehicle incident, like a driver or passenger.
  - **Exposures based on coverage type.** Choices reflect the coverages on the policy.

After you create individual exposures, 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 displays the exposure types generated for a vehicle on the policy:

Completing the New Claim Wizard

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

Optional New Claim Wizard Screens

"Claim Action Navigation Panel" on page 60 describes other screens that are part of the New Claim wizard. For auto claims, these screens are always available after you have chosen a policy and finished step one.

- **Parties Involved**. A screen in which you can enter all contacts that you did not enter elsewhere. Enter other types of contacts, as well as contacts normally entered on a step screen. For example, if the caller suddenly thinks of a witness name, you can enter it rather than navigating back to the previous step.

- **Policy General**. This screen and the one following show editable information on the selected policy. Editing policy information negates its verified status. See "Working with Policies in Claims" on page 71.

- **Policy Details**. The **General** screen is the policy overview. The **Details** screen shows which vehicles or property 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 screen to review existing documents and add, link, or indicate the existence of a new document to the claim. It is the same screen you reach in ContactCenter when you select **Documents**. This screen is available after you complete step one.

- **Notes**. Use this screen to add a new note.

New Claim Wizard and the Lines of Business

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

Policy Type	Loss Type	Flows (steps) defined in default wizard
Business Owner's (BOP)	General liability, Property	main (9), quick claim property (2)
Commercial auto	Auto only	main (6), quick claim auto (2), first and final (2)

Policy Type	Loss Type	Flows (steps) defined in default wizard
Commercial property	Property	main (9), quick claim (2)
Farmowner's	General liability	main (5)
General liability	General liability	main (5)
Homeowner's	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 a policy to have a significant number of `RiskUnits`. 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	Specific Feature
Find Policy, step 1	Select your policy or create an unverified policy.
Affected Properties, step 2	The vehicles contained in the policy show. Select the one that is affected.
Basic Info, step 3	This section gathers the contact information.
Loss Details, step 4	The section captures loss information and is where you add incidents, such as those affecting vehicles, pedestrians, or property damage. You can add any existing witnesses, officials, or police reports.
Services, step 5	Use this section to assign additional services, such as rental, towing, appraisal or auto body 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 following table lists specifics in the wizard steps for the Commercial Property line of business:

Wizard Step	Specific Feature
Find Policy, step 1	Select your policy, or create an unverified policy.
Affected Properties, step 2	The policy properties show on the screen. Select the one that is affected.
Basic Info, step 3	This section gathers the contact information.
Loss Details, step 4	The section captures loss information and is where you 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	This screen captures the 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 Homeowner's LOB

The claims intake process for Homeowner's claims is usually faster than the intake for auto claims. A Customer Service Representative (CSR) can take 10 minutes to gather data for a Homeowner's claim while taking up to 45 minutes to gather the auto claim information. As such, the New Claim wizard has only four steps.

The benefits are:

- Damage mitigation using Services earlier in the process. Dispatching services early in the claim process can prevent issues from escalating. An example is a leaking pipe, which can escalate to damaged contents and mold issues.
- Questions for capturing detailed damage information are on the claim.
- The user interface is designed to capture information quickly and more intuitively.
- Automatic incident creation upon selection.

Specific Features in the Homeowner's New Claim Wizard

The following table lists specifics in the wizard steps:

Wizard Step	Specific Feature
Find Policy, step 1	In **Claims History**, you can see immediately if there are other related claims, the status of the claim, the loss date, and who was assigned to it. Finding information at this level can alert an adjuster or CSR of potential fraud.
Basic Info, step 2	ClaimCenter pulls into the claim the coverage limits on the policy. This step can save you from having to manually open the policy screens to see policy detail.
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. Property incidents include Dwelling, Personal Property, Other Structures, and Living Expenses. Selecting damage types of either fire or water expands the screen and enables you to capture additional detail and ask the right questions about the damage. This step also captures any witnesses, officials, or reports.
Services, step 4	This screen is where you assign services. If done early in the claim process, assigning services can help keep damages to a minimum. In the base configuration, services is on the `Claim` entity and the `Dwelling Incident` entity if one has been defined in the claim. The Gosu code can be edited in Studio.
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 it to an adjuster or use automated assignment.

See Also

- "Homeowner's Line of Business" on page 285

Configurable Risk Units

Step two of the New Claim wizard for commercial auto and commercial property displays the list of either vehicles (`RiskUnits`) or properties that are contained in the policy. From this list, you make your selection about which property or vehicle is to be included in the claim. This process is configurable in Gosu, enabling you to configure other loss types and display different types of `RiskUnits`. Examples can include configuring locations for a workers' compensation claim, or changing the `RiskUnits` to show coverages in a Homeowner's claim. See the *Gosu Reference Guide* for details.

Working with Policies in Claims

Every claim is a claim against one insurance policy. The claim's policy determines what is covered in the claim. The claim's coverages map to a claim's exposures and its coverage limits bind claim payments.This topic explains the relationship between policies and claims.

This topic includes:

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*. This means that the claim passes validation only at the *New Loss* level, but not at the *Ability to Pay* level. To make payments and complete a claim, ClaimCenter therefore needs a verified policy.

Validating Policies

Every claim must be associated with a policy when it is first created. ClaimCenter validation rules verify that when claims are first created, they are associated with a policy, even an unverified one. This enables a novice call center employee to start the claim process. However, as claim processing progresses to making payments, policy validation rules look for a verified policy.

Snapshots of Policies

Policies are complex, and change as coverages change and as renewals, endorsements and cancellations occur. For ClaimCenter, what is important about a policy is its state when the loss occurred. Therefore, when ClaimCenter refers to a policy, it means a *snapshot* of the policy; its state on the date of loss.

Working with Policies in ClaimCenter

You are limited in performing actions on policies. These limited actions include:

- **Searching for candidate policies**. Enter as much information that helps its search in the external system, so it can return a list of possible policies for selection.
- **Retrieving a snapshot of an existing policy**. Selecting one of the candidate policies associates it to the claim. This operation retrieves full policy information, correct as of the claim loss date.
- **Creating a new policy**. If you want to open a claim without knowing about the policy, enter possible policy information. You need not know the correct policy number.
- **Editing a policy**. Change actual policy information and/or extra policy information that is local to ClaimCenter.
- **Refreshing a policy**. Replace policy information with a fresh policy snapshot.
- **Replacing a policy.** Replace the claim's policy with a new policy.
- **Changing how ClaimCenter displays policy information**. Configure the Policy screen of a claim to display tabs showing aggregate limits, lists of insured properties and vehicles. Select the tabs to display using the PolicyTab typelist. For details, see the Configuring Policy Behavior section of the *ClaimCenter Configuration Guide*.

Searching for Candidate Policies

The New Claim wizard helps you find the correct policy or you can create an unverified policy. You can either enter the policy information or search for candidate policies. Also, use the Search tab to search for the claims of any verified policy.

Enter search information, such as the insured name and address, the PIN number of the vehicle, or any part of a policy number. After entering the date of loss, the integrated external policy system returns a summary of all policies matching your search criteria. The summaries contain a list of all vehicles (or properties) insured under the policy, along with the total number of items in the list.

The list of vehicles or properties can be truncated if the policy contains a large number of them. If the list must be truncated, an attempt is made to retain the correct vehicle or property in the returned list by using the search criteria. If truncation does occur, a warning generates indicating this. The external system returns the totals in the TotalVehicles and TotalProperties parameters. The configuration parameters IgnorePolicyTotalPropertiesValue and IgnorePolicyTotalVehiclesValue suppress these warning messages. If you retrieve this policy, it always contains the entire list of properties or vehicles.

To Select a Verified Policy for a New Claim

1. Navigate to New Claim in the Claim tab.

2. Click Select a verified policy.

3. Enter the policy number and click Next.

Or

1. Navigate to New Claim in the Claim tab.

2. Click Select a verified policy.

3. Click the magnifying glass icon.

4. Enter the data and click Search.

To Search for a Claim by its Policy

1. Navigate to Claims in the Search tab.

2. Enter the policy number and click Search.

To Create a New (Unverified) Policy

1. Navigate to New Claim in the Claim tab.

2. Click Create an Unverified Policy and enter requested information and any policy number.

3. Click Next.

Requested information can include some covered vehicles or property, policy endorsements, or statistical codes.

Retrieving the Correct Policy

The second and final step in adding a policy to a new claim is selecting it from the candidates returned by the policy search. The external policy system retrieves and transfers a snapshot of the entire policy, valid on the date of loss to ClaimCenter. Retrieval occurs automatically when you select a verified policy. However, if you have a list of candidate policies resulting from your search, then you must manually select it.

Editing a Policy Snapshot

You can edit or manually create a policy snapshot at any time, and even provide a policy number for it.

> **Note:** If the external policy provider is unavailable, this is the only way you can open a new claim.

Since any edit to a verified policy de-verifies it, you have a powerful incentive not to make any changes. To keep a policy verified *and* be able to edit its information, ClaimCenter uses additional fields that are attached to the policy.

These fields:
- Are internal to ClaimCenter.
- Are independent of the verified data.
- Survive a policy refresh or replacement.
- Can be edited without fear of policy de-verification.

You must have a role containing the `Make Policies editable` permission to be able to enter an unverified policy and to edit a verified one.

To Modify a Verified Policy

1. Select a Claim

2. Select Policy menu action and click Edit.

3. Click OK to deverify (in popup) and make your edits.

4. Click Update to save your work.

> **Note:** Clicking OK immediately deverifies the policy, even if you make no edits. Select Refresh to reverify it.

To Modify an Unverified Policy

1. Select a **Claim**.

2. Select **Policy** menu action and click **Edit**.

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

To Modify the ClaimCenter-only Fields of a Verified Policy

1. Select a **Claim** and select the **Policy** menu action.

2. Click **Edit**.

3. **Cancel** the OK to diversify popup.

4. Make your edits and click **Update**.

Your edits are restricted to the ClaimCenter-only fields relating to the policy, if there are any.

Refreshing a Policy Snapshot

The **Refresh** button in the **Policy** screen of a claim requests a new snapshot of the same claim. This request re-verifies the claim. Refreshing also overwrites current policy information. This information includes all your edits, except for the ClaimCenter internal fields and the information relating to contacts, claim contacts, and the parties involved. All old contact information also remains, except when there is a new contact, a new claim contact, or a new involved party. In these cases, the new contact information replaces the old entry. The old entry is also retained, with the word *former* preceding the old contact information.

In detail, the **Refresh** button calls the method `retrievePolicyFromPolicy(Policy)` and passes it the current policy to retrieve again.

A policy refresh also triggers validation of the claim and its exposures, at the same validation level the claim had before the refresh.

To Refresh a Policy

1. Select a **Claim**.

2. Click the **Policy** menu action.

3. Click **Refresh Policy** and **OK** to refresh.

Refreshing your policy snapshot cancels all your edits, but leaves all ClaimCenter-only fields unchanged.

A Refresh Can Return Different Information

ClaimCenter retains a single view of the policy. Its details are as of the loss date. However, there can be a problem with this snapshot. A carrier can allow a retroactive *out of sequence* policy change, which could alter the policy on the loss date and make the snapshot dated. If you refresh the policy after such a change, the new snapshot is different but correct.

Example

A policy has one vehicle with collision coverage. However, the insured adds a second vehicle with collision and towing coverages, and adds towing coverage to the original vehicle. If there was a damage claim for the first vehicle before this retroactive change was made, the snapshot would not show the towing coverage. But a refresh made after the retroactive change would include towing coverage on the first vehicle.

The original policy had a vehicle (ID=1) with vehicle number (exposure unit number on the policy) equal to 1. The refreshed policy also had a different vehicle (ID=2) with the same vehicle number. Therefore, the claim would reference the vehicle (ID=2). This is because it had the same vehicle number as the original one.

The claim owner is typically unaware of policy changes. If this is a problem, you can add an activity to the work-plan that asks that the policy be refreshed and checked for any changes before the claim is closed. You can also ask that the policy system notify you of out of sequence changes on policies it has already given you, to know when a refresh is advisable.

A Refresh Can Erase or Replace Claim Information

When you refresh a policy, ClaimCenter removes the link from `Exposure` to `Coverage`. It also checks to see if any of the aggregate financial values have changed, and if so, they are recalculated. Guidewire recommends that new claims never be intentionally created with the wrong policy, and that `Refresh` be disabled for claims in an advanced state.

Parties Involved, Claim Contacts, and Contacts

Unlike other policy objects, no references to a contact or claim contact are nulled on the claim or the claim's related objects. Any policy-related roles that a contact in the parties involved list are replaced by new roles that indicate that the contact *formerly* held a policy related role. For example, if the contact was the *Insured* on the old policy, then that role will be replaced by a *Former Insured* role. The contact still has all of its other previous roles.

If a claim's policy changes multiple times, then it is possible for more than one contact on the claim to have the same *Former* policy role. For example, multiple contacts could be a *Former Insured* on the claim but only one contact can be the *Insured*.

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, will no longer be present in the claim after replacing the policy.

Policy replacement can cause exposures to become invalid. This occurs 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 screen of the `New Claim` wizard and select a new policy.

Coverage Verification

ClaimCenter leverages your organization's best practices in reviewing the claim's characteristics. This helps you to create exposures that make sense and warn or prevent 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.

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 sense in creating an exposure.

The Coverage Verification feature checks for all of these types of incompatibilities. You can define what incompatibilities to check for, except for an incompatible loss party. In that case, you cannot create such an exposure. Except for an inappropriate loss party, 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 only cover a first party.

The `LossPartyType` typelist categorizes exposures by loss party. Thus, if you have selected the loss type to be first party, ClaimCenter displays only the coverages categorized for first party loss types. If you select 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 are appropriate loss causes for comprehensive, but not collision coverages.
- Collision with Motor Vehicle or with an Animal is 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 "To View or Edit Loss Causes and Coverages" on page 77.

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

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

The following example displays the beginning of the default table of loss cause and coverage pairs:

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

To View or Edit Loss Causes and Coverages

To view this table of inappropriate pairings of loss causes and coverages navigate to: **Administration → Coverage Determination → Invalid Coverage for Cause**. If you click **Edit** in this table, then you can add or delete inappropriate loss cause and coverage pairs to conform with your business rules. See "Coverage Verification Reference Tables" on page 413.

Incompatible Exposure

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

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

ClaimCenter maintains a table of incompatible exposure pairs which 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]

The following example shows the beginning of the default table of incompatible exposures:

To View or Edit Incompatible Exposures

To view the table of inappropriate exposure pairs navigate to **Administration → Coverage Determination → 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 checkbox and click **Remove**. Click **Update** to save your changes.

See "Coverage Verification Reference Tables" on page 413.

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 displays 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]

Notice in the following example the lists of incompatible fault rating and coverage pairs:

To View or Edit Liabilities Incompatible with Exposures

To view and edit the table of inappropriate pairings of fault rating and exposure navigate to **Administration → Coverage Determination → Invalid Coverage for Fault Rating**.

If you click **Edit**, then you can add or delete inappropriate pairs to conform with your business rules. Using drop-down menus, you can choose exposure names or fault ratings. To remove a table entry, select its checkbox and click **Remove**. Click **Update** to save your changes. See "Coverage Verification Reference Tables" on page 413.

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.

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`

The Coverage Verification rules execute as other Validation rule sets. They run when you save any new exposure.

> **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 group of coverages, or an account. The purpose of using aggregate limits is so that ClaimCenter can track the payments made either to a claim or an account and warn you if there is an issue.

A limit that applies to an account establishes a maximum liability for all claims made against all of the policies belonging to that account. 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.

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

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

There are two basic types of aggregate limits: **Loss date** and **Reported date**. For either type, a claim applies to the limit if the claim's date is on or within its policy's effective and expiration date. For **Loss date** aggregate limits the loss date must fall within the effective dates of the policy. For **Reported date** limits, the reported date must be within the effective dates.

See also
- "Managing Aggregate Limits" on page 591 in the *Configuration Guide*

Viewing and Setting Aggregate Limits

In ClaimCenter, if you select the **Policy** link on a claim, you can see the **Aggregate Limits** link on the **Policy** → **Aggregate Limits** screen.

You can define aggregate limits on the **Aggregate Limits** tab of a claim's **Policy** screen.

- If the policy is part of an account, any aggregate limit you define on that screen 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** tab apply only to that policy.

Configuring Aggregate Limits

You can configure how aggregate limits are computed, by specifying:
- What policies, policy types, and/or accounts to use.
- What payments sum to use. Choices include Total Payments, Total Net Incurred, or Total Gross Incurred.

To display the **Aggregate Limits** subtab in the **Policy** screen, use the `AggregateLimits` typecode of the `PolicyTab` typelist.

Transaction approval rules, in the Transaction Post-Setup rule set, can check to see that payments do not exceed (or come close to exceeding) the policy's aggregate limits.

The `AggregateLimitType` typelist controls whether annual aggregate limits are computed starting from the date of loss or the date the loss was reported.

Aggregate Limit Key Properties

Aggregate limits have the following key properties:

Property	Description
LimitAmount	The amount of the aggregate limit.
LimitType	The aggregate limit type, either loss date or reported date.
PolicyPeriodID	The policy period to which the aggregate limit belongs.
CoverageLines	An aggregate limit can have multiple coverage lines or none at all.

Aggregate Deductibles

The `AggregateType` typelist selects whether the **Aggregate Limits** subtab of the **Policy** screen displays aggregate limits or aggregate deductibles.

See also

- "Managing Aggregate Limits" on page 591 in the *Configuration Guide*
- For more about policy periods, see the section "Configuring Policy Periods" on page 593 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, homeowner's, 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 (collision, comprehensive, towing for example) defined in the `CoverageType` typelist. 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 subtabs of the **Policy** section in a **Claim** screen. These subtabs include **Aggregate Limits**, **Endorsements**, **List of Insured Vehicles and Properties**. You specify these typecodes to customize the **Policy** screen. 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 what type of claim and payments you can make on it for a given date. However, PolicyCenter 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:
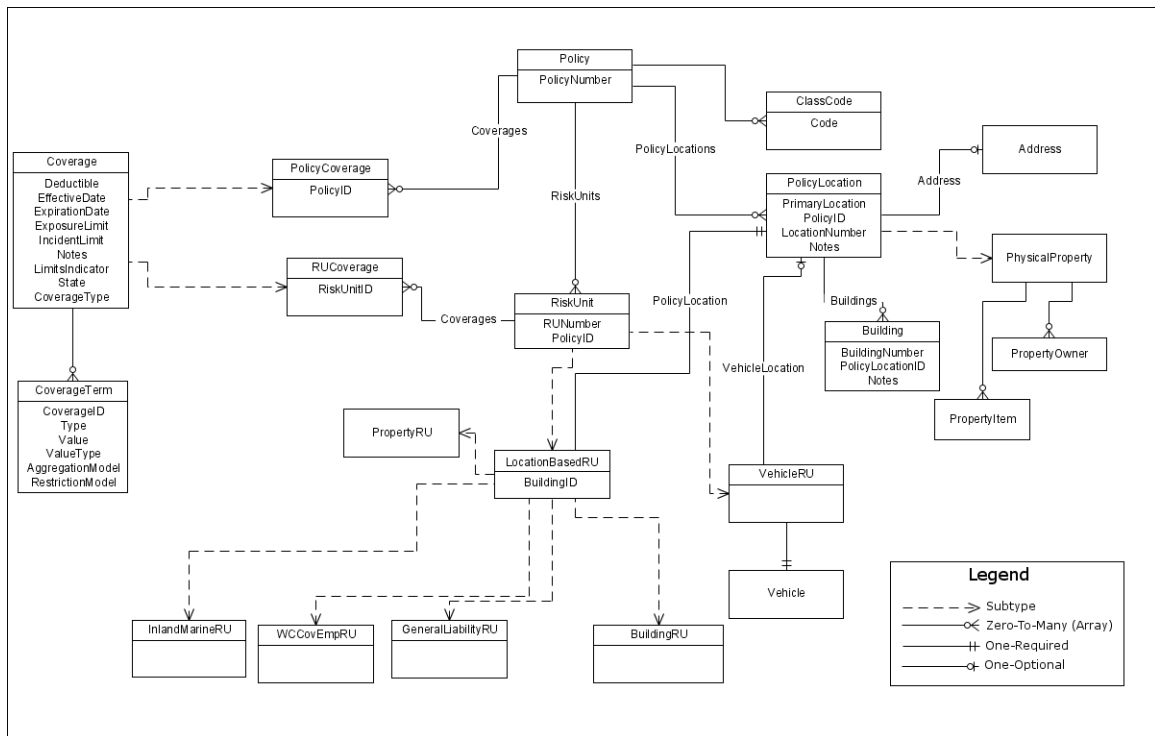
Claim Policies and the Policy Administration System

ClaimCenter integrates with policy administration systems, including PolicyCenter.

See also
- "Policy System Integration" on page 335 for details.
- "Metrics and Thresholds" on page 418 to learn how to administer thresholds in ClaimCenter.
- "Enabling Integration between ClaimCenter and PolicyCenter" on page 64 in the *Installation Guide*.
- "Claim and Policy Integration" on page 443 in the *Integration Guide*.

Claim History

Each claim contains an non-editable **History** screen, which provides an audit trail of a claim's actions. It records all important events associated with a claim, as well as minor events, such as each time a claim is viewed. To access a claim's history, click the **History** menu action while viewing the claim.

The History screen also has a button bar, containing filters for managing your view of history events:

- **Filter.** Filter the history list by the type of event, chosen from a drop-down menu.
- **Refresh.** Show the latest list of history events for the last filter used.

This topic includes:

- "Contents of a Claim History" on page 83
- "Adding History Events" on page 85

Contents of a Claim History

All claim history shows in a sortable table.

- **Type.** The claim event causing the entry in the History table. Events include the claim being opened, an exposure being closed or reopened, a stopped check, and so on. The following table is a full list of what events 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.** A 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 85 for details on how to do this.

The following events are the allowed types of history events, as shown in the `historyType` typelist:

History event type	Description
Mark for Archive	The claim has been flagged for removal to the archive database.

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

Viewing a Claim is Part of its History

Viewing a claim is an event that notes each time the claim is opened. Keeping a history of claim views can be helpful in tracking whether an adjuster has been working on a claim or non-authorized users have been viewing claims.

The History of Financial Transactions

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 will be 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 153.

Another type of financial action that becomes a part of the history is a check's being 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 160.

Claim History of a Policy

ClaimCenter shows a policy's claim history upon claim creation in the New Claim wizard, or after you search for a policy. Adjusters can view the policy's claim history. See "Selecting a Verified Policy" on page 62 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 Studio to monitor the claim and determine if a specific change has occurred. You then write an entry into the **History** screen. You can add your own types of events to the `CustomHistoryType` typelist. You then create rules that note the event in the history. The following table lists the event types already in `CustomHistoryType`. You can add to these events:

Custom history Event type	Description
Auto: No Fault rating	Claim exception: fault rating is not set on auto claim.
Exposure with no reserves	Claim exception: no reserve is set for an exposure.
Exported to Mainframe	Integration: new claim exports to mainframe.
Data change	Any claim data has changed.
Create recovery bill	Create an invoice to bill for a recovery.

chapter 9

Archiving

Archiving is the process of moving a closed claim and its associated data from the active ClaimCenter database to a document storage area. You can still search for and restore archived claims. But, while archived, these claims occupy less space in the active database.

This topic provides an overview of the concepts relating to archiving claims from the perspective of the typical ClaimCenter user.

This topic includes:

- "Archiving Overview" on page 87
- "Archiving Claims" on page 88
- "Searching for Archived Claims" on page 89
- "Restoring Archived Claims" on page 91
- "Configuring Claim Archiving" on page 92
- "More Information on Archiving" on page 92

Archiving Overview

Claims archiving in Guidewire ClaimCenter has the following characteristics:

- ClaimCenter only archives Claims that have been closed for the number of days set by a `config.xml` archiving parameter. You can configure ClaimCenter to match your concept of a closed claim.
- ClaimCenter automatically identifies claims that need to be archived, and then archives them. It does this by comparing `Claim.DateEligibleforArchiving` against current time. `Claim.DateEligibleforArchiving` is set using the archiving parameters in config.xml each time a claim is created, archived, or restored.
- Some claims can be skipped or excluded in the archiving process based on:
  - Whether or not they are still attached to other open objects.
  - Rules you write to prevent archiving. You can look for certain conditions on claims and exclude them or skip them in the archiving process. For instance, you might want to skip all claims associated with a certain catastrophe until you have run reports that total catastrophe statistics and financial items.

- Before completing the archive, ClaimCenter can act on certain rules you write. You can write these rules to preserve more information in the active ClaimCenter database than can be stored in `ClaimInfo`.
- ClaimCenter enables you to search for archived claims in a similar fashion to searching for non-archived claims in the main database. For both active and archived Claims, simple search is based on the `ClaimInfo` object. This object enables you to search for a claim without knowing whether a claim has undergone the archiving process.
- Because search uses the `ClaimInfo` object, ClaimCenter presents the same claim search results containing the same claim summary information whether the claim is active or archived.
- You can extend the `ClaimInfo` object to include fields that you might want to use in searching for both active and archived claims. You can also define other objects that might preserve a subset of denormalized claim data in the active database. These objects can be used in the search itself or be shown only in search results.
- ClaimCenter restores an archived claim if you click the **Retrieve from Archive** button in Archived Claims search results.
- ClaimCenter returns a restored claim to the ClaimCenter database. The restored 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 restored the claim.
  - Metadata about the archiving status of the claim has changed in the `ClaimInfo` object and on the `Claim` object itself.
  - You might have written rules to restore associations that had previously been broken with non-archived objects. However, you might have elected to revive these associations in different ways. You can also configure other pre-restore rules that fit your business process.
- ClaimCenter generates a `ClaimChanged` event every time a claim changes. The `ClaimChanged` events are archiving, retrieval, claim exclusion from archiving, and archive failure.
- The Claim History records a new entry each time ClaimCenter archives or restores the claim.

See also
- "The Domain Graph" on page 279 in the *Configuration Guide*
- "Archive Parameters" on page 39 in the *Configuration Guide*
- "Domain Graph Parameters" on page 52 in the *Configuration Guide*
- "Archiving Claims" on page 665 in the *Configuration Guide*
- "Info Pages" on page 159 in the *System Administration Guide*

The Advantages of Archiving

The main advantage of archiving claims is to improve the application's operational performance. As the application handles more claims, its database storage requirements increase, its table lengths increase, and its performance degrades. Archiving can improve performance in the face of unbounded claims growth.

If you have a legacy system that contains many claims, you can add them to your main database and immediately archive them. You can then search for and restore these legacy claims in ClaimCenter.

Archiving Claims

ClaimCenter archives closed claims and related information. Related objects must implement `Extractable` and have foreign key relationships that traverse to the `Claim` object.

Related objects include the policy snapshot, notes, calendars, exposures, activities, matters, and the claim's Access Control Lists (ACLs).

See Also
- "The Domain Graph" on page 279 in the *Configuration Guide* for an explanation of what the domain graph is and how to use it.

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

What ClaimCenter Does Not Archive

It is not possible to archive all claims. The following table contains a list of conditions that can prevent ClaimCenter from archiving a claim or a claim object.

Types of claims that cannot be archived	Reason
Claims with pending messages	This table must be empty. It cannot contain messages that have been sent. It is unlikely that an old, closed claim is in this condition. If it is, the archiving batch process skips this claim for now, but continues trying until it finds that there are no more active messages.
The first claim attached to a bulk invoice	Claims that have payments made by a bulk invoice can be archived. But a bulk invoice can be connected by an activity to one claim, the first one, in the bulk invoice. If so, then the claim cannot be archived. ClaimCenter never attempts to archive a bulk invoice.
Claims that have aggregate limits	If a claim's policy has aggregate limits, ClaimCenter cannot archive the claim.
Claims that are part of an unfinished workflow	It is not possible to close a claim that has an active workflow. ClaimCenter only attempts to archive a closed claim.
Claims with open activities	The archive work item writer does not pick up claims with open activities. If a claim was archived with open activities, those activities would disappear from the person's **Desktop** and would not be found or closed unless the claim was restored. There is an archive rule, *Open Activities Rule* (ARCO4000), that skips claims with open activities. 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 processed it. The rule skips claims with open activities. Guidewire recommends that you do not modify this rule.
Excluded claims	The writer does not process claims already marked as excluded. You can write rules for the archive batch process to exclude certain claims.

Entities You Cannot Archive

It is not possible to archive the following entities:
- `BulkInvoice`
- `ClaimInfo`
- `ClaimAssociation`

Searching for Archived Claims

A key feature of claim archiving is to be able to search for archived claims alongside active ones. To accomplish this, ClaimCenter creates a `ClaimInfo` object for each claim as it creates the claim. This object contains key search information for use in finding archived claims.

Simple search is based solely on the claim stub found in the `ClaimInfo` object and the `ContactInfo` object. The `ContactInfo` object contains information about claimants and the insured on the claim. Because these archived

claim stubs do not contain all claim information, ClaimCenter divides claim searches into simple and advanced searches.

- **Simple Claim searches.** Searches that can be performed on all claims. A simple search brings back active claims in the same screen and provides a link to the **Advanced Search** screen for viewing archived claims.
- **Advanced Claim searches.** Searches that can be performed either on active claims or archived claims. A drop-down list lets you select whether you are searching for active or archived claims. This is also the screen to which the **Simple Search** results link for viewing archived claims.

Simple Claim Searches

As you perform a simple search, you never specify whether to search for active or archived claims. ClaimCenter always searches for both types. The application displays summaries only of the *active* claims it finds.

If ClaimCenter finds an archived claim after you perform a simple search, ClaimCenter provides a link directing you to the **Advanced Search** screen. On this screen, you can:

- Click **Retrieve from Archive** to retrieve a claim that you are sure you want.
- Click a claim link to open the **Archived Claim Summary** screen. You can see summary information for the claim in this screen.

To perform a simple claim search

> **Note:** You cannot perform a **Simple** search by loss date or notice date.

1. Select **Simple** from the **Search → Claim** drop-down menu at the top of any **Search** screen.

2. Select at least one search criterion from the list.

   The following search criteria are available for **Simple** searches.
   - Claim number
   - Policy number
   - first name
   - last name
   - organization name
   - tax ID

3. Look at the search results, which are summaries of active claims only.

4. To view summaries of the archived claims found, click **View archived claims**. ClaimCenter displays the **Advanced Search** screen.

5. At the lower section of the screen is the **Search Results**. You can either select the claim and click **Retrieve from Archive** to work with it, or click the claim to view its details.

6. Clicking the claim displays the **Archived Claim Summary** screen. In this screen, you can see claim details and also retrieve the claim from the archived database.

Advanced Claim Searches

If you select **Archive**, your search criteria are limited. However, you can use the **Search for Date** field. You must enter a date, or range of dates, for this criterion.

To perform an advanced claim search

1. Select **Advanced** from the **Search → Claim** drop-down menu at the top of any **Search** screen.

2. Select the type of claim to search, **Active Database** or **Archive**. In this example, select **Archive** from the **Source** field.

   Unlike **Simple** searches, an **Advanced** search displays each claim found.

3. At the lower section of the screen are the **Search Results**. You can either select the claim and click **Retrieve from Archive** to work with it, or click the claim to view its details.

4. Clicking the claim displays the **Archived Claim Summary** screen. At this point you can also retrieve it from the archived database.

Finding Archived Claims without Searching

You can enter the number of an archived claim in any **Claim** drop-down menu. You can also select any archived claim by entering its number in the **QuickJump** box. However, if you select an archived claim in this way, you must restore it before you can work with it.

Restoring Archived Claims

After you have located an archived claim, you see a summary of it. To work with an archived claim you have found, first restore it to the ClaimCenter database.

After performing a **Simple** search for a claim and seeing the list of archived claims found, select the checkbox for one or more archived claims and click **Retrieve from Archive**. Enter a comment about restoring the claim and click **Retrieve from Archive** again. You see the claim's **Summary** screen.

> **Note:** You must enter a comment before you can restore the claim.

Restoring a claim also:

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

If you restore a claim, ClaimCenter creates two activities and assigns one to the current user and one to the assigned user for the claim. If the owner of the claim is inactive, ClaimCenter sends a notification to the inactive user's supervisor. You cannot change or configure this action.

Reassigning the Restored Claim

All restored claims must be assigned, just as all newly created claims are. The `AssignClaimToRetriever` configuration parameter in `config.xml` determines claims assignment. If you want to reassign restored claims to the user who restored them, set this parameter to `true`. The default is `false`, which assigns a restored 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 restored claim to the supervisor of the group. If ClaimCenter cannot reassign the restored claim to the original group, ClaimCenter assigns the claim to *defaultowner*.

The default owner in the base configuration contains no roles and is assigned to the root group. Its purpose is to provide an owner for a claim if ClaimCenter cannot reassign the restored claim to anyone.

> **IMPORTANT** Do not delete the default owner from the application because there can be problems assigning restored claims if the restored owner is not a member of a group.

Restored Claims Generate a New Activity

Restoring a claim always creates an activity sent to both the claim owner and the claim restorer by using the activity pattern defined by the `config.xml` parameter `RestorePattern.` This activity notifies the claim owner and restorer that this restored, active claim now exists.

The activity can also enable its recipient to reassign the activity. This feature can be useful because the restore process can assign an activity to a user who no longer exists or no longer has permission to see the claim. If you have created 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.

Permissions Needed to Restore a Claim

To restore an archived claim, you must have both view and edit permissions on the claim. If the claim is part of an ACL, you must be part of the same ACL to restore it.

Restored Claims Contain a New Note

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

> **Note:** If a claim has been restored, worked on, closed again, and is ready for archive, ClaimCenter might not re-archive it before the claim meets the specific retention time.

Configuring Claim Archiving

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

- "Archive" on page 48 in the *Rules Guide* for a discussion of the Archive business rules
- "Configuring Claims Archiving" on page 670 in the *Configuration Guide* for a discussion of the different configuration points associated with archiving
- "The Domain Graph" on page 279 in the *Configuration Guide* for information on how ClaimCenter builds the domain graph

More Information on Archiving

See also
- "Archiving" on page 87 in the *Application Guide* – information on archiving claims, searching for archived claims, and restoring archived claims.
- "Archive Parameters" on page 39 in the *Configuration Guide* – discussion on the configuration parameters used in claims archiving.
- "Archiving Claims" on page 665 in the *Configuration Guide* – information on configuring claims archiving, selecting claims for archiving, and archiving and the object (domain) graph.
- "Archiving Integration" on page 285 in the *Integration Guide* – describes the archiving integration flow, storage and retrieval integration, and the `IArchiveSource` plugin interface.
- "Archive" on page 48 in the *Rules Guide* – information on base configuration archive rules and their use in detecting archive events and managing the claims archive and restore process.
- "Logging Successfully Archived Claims" on page 37 in the *System Administration Guide*.

- "Purging Unwanted Claims" on page 58 in the *System Administration Guide*.
- "Archive Info" on page 160 in the *System Administration Guide*.
- "Upgrading Archived Entities" on page 62 in the *Upgrade Guide*.

IMPORTANT   To increase performance, most customers find increased hardware more cost effective than archiving unless their volume exceeds one million claims or more. Guidewire strongly recommends that you contact Customer Support before implementing archiving to help your company with this analysis.

chapter 10

Validation

Validation is a general application behavior that prevents you from saving invalid business data. ClaimCenter validates data in the following ways:

- **Field-level validation**. Validation behavior tied to one or more specific fields, which can be implemented at:
  - **The data model level.** Includes data types and field validators.
  - **The user interface level by using validation expressions**. Validation behavior tied to one or more specific fields, which can be implemented at the user interface level by using 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 five cars. The business data is invalid, but there is not any one field that is causing the error.

This topic explains the types of validation, and how ClaimCenter uses them.

This topic includes:

- "Field-level Validators" on page 95
- "Validation Rules" on page 96

Field-level Validators

Field-level of validation encompasses both the data model level and the user interface level.

Validation and the Data Model

ClaimCenter performs validation on data types and field validators at the data model level. Every time you enter data on a field with data model validation anywhere in ClaimCenter, the system checks to see if the data is in the correct format.

Data Types

ClaimCenter validates several kinds of data types to ensure that the values are legal for the field's underlying datatype. For example, you must enter a date field in a particular way, and if you do not, ClaimCenter shows an error message identifying the problem so you can correct it. Another example is a policy or claim number. Each must be in a particular format (pattern). This type of validation is in the base application, and there is no need for any configuration.

Field Validators

A field validator is a *pattern* tied to a field or datatype in the data model. If the value does not match the pattern, ClaimCenter does not save the data, and it shows an error message so you can make corrections. Field validators are used for simple invalid data validation. For example, a social security number must be in a certain format. If you attempt to enter the number without the use of two hyphens, then 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 which must be matched, such as three digits, a hyphen, two digits, a hyphen, and four digits.
- **Description**: The message shown when the pattern is not matched. For example, if you entered a social security number with a letter, ClaimCenter shows a message indicating the correct format to be used.
- **Input mask**: An optional mask that helps you enter the correct pattern. For example, the 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 to the entity field. See "Field Validation" on page 293 in the *Configuration Guide* for details.

Validation Expressions

A validation expression is an expression in Gosu code that is tied to a widget that implements field-level validation. When the expression returns `null`, validation succeeds and the application saves the data. When the expression returns a `string`, an error message, then validation fails and you see the `string`. This error message enables the user to enter as correct data. For example, you might ensure that a date-of-birth field must occur in the past.

As described previously, 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, then you use a validation expression in the applicable PCF file. However, if you want the expression to apply to multiple date-of-birth fields, you might write a rule for it instead, as described in "Validation Rules" on page 96.

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 does rule validation 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 97.

If a goal of a claim is to eventually make payments on it, rules can ensure that the claim contains all required data to process it at that level. Each time that you click **Update**, ClaimCenter runs configurable validation rules in a certain order before data can be saved to the database. These rules check the data and advance the maturity of the

entity as far as it is qualified to advance. Objects in ClaimCenter are not allowed to move backwards in maturity because these levels often correspond to information being sent to external systems.

ClaimCenter automatically performs validation checks on these 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. These rules ensure that the claim 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 97
- "Validation Levels" on page 98
- "Pre-update and Validation Rules" on page 98
- "Validation Errors and Warnings" on page 99
- "Running Validation Rules Manually in the User Interface" on page 99

Validatable Entities

An entity must be validatable so that you can run pre-update and validation rules associated with it. ClaimCenter validates only the following entities, and in the following order:

1. `Policy`

2. `Claim`

3. `Exposure`

4. `Matter`

5. `TransactionSet` (and `ReserveSet`, `CheckSet`, and other subclasses)

6. `Group`, `User`, and `Activity` (in no particular order)

7. Any other custom validatable entity

Claims, or any validatable entity that has a field that triggers validation, can have related subobjects. Whenever the claim itself is created or modified, claim validation rules are run. 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 are also run. These rules run because validation logic might exist at the claim level that is related to information at the subobject level.

Custom Validatable Entities

You can create custom entities that are validatable and have *Pre-update* and *Validation* rules run on them. To do so, you must create:

- The entity and implement the validatable delegate.
- Any PCF components, if necessary.
- Rule sets and rules. The rule set name must be named *YourEntityName*`ValidationRules`. If you use the `reject` method, you must pass in an `errorLevel` because custom validatable entities do not mature. Guidewire recommends a level such as *New loss completion*, code `newloss`, since it is almost always required. This technique is used for both warnings and errors.

Validation Levels

Validation levels are defined in Studio in the *ValidationLevel* typelist. The *Load and save*, *New loss completion*, and *Ability to pay* levels are required by ClaimCenter and cannot be removed. You can remove iso or external levels or configure additional levels.

In the base configuration, the validation levels are:

Validation Level Name	Explanation for Why this Level Exists
Load and save	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	If you create a claim from the wizard, this level defines the minimum amount of information for it to be saved as a claim.
Valid for ISO	(Optional) This level verifies that all required fields are complete before sending to ISO.
Send to external system	(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 defined that uses this level.
Ability to pay	This level ensures that a claim has all the required data needed to make a payment on it.

Implementers can write integration programs to take validation level into account. For example, a claim might exist in ClaimCenter at the *New loss completion* level, but not be sent to a back-end system until *Send to external system* is achieved. One reason that claims cannot go backwards in validation level is that they might have already been sent to an external system based on validation level achieved.

Note: Some entities have rules that run, such as *Transaction Validation* rules. These rules are not tied to particular level but can generate warning or error messages.

Validation Levels in the User Interface

In the base application, you can see the validation level for a claim and an exposure. For a claim, refer to the **Claim Status** screen and look for the **Claim Validation Level** field to see what level the claim is at. For an exposure, refer to the exposure's **Detail** tab under the **Validation Level** field.

Pre-update and Validation Rules

If a validatable object is either created or modified, then Pre-update rules for that object are run first. Pre-update rules for that object are also run first when a subobject triggers the validation of the parent. Validation rules fire after Pre-update rules.

- Pre-update 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. Pre-update rules can create an activity so that the correct person can review the document.
- Validation rules always promote an object to the highest possible level. As the result of a change, the system allows the change if an object:
  - Does meet all of the conditions at the next higher level.
  - Does not violate any conditions at the current or lower levels.

  Promotion also occurs as far as possible, possibly resulting in a promotion only to the next highest level or to multiple levels.
- In addition, validation rules can verify that rule conditions are met. If they are not, the system can show either warning or error messages.

If the object fails validation, any work that was done by the Pre-update rules is also rolled back.

Validation Errors and Warnings

Validation rules have two types of failure: warnings and errors. You can implement one or both of these types. Both types of validation messages are shown in the **Validation Results** window, 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 do not allow you to continue until you fix them. Error messages will only display during an update in two cases:
  - If you first save a claim or exposure, and it does not pass all validations at the Load and Save level.
  - If an edit of a claim or exposure would have forced the object to revert in maturity level.

  Note: ClaimCenter only displays warning and errors 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 attempting to save a claim, a rule can notice that an optional field is blank and give a message asking that it be filled in. If you attempt to 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 pop-up **Validation Results** windows. Clicking an error or warning in this window takes you to the object in question so you can 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, navigate to a claim, click the **Actions** menu, and click **Claim Actions**. You can choose to validate 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 might manually run validation rules on the claim and its exposures to see if the claim reached the *Ability to pay* maturity level.

See Also
- "Claim APIs" on page 89 in the *Integration Guide*
- "Validation" on page 79 in the *Rules Guide*

chapter 11

Claim Fraud

Fraudulent claims are a continuing problem for all who handle them, and identifying suspicious claims is difficult. Too often, flagging a suspicious claim is left to some *ad hoc* process that might be different for each adjuster. ClaimCenter, recognizing the importance of uncovering fraudulent claims, provides a mechanism to help you determine when to further investigate a claim.

The centerpiece of the ClaimCenter fraud detection is its ability to analyze claims rationally and determine a risk potential (Special Investigations) score for them. ClaimCenter creates this score using both a set of business rules to analyze a claim's information for possible fraud, and also a set of questions that the adjuster answers. As the adjuster adds more data to the claim, and again answers the Special Investigations 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 provides a number of benefits, including:

• Reducing leakage in handling claims.
• Enforcing business processes evenly across the organization.
• Assigning the same standardized weight to each suspicious fact in each claim.
• Providing transparency to the process of deciding what to investigate.
• Providing a fact-based evaluation of all claims, rather than using *intuition*.
• Keeping an audit trail of why and how claims became suspicious.

Many of these benefits affect your carrier's bottom line. They can also be important from a legal perspective.

This topic includes:

Fraud Detection Overview

Special Investigation (SI) rules and question set answers identify suspicious characteristics of a claim, and assigns points to each of these characteristics. The sum of these points is the Special Investigations score. Depending on your business logic, you can set up your own suspicious claim analysis:

- Create a Special Investigations rules to detect conditions that your business practices have been shown to be fraud indicators.
- Create Special Investigations question sets that an adjuster asks. Again this is based on your company's experience and business practices, to indicate fraud potential.
- Assign different point values to all suspicious characteristics obtained from both rules and answers.
- Create a single Special Investigations score for each claim from the sum of all points.
- Select the score threshold at which to create an activity for further investigation.

Rules can Evaluate Risk Potential

Fraud Detection
Flow Diagram

User answers SI questions → Fraud Detection (SI) question set score recalculated when questions completed

Rules Engine runs Fraud Detection (SI) Rules when claim is saved ← User modifies Exposure or Claim

Is any rule or question true for the first time? — NO → EXIT Stop SI processing

YES

Is question or rule name already added to Claim? — YES → EXIT Don't add a duplicate entry to the SI array

NO

Write rule or question name to Claim's SI array, and increment its SI score

Does SI score reach its threshhold value? — NO → EXIT Don't escalate to Supervisor

YES

Create an SI review activity for the Claim owner's supervisor

Does Supervisor decide to escalate Claim to SI Team? — NO → EXIT No SI escalation desired

YES

Create SI escalation activity; assign to SI group; look for fraud

Legend:
- MANUAL: User input
- MANUAL: User decision
- Automated rules-driven decision
- Automated rules-driven action
- Automated end of process

Rules which 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 Special Investigations rule set, where they run regularly (see "After Special Investigations Rules Run" on page 104).

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 Investigations rule is true, ClaimCenter performs these actions:

- It 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 "Driver is a minor not listed on the policy" rule description to the claim's Special Investigations array. It also adds the driver's name in the Additional Information part of the array.
- It increments the Special Investigations score by the value specified in the rule's actions.

After Special Investigations Rules Run

A good practice is to not have the Many Special Investigations rules run when a claim is created, but at later points in the claim's lifecycle. A claim pre-update 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 pre-update rule set, then decide when to run based on this stage. The `SimpleClaimTimer` typelist contains the stage names. This mechanism restricts rules to a specific claim lifecycle stage.

Question Sets also Evaluate Risk Potential

Also, 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 example questions which can help in that determination:

Points	Possible questions in a Fraud Evaluation question set 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 communicated 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	Is 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	Possible questions in the Special Investigations question set 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 it not been seen for some time?
choice	If yes, then not for 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 vehicle?
yes = 1	Do appraisal photographs show only close-up damage views - but not enough to identify it?
yes = 1	Was the vehicle repaired before the claim was reported?

Points	Possible entries in the Special Investigations question set for workers' compensation claims
yes = 2	Is it possible injury 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

- If a question starts "If (another question) is yes", then you create it to be a conditional question. The tab displays it only when the other question's answer is yes.

- After a question's points are shown as *choice*, then the question is of type choice. You create it to display several answers, each associated with a different number of points. For example, the question "What is the claimant's credit score?" could have this set of possible answers (choices) and points: below 500 (3 points), 501-600 (2 points), 601-700 (1 point), or above 700 (no points).

By assigning points to each question or answer choice, ClaimCenter can calculate their sum, which (along with the points from the Special Investigations rules) is the Special Investigations 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 a one or more Special Investigations questions are answered, ClaimCenter performs these actions:

- It adds the question description to the Special Investigation array for display, along with its score.
- It recalculates the Special Investigations score by any change in the question set's total points.

After Special Investigation Question Sets Run

Access the SIU question set with the **Refer to SIU team** button in the **Special Investigation Details** screen from the **Special Investigations Details** tab on the claim's **Loss Details** screen. After you enter or change any answer, ClaimCenter recalculates the claim's Special Investigations score. After you create questions in a single question set, you insure that all questions will be visible and answerable.

The Special Investigations Score

The Special Investigations score is the sum of the Special Investigations Rules score and the Special Investigations Question Set score. After it reaches a defined threshold, a rule in the claim pre-update rule set creates an activity for the claim handler's supervisor to review this particular claim. Any user with administrator privileges can set this threshold with the `SpecialInvestigation_CreateActivityForSupervisorThreshold` script parameter. The default is five.

Upon receiving the activity, a claim supervisor reviews the contents of the **Special Investigation Details** subtab and details of the claim. After review, the supervisor can enter a comment in the **Supervisor Notes** box. The supervisor can choose to escalate the claim to another user by checking the **Refer this claim to SIU team** box in this screen. If checked, ClaimCenter then assigns the activity to a member of the Special Investigation group by round-robin assignment. It 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.

The Special Investigation Details Screen

While viewing a claim, use the **Special Investigation Details** screen to view and track details of suspicious claims. Accessed from the **Special Investigations Details** tab on the claim's **Loss Details** screen, this screen contains:

- **Investigation trigger parameters detected on this claim**: The Special Investigations array. It contains Special Investigations rule descriptions of the rules which this claim violates. It also has additional information pertaining to the rule, and the total (**Subtotal Score for Special Investigation Trigger Parameters**).
- **General SIU**: The first Special Investigations question set, including answers and corresponding points if the questions have been answered.
- **Auto SIU**: The second Special Investigations question set. **WC SIU** is for workers' compensation claims.
- **Subtotal Score for Special Investigation Questionnaire**: Total of all question set points.
- **Total Score for Special Investigation Escalation**: Total points from rules and question sets.
- **Refer this claim to SIU team**: Whether the claim was escalated to a claim supervisor or to a fraud investigator or Special Investigation team.

- **Supervisor Notes**: Created by the person who escalated the claim to the SIU.

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 264 for information on creating and editing question sets.

To Update the Rules and Answers

Re-saving the claim runs the Special Investigations rule set. With the correct permission, you see and can edit any or all the questions. Click **Edit** to do so, and **Update** to save the answers.

To Refer the Claim for an SI Review

If you have the `editsensSIU` permission, and click **Edit**, then **Yes/No** radio buttons are enabled next to the **Refer this claim to the SIU team** phrase. If you select **Yes**, then the optional **Supervisor Notes** field appears.

To access, select a claim and click **Loss Details** (on the left menu) → **Special Investigation Details** (at the top of screen) → **Edit**. This displays the editable **Special Investigation Details** screen.

SI Permissions

SI information is considered privileged. Only the claim owner and managers with the `editsenssiu` permission can:

- see the question answers
- edit them
- access **Date referred** and **Total Score**

You 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 questions, **Supervisor Notes** and **Refer this claim to SIU team**.

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. Today, especially in the United States market, this process is often managed by other systems, such as *CCC Information Services* or *Audatex*. 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.

This topic includes:

- "Assessment Overview" on page 109
- "Working With Assessments" on page 110
- "Data Model for Assessments" on page 112

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. The difficulty is, however, in determining the lengths of 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 (evaluators, or assessors). See "Sources" on page 111.
- Itemizing, then categorizing (grouping) property for assessment. See "Damage Tables" on page 111.
- Managing documents and notes associated with the assessment process. See "Documents and Notes Used in Assessments" on page 112.
- Sending work orders to multiple sources to perform evaluations.

- Collecting and evaluating the estimates and quotes generated by the work orders. See "Damage Tables" on page 111.
- Agreeing to the loss value. This is 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 "Sources" on page 111.
- Evaluating the quality of the indemnification. See "Event Lines Table" on page 111.
- Maintaining a status display of the assessment work orders and repair orders. See "Event Lines Table" on page 111.

For vehicle losses, providing timely assessment services is a key component of controlling leakage. Ideally, the end of every first notice of loss (FNOL) conversation concerning an auto loss includes the insured's being told:

- 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, and 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 access the Assessments screen

1. Navigate to a claim and click **Loss Details**.

2. Select an auto (under the **Vehicles** section) or property (under the **Properties** section).

3. Click the **Assessments** tab.

The 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 that can be used for any purpose.
- **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.
- **Assigned User**: The adjuster or other user assigned to this part of the claim.
- **Externally Owned**: (Yes/No radio buttons) Is this assessment assigned to an outside agency?
- **Comment**: Another text field that can be used for any purpose.
- **Total-Approved:** The auto-generated total of all **Estimate** amounts of all **Approved** items in each **Damage** table.
- **Total-In Review:** The auto-generated total of all **Estimate** amounts of all **In Review** items in each **Damage** table.

Sources

The Sources drop-down list contains all contacts (persons or vendors) who provide or will provide assessment services, including estimating, quoting, repairing and restoration, and replacement. You can use ContactCenter to maintain lists of searchable sources, or select (enter) them manually. It contains these columns:

- **Name**: The name of the assessor—required unless the entry comes from ContactCenter.
- **Source Type**: The category of assessor, such as internal appraiser or trusted body shop.
- **External Assessor**: Whether the source is an employee of the carrier.
- **Description**: A text field that can be used for any purpose.
- **Create Time**: The time when this source is added. ClaimCenter creates this time stamp.

Damage Tables

These tables contain lists of damaged or lost property and contain slightly different information, depending on the loss type (auto, fixed property) or the contents of a building or auto. These tables show the following information:

- **Description**: A free-form field typically used to describe the item.
- **Action**: Whether the amount for this item has been *Approved*, *Denied*, or is being *Reviewed*. These values are from the `AssessmentAction` typelist, except for the Contents table. The Contents table uses `AssessmentContentAction`, a typelist that also has the value *Depreciate*. Depreciate means that to be approved, the item's value must be depreciated to arrive at a more accurate amount.
- **Source**: The contact that produced other information (such as Estimate or Value) shown in this line of the table.

All these tables try to group items into categories, and the Contents table groups its categories into Schedules.

The following table lists the typelists that determine the kinds of Categories, Schedules, and Actions, and it also lists the unique information maintained by each kind of table:

Damage Table Name	Loss Type	Category Typelist	Other Unique Fields	Action Typelist
Content Items	Property	ContentLinetItemSchedule and ContentLinetItemCategory	# of items, Brand, Date Acquired, Purchase Cost, Value	AssessmentContent-Action
Building Components	Property	PropertyLinetItemCategory	Estimate, Comment	AssessmentAction
Vehicle Line Items	Auto	VehicleLineItemCategory	Estimate, Comment	AssessmentAction

The Line Item Category and Line Item Schedule typelists are based on IRS-Publication 584B: Business Casualty, Disaster, and Theft Loss Workbook. All these typelists are extendable.

Each table also includes a **Create Time** timestamp on each line.

Event Lines Table

This table is a list of the events that result in satisfactorily indemnifying the claimant for his monetary loss. A typical sequence of events might include these events, all of which are typecodes of the `AssessmentEvent` typelist:

- **Assignment Accepted**: An adjuster has been assigned to the activity of assessing this claim.
- **Estimate Date Set**, **Complete**, **Accepted**: The damage has been assessed and a quote has been received and accepted.
- **Repair Date Set**, **Re-set**, **In progress**, **Complete**: The damage repair is monitored until completion.

The **Event Lines** table also includes:

- **Date**: After the event occurred.
- **Note**: A free-form comment field.
- **Created:** A timestamp.

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. This is the same for **Notes**. Also, you can add notes directly to the Event Lines table of any Assessment screen.

The Workplan Screen

The **Workplan** screen contains a new filter to show activities pertaining to Assessments.

Permissions

You do not need special or additional permissions to view or edit the Assessment screen of a claim. Access to the claim itself is sufficient to view and edit Assessment screens.

Data Model for Assessments

There is one assessment process per vehicle or fixed property. Hence, Assessments is an extension to the `Incidents` entity. Entities related to Assessment include:

Assessment Entity	Contents and Use
AssessmentSource	Multiple parties can inspect and assess the same vehicle or property. This array captures this information.
AssessmentLine	Many events related to an Assessment can take place. For example, Assignments can be scheduled and canceled.
AssessmentItem	Both vehicles and property have this itemized list of damages and costs to indemnify.
AssessmentContentItem	Property, in particular, has both the structural component captured in the AssessmentItem array and itemized content. The difference between the two is the depreciation on the items. This array captures the list of contents.

The Assessment feature uses a number of typelists. All are extendable. The IRS uses the category and schedule typecodes.

Assessment Typelist	Contents and Use
AssessmentAction	Action taken for each estimate: `Review`, `Approve`, or `Deny`. For auto and fixed property losses, but not for contents that can depreciate.
AssessmentContentAction	Action taken for each estimate: `Review`, `Approve`, `Depreciate`, or `Deny`. For contents losses.
AssessmentEvent	Events capture the time line of the assessment process. Some typical events include `Assessor Assigned`, `Estimate Complete`, `Estimate Accepted`, `Repair Date Set`, and `Repair Complete`.
AssessmentSource	The source of the assessment: the `Insured` or `Claimant`, an `Approved Vendor` or `Internal Appraiser`, or a `Desk review` (appraiser's combination of assessments from different sources).
AssessmentStatus	`Open` until the Insured or Claimant is satisfied, then `Closed`.
AssessmentType	`Property`, `Auto`, or `Contents`, which can be from either a damaged auto or building.
ContentLinetItemCategory	Items found in offices, such as staplers, scissors, servers and monitors. They are categorized by typecodes of the `ContentLinetItemSchedule` typelist.
ContentLinetItemSchedule	Categories of the items found in the `ContentLinetItemCategory` typelist.
PropertyLinetItemCategory	A `Building` or its major parts, such as its `Roof`, `AC's`, `Heating`, `Plumbing`, or `Lighting systems`.

Assessment Typelist	Contents and Use
`VehicleLineItemCategory`	Major systems of a vehicle: `Body`, `Brakes`, `Engine`, `Suspension`, and so on.

Catastrophes

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

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 link every claim that comes in due to a catastrophe as being associated with that catastrophe. If you do not, you risk leakage due to not recovering money for that claim from the reinsurer. You can also use rules that identify claims that match a catastrophe's profile, but that 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 these 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 a Loss Cause, such as wind).

For example, a carrier declares Hurricane Katrina to be a catastrophe. It involves claims in the states of Florida, Alabama, Mississippi, and Louisiana for property damage due to flood, wind, or rainstorm. It also occurred during the period of time from July 2005 to December 2005.

ClaimCenter assists carriers handling catastrophes by:

- Defining and maintaining a list of catastrophes. See "The Catastrophe List" on page 116.
- Associating at most one catastrophe to a claim. See "Associating Catastrophes and Claims" on page 118.

Catastrophe Management and Reports

Supervisors and managers can run reports relating to catastrophes. Running and viewing reports is a useful management tool enabling you to see aggregated information in one place. You can adjust work loads to accommodate issues that might affect your business, such as catastrophes. If you have the appropriate permissions—reportmanager and reportuser—you can access reports from the **Report** tab.

See "Claim Catastrophe Detail" on page 85 in the *Reporting Guide* for details on how to run reports and to see a list and description of the catastrophe related reports.

Working With Catastrophes

ClaimCenter divides the management of catastrophes into the following tasks:

- Creating and maintaining a list of catastrophes.
- Associating a catastrophe with a claim.
- Finding and associating claims that have been created prior to the catastrophe's being entered into the system.

This topic includes:

- "The Catastrophe List" on page 116
- "Working with Catastrophes" on page 117
- "Catastrophe History" on page 120
- "Using Catastrophes Defined by ISO" on page 117

The Catastrophe List

Access the list of catastrophes through the **Catastrophes** menu item of the **Administration** tab.

This list describes all attributes that ClaimCenter maintains for each catastrophe. They include:

- **Status**: A catastrophe can have the status of **Active** or **Inactive**, controlled by the **Activate** and **Deactivate** buttons.
- **Name**: Any value is acceptable, and you can search on the name.
- **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 state of Washington.
- **Begin Date** and **End Date**: The date range of the catastrophe.
- **Type**: Generated from a governing body, such as ISO in the United States, or Internal. Values are in the CatastropheType typelist. See "Using Catastrophes Defined by ISO" on page 117.
- **PCS Serial Number**: Optionally, enter ISO's Property Claim Service (PCS) serial number.

- **Comments**: A free-form text field typically used to describe the catastrophe.
- **Last Edited** and **Last User**: Which user edited the catastrophe, and the date of the last edit. The system does not use thee fields elsewhere.
- **Coverage Perils**: Each Coverage Peril is defined by both a Loss Cause (from the `LossCause` typelist) and a Loss Type (from the `LossType` typelist).
- **Zone Type**: The geographical region in which the catastrophe occurred. Every claim associated with this catastrophe *must* have its loss location in an affected area. Region information is not in the list of catastrophes. It can only be seen by editing the catastrophe of interest.

These fields can be seen in the **Catastrophe Details** screen.

Working with Catastrophes

This topic contains the steps for working with catastrophes.

To add a new catastrophe

1. Navigate to **Administration** → **Catastrophes** menu item. Click **Add Catastrophe**.

2. Enter your data and click **Update** to save your work.

To edit an existing catastrophe

1. Navigate to **Administration** → **Catastrophes** menu item.

2. Click **Edit**, and make your changes.

3. You can click **Add** for **Perils**, **States** and click **Update**.

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 will still be associated with the catastrophe. Searching and report generators must still be able to find the catastrophe.

1. Navigate to **Administration** tab → **Catastrophes** menu item → select its checkbox. Click **Deactivate**.

2. The catastrophe has an **Inactive** status.

   Note: You cannot associate a claim with a catastrophe that has been marked *inactive*.

To re-activate a catastrophe

1. Navigate to: **Administration** tab → **Catastrophes** menu item.

2. Select **Activate**.

This catastrophe status is now **Active**.

Using Catastrophes Defined by ISO

In the United States, ISO produces a list of catastrophes that a carrier can use to define its 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 (estimated total liabilities) and a catastrophe number, which can help correlate your catastrophe data with other information. You can also use ISO's severity data to help estimate your own liabilities and reserve levels.

   Note: ISO provides this information in a CSV file.

Catastrophe Bulk Association

A prior section, "Catastrophe Overview" on page 115, describes creating a catastrophe profile in ClaimCenter through the **Administration** tab → **Catastrophes** screens before attaching claims to it. Often, adjusters create claims that are caused by the catastrophe *prior* to the catastrophe's having been entered into the system for reasons such as the following:

- The government has yet to deem the event a catastrophe and give it a *cat* code.
- The carrier has not yet entered the catastrophe code into the system.

Claims already in ClaimCenter need to be linked to the catastrophe. You can search for claims that match the catastrophe profile but have not yet been linked. Not all claims that come back as a match are necessarily due to the catastrophe, so you must decide whether to link a 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 due to the catastrophe. If it is, the claim owner sets the *cat* field on the claim and completes the activity. If not, the claim owner only completes the activity.

To see how to find claims and associate them with a catastrophe, see "Working with Catastrophe Bulk Association" on page 119.

Associating Catastrophes and Claims

On a claim, a catastrophe is nothing more than a new claim characteristic. A claim can be associated with at most one catastrophe. After this association is made, rules can perform a number of useful functions:

- Assignment rules can be written to assign claims to *catastrophe management* groups.
- Reports can be written that track reserves and payments for claims associated with the same catastrophe, or determine the costs of a catastrophe.

See Also

- "Catastrophe-Related Rules" on page 72 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. Click **Edit**.

2. Select a **Catastrophe** name from the **Catastrophe** drop-down menu and click **Update**.

ClaimCenter checks:

- Whether the claim's loss date is within the catastrophe's date range.
- Whether the claim's location matches the zone type for which the catastrophe is valid.
- Whether the claim's cause of loss and loss type matches one of the catastrophe's defined perils.

The application's 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, it issues an error message. While the rules allow association with a catastrophe if the claim's Loss Cause or Loss Type does not match the catastrophe's Peril, they issue a warning message. The following table describes these errors and warnings:

If the catastrophe does not match...	Allow the Association?
date, place AND peril	no; reject
peril	yes (warning)
place	no; reject

If the catastrophe does not match...	Allow the Association?
place and peril	no; reject
date and peril	no; reject
place and date	no; reject
date	no; reject
it matches all three	yes

ClaimCenter help for associating a catastrophe with a claim

After ClaimCenter has the Loss Location, Loss Date, Loss Type and Loss Cause (peril), it can determine whether the claim could be a caused by a catastrophe. It does not, however, automatically make this association. Instead, it alerts you by creating a Review Claim for Catastrophe activity for you to decide if you want to make the association.

If the catastrophe matches...	Allow the association?	ClaimCenter Issues a message or creates an activity:
date, place AND peril	yes	Create one activity to alert you of a potential match to the catastrophe.
date, place, not peril	yes	Create one activity to alert you of a potential match to the catastrophe.

If a new claim seems to fit into a catastrophe category but is not so defined, ClaimCenter creates an activity.

Working with Catastrophe Bulk Association

Perform the following steps to search for claims that do not have a catastrophe associated with them, and then associate them if they meet the catastrophe criteria. The system does not automatically associate a claim with the catastrophe. The claim owner must do the association.

To associate a group of claims with a catastrophe

1. Navigate to the **Administration** tab and select **Catastrophes** from the left pane in the user interface.

2. Click the catastrophe's link to open the **Catastrophe Details** screen.

3. Click **Find Unmatched Claims**. The application searches only *active* catastrophes.

   ClaimCenter performs a search by using a batch process 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.

   The batch process gets scheduled that night and then the system displays the following message:

   > The number of matched claims will be available the next business day at 8 am.

   The system marks each claim that the criteria apply to. If the number of found claims related to a catastrophe exceeds the system configurable limit for the number of found claims, `MaxCatastropheClaimFinderSearchResults`, only the limited number of claims are processed. The rest of the claims will be processed the next day.

   The `CatastropheClaimFinder` batch process runs according to the time set in the `scheduler-config.xml` file. The section of the user interface called **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.

4. You must find the claim and navigate to its **Loss Details** screen. You can search in one of two ways:

- Click the **Desktop** tab → **Activities** and change the filter on the **Activities** screen to **All open**. The activity subject is **Review for Catastrophe**.

- Click **Search** → **Activities**, and under the subject section, select **Review for Catastrophe** in the drop down menu.

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 is a custom event, and this behavior can be removed. See "Claim History" on page 83.

chapter 14

Service Provider Performance Reviews

An important part of claim handling is providing services that help resolve losses. This includes using or recommending a service provider such as a body shop, assessor, attorney, or physical therapy clinic. ClaimCenter provides a mechanism to manage 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.

After 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.

This topic includes:

Overview of Service Provider Performance Reviews

The central element of the Service Provider Performance Reviews feature is the review. A review consists of sets of scorable questions - a questionnaire or survey - asked about a vendor for work performed on a specific claim. You use the review's score to make decisions about vendors.

Service Providers

A service provider is any contact which provides a service during the resolution of a claim, and is unrelated to the carrier. Examples include:

- Property and auto damage assessors
- Attorneys and law firms
- Auto body shops, auto glass shops, and auto repair shops
- Medical clinics, home care workers, nurses, physicians, and physical therapists

Typically, a carrier contacts the service provider and requests services, but the insured or other claim contact can also contact a service provider directly.

ClaimCenter considers all service provider categories to be contacts and stores them in its Address Book. You can categorize your service providers. For example, you can create different categories for auto glass repair, auto body repair, and transmission repair, and then create reviews that pertain to each provider category.

Reviews of Service Providers

In addition to the normal contact information, ClaimCenter stores review information, the average scores of the reviews, for each service provider. After you search for service providers, your search can also consider these scores. For example, by specifying the Auto Repair category and a location, ClaimCenter provides a list of auto repair shops close to the accident site, ranked by review score.

Review Scores and Recommendations

ClaimCenter provides a mechanism for:
- Defining different review types
- Collecting individual vendor reviews based on the service they provided on individual claims
- Scoring the review answers
- Combining the scores for each vendor
- Using these scores to rank them

Working with vendors based on their review scores is the central focus of Service Provider Performance Reviews. For example, you can restrict searches for vendors to those with a sufficiently large score, list providers by score, and generate reports on vendors based on scores.

Contents of a Review

All reviews consist of the following parts:
- A **header**, containing information common to all `ReviewTypes`.
- The review itself, which is a set of **questions**. The questions can be divided into **categories.**
- Answers to the questions, if the review has been given.
- **Scores,** both overall and category scores, which appear only after the review is complete. Only then is it scored.

Scoring

Typically, the insured, the claimant, and perhaps another contact, provide information to the claim adjuster or another user, who then answers the review's questions. This process results in a scored review that evaluates the services provided by a vendor on a single claim.

Each review can have several scores. There is a total score and a score for each category of questions it contains. ClaimCenter attaches the scored review to the claim. ClaimCenter then creates vendor scores: the average total score and average score for each category from all reviews from all claims for which the vendor provided services. These vendor scores are the main tool for managing categories of service providers.

The default questions have answers that range from zero to one hundred points. Scores, simple averages of the answered questions, are in this same range.

Review Scoring

ClaimCenter provides two mechanism to score individual reviews, one to score individual sets of questions (categories), and another to score the entire review. These scoring mechanisms are similar. Both are simple arithmetic averages, with each answered question given equal weight.

The overall score of an individual review is the arithmetic average of all *answered* questions. Un-answered questions do not affect this average. If you want to have particular questions always affect the score, then define those questions as mandatory and provide appropriate default answers for them. Similarly, each category score of a single review is the average of all answered questions in that category.

ClaimCenter scores an incomplete review each time it is saved to the database. After the review is complete and submitted (click **Complete**), it is attached to the claim and is never re-scored. The review becomes uneditable.

Contact Scoring

Like reviews themselves, each vendor can be given two kinds of scores, an *overall* score and a set of *category* scores.

- **A contact's overall score** is the arithmetic average of all overall scores from reviews pertaining to that contact. To be included, a review must be associated with *both* the individual contact and the contact's subtype.
- **A contact's category scores** are similarly the average of all scores from the same category in individual reviews that pertain to that contact.

Because different review types can reuse the same categories, this sum can include category scores taken from all review types that include the category. For example, you might have created review types for auto glass repair and for auto repair, both of which have the category of glass installation. A vendor's category scores are the averages of the same categories from all reviews.

Unlike review scores, which attach to the claim when completed, vendor scores update asynchronously. This is done by either by a batch process or by an API call.

Using Service Provider Performance Reviews

Both ClaimCenter and ContactCenter incorporate the features of Service Provider Performance Reviews. From the ClaimCenter **Contact Details** screen, you can work directly with reviews on claims. You can view, edit, complete, or delete them. Use the **Search** tab to search for contacts with review scores above a minimum you set. In ContactCenter, you can perform the same search, view the full review form (`ReviewType`), and see each contact's scores. This includes both overall and by category for all review types associated with the contact.

Working With Reviews

In ClaimCenter, the **Reviews** tab in the **Contact Details** screen of a claim is the starting point for working with reviews. To access it, select a claim and click **Parties Involved** → **Contacts** → **Reviews** tab. A list of all reviews allowed for the contact on this particular claim shows. In ContactCenter, displaying a contact shows all reviews associated with the contact, for all claims. To access, click the **AddressBook** tab → select a contact → **Reviews** tab.

The **Reviews** tab appears only if reviews exist for that contact (in ContactCenter) or if at least one review exists for that contact in that claim (in ClaimCenter).

Viewing or Editing a Review

From the **Reviews** tab, select a review. To edit it, click **Edit**. You can view, but no longer edit, a review after it has been completed.

Beginning a Review

You start a review of a particular vendor by selecting a review type for the review. Clicking **Add New Review** displays all review types available for the current contact based on the vendor's contact subtype.

To begin a review

 1. Navigate to a claim.

 2. Select **Parties Involved** → **Contacts** → **Reviews** tab → **Edit** → **Add New Review**.

 3. Select a type.

Or

 1. Navigate to the **AddressBook** tab.

 2. Select a contact and click the **Reviews** tab.

 3. Click **Add New Review** and select a type.

After you have started, you can answer the review questions at any time, from either ClaimCenter or ContactCenter. If you navigate away from the review, it is saved with its current answers. You can return to a review and continue to add to it or edit existing answers. To reopen a review for additional editing, see ""Viewing or Editing a Review" on page 124.

> **Note:** From ClaimCenter, you must be in **Edit** mode to enable the **Add New Review** button, but not if you begin from a ContactCenter screen.

Completing a Review

After selecting a review from a list of reviews, check the reviews you want to complete and click **Complete Selected** at the top of the list. After a review is complete, ClaimCenter calculates its score but does not immediately change the vendor's score to reflect the new score.

Deleting a Review

To delete reviews, select the reviews you want to delete from the list of reviews and click **Delete Selected**. Although you cannot edit a completed review, it can be deleted and you can start a new one.

> **Note:** Separate permissions are needed to delete incomplete and completed reviews. You could use these permissions to allow adjusters to delete started, but not scored, reviews.

Searching for a Contact by Score

You can search for contacts in either ClaimCenter or ContactCenter:

1. In ClaimCenter, navigate to **Search** → **Contacts** → **Contact Type** that has reviews.

2. Enter **Minimum Score** and click **Search**.

Or

1. Select the **AddressBook** tab → **Search** → **Contacts**.

2. Enter a **Contact Type** and a **Minimum Score** and click **Search**

You enter **Minimum Score** by using a drop-down list, with choices of 0, 10, 20, 30, and so on. You can customize this screen by changing the PCF files. Results are returned when the review value is equal to or greater than the search value.

Search results include a column of overall scores, and you can sort the list by clicking on the column's title. Scores are not used in the default sort order.

Working With Review Types

It is not possible to edit, duplicate, or delete a `ReviewType` inside ClaimCenter. Instead, you must generate and export them, work with the exported XML files, and then re-import them. For details see "Configuring Service Provider Performance Reviews" on page 125.

Configuring Service Provider Performance Reviews

In the base configuration, ClaimCenter provides one `ReviewType`. To modify it, or to create a new one, you must export the provided `ReviewType` and re-import it. You can export and use the provided `ReviewType` called Auto Repair Shop Review without modification. It is part of the sample data provided. Also, you can first edit this `ReviewType` or even create a new `ReviewType` based on it, and then export it for use. See "Importing and Exporting Administrative Data" on page 410.

In addition to creating, editing, and exporting a `ReviewType`, you can also create or reuse categories and associate them with `ReviewTypes`. Then link existing `QuestionSets` and those you create to categories.

This topic is an overview. For details, refer to the *ClaimCenter Configuration Guide*.

Configuring ReviewTypes

Use this procedure to create and export `ReviewTypes`. If the `ReviewTypes` have been exported, you cannot change them. Instead, you must edit another copy and re-export it.

1. To begin, find and make a working copy of the `ReviewType` in the sample data directory.

2. Give the `ReviewType` a name and description, and point it to the contact subtypes to which it applies.

3. Add new `ReviewCategory` and/or `ReviewServiceType` typecodes, to assign and/or report on `QuestionSets` in new ways.

4. Use the XML file or CSV file import to add the `ReviewType` to your installation.

Configuring Categories

Categories (more properly, `ReviewCategoryQuestionSets`) are groupings of question sets. These entities must have:

• A foreign key to at least one `ReviewType`. Different `ReviewTypes` can contain the same category.

- Foreign keys to at least one `QuestionSet`. Different categories can share the same `QuestionSet`. You can use existing `QuestionSets` and create your own.
- A typekey from `ReviewCategory`. It is used to identify a group of categories that contribute to a particular category score.
- An `elementorder` field of integers that determine the order in which the categories appear in the `ReviewType`.

Configuring QuestionSets, Questions, and QuestionChoices

After creating a new `QuestionSet`, give it the `questionsettype` of `spmreview` (other types are used in other parts of ClaimCenter). The main part of this entity are the pointers to the individual questions it contains.

For details and examples of XML file definitions of `QuestionSet`, `Question`, `QuestionChoice`, and `QuestionFilter` entities, see "Question Sets" on page 263.

Configuring Scores

By default, ClaimCenter scores are arithmetic means with each question given an equal weight. If you want to weight questions differently, then include un-answered questions in the scoring, or calculate overall or category scores other than as arithmetic averages. You must write your own `ContactReviewPlugin` in ClaimCenter. Refer to the *ClaimCenter Integration Guide* for details. This plugin can also modify the batch process that controls when different contact subtypes are updated.

Gosu Customizes Service Provider Performance Reviews

ClaimCenter provides an API so that Gosu can customize this feature. For example, you can write rules, such as: *if the overall vendor score for a particular review type is greater than a threshold, set its Preferred Vendor field.*

Review Permissions

These are the main permissions:
- `reviewviewlist` – To view the list of reviews in the **Address Book** tab.
- `reviewviewdetail` – To view the details of reviews in ClaimCenter.
- `reviewedit` – To edit the **Review** screen showing the scores for each claim.
- `reviewcreate` – To create a new review.
- `reviewdeletecompleted` – To delete a completed review that has been sent to ContactCenter for calculation.
- `reviewdeleteincomplete` – To delete a review that has not been not completed.

ContactCenter also contains `reviewviewlist` and `reviewviewdetail`.

Permissions for Contacts

If you need more granular control over who gets to view, edit, create, and delete contacts, do not use the simple view and edit permissions. You can also have specific contact managers that manage certain subtypes of contacts. Therefore, you want the system to enforce permissions at the contact subtype level. This is especially important for the Service Provider Performance Reviews feature, where the list of contact subtypes (service providers) is an integral part. Guidewire recommends that only specific contact managers manage the lists of these contact subtypes.

The main permissions for ContactCenter are `abview`, `abedit`, `abcreate`, and `abdelete`. With administrator privi-leges, you can assign these permissions to particular users for certain contacts or contact subtypes. For example, you can grant one user the ability to manage the Auto Body Shops contact subtype, and another to manage other contact subtypes. Remember that if you grant a permission to a contact type, then you grant the same permissions to all that contact's subtypes.

Synchronization of Contacts Between ClaimCenter and ContactCenter

Contacts move in both directions between ContactCenter and ClaimCenter. You can configure if and when this synchronization occurs. Refer to the Contact Management documentation *Guidewire Contact Management Guide* for details.

Data Model for Service Provider Performance Reviews

Service providers, any contact type or subtype, can have review scores (overall and category scores) associated with them. In addition, each claim can store a review's answers and scores. The other changes to the database concern the review. In general, questions (sometimes with answer choices) are grouped into sets of questions, which are further grouped into categories, which are associated with a review type. Finally, review types are associated with defined contact subtypes.

Review Related Entities

Two entities, `Review` and `ReviewType`, form the basis for the Service Provider Performance Reviews data model. The left side of this diagram are abstract entities used to create objects shown on the right side of the diagram. `ReviewType` and `Review` entities are related in the same way that Activity Patterns and Activities are related:
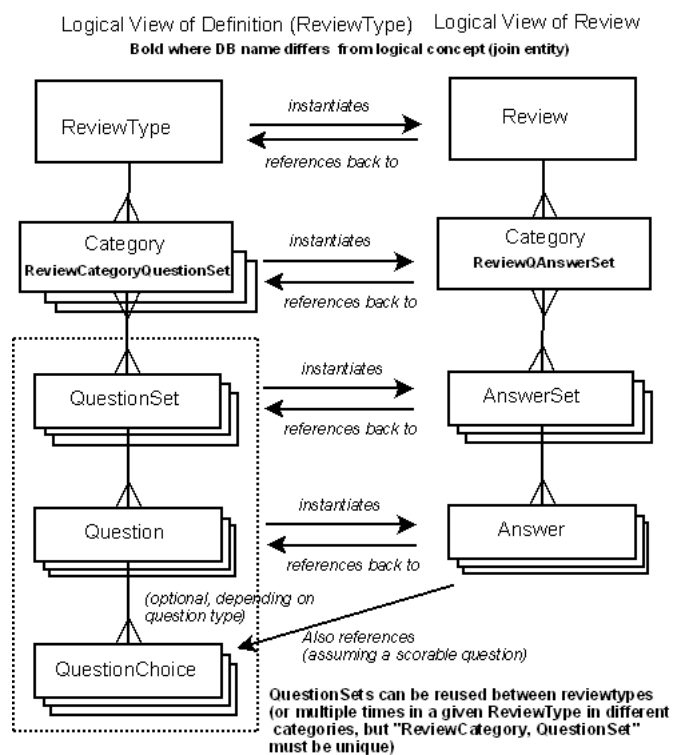
- **Review Type** – An electronic questionnaire type associated with a particular contact subtype and all its subtypes that is used to collect customer feedback about contacts. An example, included with each release, is an Auto Repair Evaluation.
- **Category** – A join table that relates a `ReviewType` to one or more `QuestionSet` objects. You can divide a questionnaire into one or more sections, or Categories. Categories of this form might include Quality of Work, Delivery, and General Satisfaction. Typecodes of `ReviewCategory` relate similar Categories to each other. This entity exists only to allow many-to-many relationships between `ReviewType` and `QuestionSet`, so that

`QuestionSets` can be used several times in a questionnaire. Each set is related to a specific category of the questionnaire.

- **QuestionSet** – A group of individual questions.
- **Question** – A member of a `QuestionSet`.
- **Question Choice** – Potential answers to a particular question, such as true/false or a list of choices (*optional*).

After someone creates a review, a parallel set of entities are created:

- **Review** – One entire questionnaire, containing one or more `AnswerSets`.
- **ReviewAnswerSets** – Pointers to filled in question sets. Each one is an `AnswerSet`.
- **AnswerSet** – A set of a particular question set's answers.
- **Answer** – One reply to a question set.

For more details on question sets and their related entities, see "Working with Question Sets" on page 264.

Typelists

Two typelists, which must be present and identical in both ClaimCenter and ContactCenter, affect Service Provider Performance Reviews:

- **ReviewCategory** – The set of categories into which groups of questions can be assigned, and from which category scores will be generated.
- **ReviewServiceType** – The set of possible service types into which individual `Review` objects can be assigned. Service types are a reporting category and appear in a drop-down list in the `Review` header.

ContactCenter Data Model

Service Provider Performance Reviews uses the entity `ReviewSummary` and extend ContactCenter's `ABContact` entity.

ReviewSummary Entity

`ReviewSummary` is an entity capturing a summary of a `Review` object's information, passed from ClaimCenter. It contains the `Review` object's header information, including the overall score, and a list of category scores. However, it does not include the actual questions and answers.

Each `ReviewSummary` belongs to a particular `ABContact` and uses a claim number to associate it with the claim from which it was obtained.

ABContact Entity

Service Provider Performance Reviews extends the `ABContact` entity in ContactCenter in two ways:

- **Score** – Contains the overall Score for this `ABContact`, as calculated from `ReviewSummary` entities by the `ABContactScoring` batch job.
- **CategoryScores** – An array containing the category scores for this `Contact`, similarly calculated from `ReviewSummary` entities by the `ABContactScoring` batch job.

ClaimCenter Financials

Claim Financials

The financial aspects 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. Use the ClaimCenter financials feature 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:

See Also
- "Configuring Financials" on page 599 in the *Configuration Guide*
- "Financials Integration" on page 195 in the *Integration Guide*
- "Multiple Currencies" on page 171 in the *Application Guide*
- "Bulk Invoices" on page 189 in the *Application Guide*

Financial Overview

The financials 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* allow 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. This action decreases 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 main 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	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 them.
Recoveries	Negative payments (checks received). They can be entered, updated, approved, or deleted.

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 some financial condition. See "Summary of Financial Calculations" on page 165 for how to compute them.

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 379.

Checks are Not Transactions

ClaimCenter gives checks and payment distinct meanings. 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 which is split into a check for the injured person and a percentage going to his lawyer through a second check.

Transactions Contain At Least One Transaction Line Item

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`, as described previously. 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.

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 "The Financials Data Model" on page 166.

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 140. 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 134
- "Definitions of Reserves Calculations" on page 135
- "Total Incurred" on page 136
- "Set Reserves Can Be in More than One Currency" on page 136

Reserve Overview

This section contains the following:

- "Reserves Estimate Liabilities" on page 134
- "Uses of Reserves" on page 134
- "Closing a Claim or Exposure Zeros All its Reserves" on page 135
- "Payments Can Cause Available Reserves to Become Negative" on page 135

Reserves Estimate Liabilities

There are two ways to set reserve amounts: *Case Reserves* and *Average Reserves*.

Case Reserves. Use this method to set and adjust reserves on a case-by-case basis. To be most effective, first subdivide claims into exposures, cost types, and even cost categories, each with its separate reserves. Estimating these smaller pieces makes the overall estimate of the reserves needed more accurate. After applying the Case Reserves method, you can monitor the decrease of reserves as payments are made. This can help determine whether a claim is resolved within normal cost limits.

Average Reserves. This method sets the entire claim's (or exposure's) reserves amounts based solely on the actuarial information of how much it has 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), then set reserves using this classification. This method is 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 that specific claim which 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.

The base configuration is set up for case reserves, however you can configure the system for average reserves.

Uses of Reserves

Think of reserves as driving the application's financials. Specifically:

- **Reserves categorize liabilities by coverage (exposure).** They can subcategorize into even smaller divisions, such as a bodily injury exposure dividing into physician, hospital, therapy and administrative costs. Categorizing reserves make tracking of specific claim costs more accurate.

- **Reserves track projected costs of claims as soon as they are created.** This allows timely, 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.

- **Reserves prevent excessive payments made on a claim.** ClaimCenter both controls who can set or increase reserve levels and can stop payments in excess of reserves. This can also help identify fraud.

- **Reserves ensure that a claim can be paid.** After a reserve is associated with an exposure, hence a coverage, it is easy to compare the policy's coverage limit with the potential claim amount.

- **Reserves help in assigning claims.** For example, they can help steer claims with large potential liabilities away from inexperienced adjusters.

- **Reserves assess adjusters' performance.** You can compare actual settlements to the amount of reserves.

Closing a Claim or Exposure Zeros All its Reserves

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, Total Reserves become equal to all eroding payments, and Total Incurred becomes the total of *all* payments, eroding and non-eroding. As an example, if a reserve is set to $1000, payments of $600 are made, and the claim closed, Total Reserves would no longer be $1000, but rather $600. Open Reserves remain at zero.

Payments Can Cause Available Reserves to Become Negative

Payments can exceed reserves when its `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 (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 Can Create Negative Reserves" on page 140
- "Negative and Zero Dollar Transactions and Checks" on page 142

Definitions of Reserves Calculations

Reserves can decrease as payments are made against them. ClaimCenter defines how payments decrease reserves differently, depending on when payments are recognized.

The following are calculations used in reserves.
- **Total Reserves.** All approved reserves, with no payments deducted. Never changed by payments while the reserve line's claim or exposure is open. It becomes equal to the sum of all eroding payments on a closed claim. See "Closing a Claim or Exposure Zeros All its Reserves" on page 135.
- **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.

ClaimCenter defines two types of *Total Incurred*:
- **Total Incurred (Gross).** Open Reserves plus all payments made today or earlier.

- **Total Incurred (Net).** Total Incurred (Gross) minus all received recoveries.

  Note: No payments on open claims decrease Total Reserves, and recoveries never change *any* reserves. Only *eroding* payments decrease reserves. See "Eroding and Non-Eroding Payments" on page 140.

Total Incurred

Carriers can use Total Incurred as a quick indicator of a claim's current cost. It does not require understanding the difference between eroding and non-eroding payments. In fact, if there have been no non-eroding payments, then Total Incurred is the *same* as Total Reserves.

Since Total Incurred makes sense for the claim as a whole, ClaimCenter displays Total Incurred for the entire claim in the title of its financial summary screens.

Notes:
- You can configure the user interface to display Current Total Incurred, and New Total Incurred in the screen which sets reserve amounts. Set New Total Incurred instead of New Available Reserves (use the `SetReservesByTotalIncurred` configuration parameter). Set reserves are based on amount left to pay (available reserves) and total amount that will be paid (total incurred).
- Net Total Incurred does take recoveries into account.

Another way of understanding Total Incurred is to use the following definition, which is equivalent to the previous one:

- **Total Incurred (Gross).** Total Reserves plus all non-eroding Payments made today or earlier.

See "Summary of Financial Calculations" on page 165.

Eroding payments do not affect Total Incurred on open claims. But supplemental payments on a closed claim do affect Total Incurred.

Set Reserves Can Be in More than One Currency

You can set reserves using multiple currencies using the *Set Multicurrency Reserve* function as seen in the following example.

Access the **Set Reserves** screen by finding a claim and clicking **Actions** → **New Transaction** → **Reserve**. If ClaimCenter has multicurrency enabled (see "Multiple Currencies" on page 171), then the **Set Multicurrency Reserves** icon shows after the **New Available Reserves** column as seen in the previous example.

You use this function to calculate and create a reserve in another currency. Adjusters would use it if they were planning on creating payments in another currency. It can help to have the reserves already set up in that other currency.

The following example shows what happens when you select the icon. It opens the **Multicurrency Reserve** screen. You can now change the currency (in the **Currency** column) and select whether the new amount is calculated manually or automatically.

Amounts show in two currencies, with the primary amounts in the selected currency. In this example, it is in Euros. The selected currency becomes the transaction currency for the new reserve. Secondary amounts are in the *claim* currency and do not show in the user interface.

If you create a claim with a different claim currency, after entering the new amount, the **Change** column shows the claim currency.

Set Reserves and Exchange Rates

After you change the currency to a different type, the screen shows exchange rate information with the automatic exchange rate mode button selected. This occurs if you have the *Exchange Rate Manual Override* (exchratemanual) permission and you selected a non-claim currency. If you do not have that permission, then the **Exchange Rate Mode** button is disabled.

Changing from mode from either manual to automatic or from automatic to manual updates certain fields. These are:

- The transaction amounts in the **Currently Available** and **Pending Approval** columns
- The claim amount in the **New Available Reserves** column, and the transaction and claim amounts in the **Check** column

The Change Column on the Set Reserves Screen

ClaimCenter calculates the amounts in the **Change** column (in the user interface) in the same way whether ClaimCenter is in multicurrency or single currency mode. The change amount is equal to New Available Reserves minus currently Available.

The **Set Reserves** screen can run in two modes depending on the SetReservesByTotalIncurred configuration parameter.

> **Note:** On the **Set Recovery Reserves** screen, the **Change** column (in the user interface) is equal to New Open Recovery Reserves minus Open Recovery Reserves.

How ClaimCenter Displays Reserves

In most of its financial screens, ClaimCenter typically shows either Open Reserves, or both Remaining Reserves and Future Payments. You can also configure it to display Available Reserves.

ClaimCenter shows *Available Reserves* when you are creating or updating reserve amounts. It shows:

- **Currently Available Reserves.** Same as Available Reserves.
- **New Available Reserves.** Available Reserves which reflect your requested new amount.
- **Change.** Defined as New Available Reserves minus Currently Available.

   Note: Available Reserves is the most conservative estimate of unused reserves. *All* payments—current, future, and not yet approved—have been deducted.

Reserve Lines

A *reserve line* is an amount of money that is set aside for expected payments related to an exposure or a claim. Every exposure (or possibly claim) ultimately will have one or more reserve lines. While you can create and even close exposures without creating reserve lines, the primary reason to create an exposure is to make payments to claimants. You cannot make payments to claimants and even vendors without reserve lines.

All transactions are related to a reserve line. Think of a reserve line as the categorization or coding of 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. However, 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/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. This means that the transactions with the same coding are associated with each other through a reserve line, in order 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, for example Total Payments with a cost type of *claimcost*, across the entire claim. This would just 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. While there are additional fields for further categorization of transaction amounts, such as `RecoveryCategory` on `Recovery` and `LineCategory` on `TransactionLineItem`, the `ReserveLine` entity does not take these fields into account. This means the financial calculations do not take them into account either. There are no break down amounts.

If you save a new transaction, ClaimCenter either finds the existing reserve line for its coding, or creates a new one. You do not create them directly. The `Exposure`, `CostType`, and `CostCategory` values for the `ReserveLine` derive from the same fields on the `Transaction` entity. These are set either by you through the user interface or by Gosu code.

In the user interface, you can see this when you create a new transaction from the **Actions** menu → **New Transaction** → **Reserve**. You also see this in the **Set Reserves** screen where you can either edit or add a reserve line. Rows that are

prepopulated represent a claim's existing reserve lines which you can edit. If you add a new row, then you create a new reserve line.

> **Note:** The reserve line is created during transaction setup, so the reserve line on a transaction will have been setup when the *PostSetup* and *PreUpdate* rule sets are run. See "Rule Set Categories" on page 45 in the *Rules Guide* for additional information.

When you make a payment, (or by recording 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 the claim's different kinds of costs. The **Financials Summary** screen, which displays one reserve line on each row, shows how reserve lines logically categorize a claim's financial information.

Notice the following based on this example:

- There are only two exposures, which are numbered.
- There are no claim-level reserve lines. If there was, you would not see the exposure numbered but instead the title **Claim Level**.
- There are four reserve lines: Auto body, Other, Vehicle inspection, and Auto body under the second exposure.
- Cost types divide each exposure's costs into two major areas: administrative expenses and claim costs.
- Cost categories further subdivide both of these making them unique, and hence a reserve line.

LineCategory Further Subdivides the Amount of a Payment or Recovery

The `LineCategory` field of a `TransactionLineItem` is another way to further divide a reserve line without creating an additional reserve line, and hence an additional reserve. For example, you can have a reserve line with a cost category called *Fees* and store all fees in that reserve. But adding line categories of *Management Fee*, *Surveyor Fee* and so on, enable you to make these granular distinctions. However, you cannot access the line categorizations through financial calculations. Financial calculations only tract amounts at the reserve line level.

Payments

Payments refer to all money paid to satisfy a claim. This includes its liabilities and its associated LAE (Loss Adjustment Expenses) and other administrative expenses.

- 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 not 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, then

ClaimCenter creates a new reserve transaction to bring the reserves back up to zero. An exception to this are payments that you schedule to be sent on a future date.

This section explains about the different types of payments and when each can be used and includes the following:

- "Eroding and Non-Eroding Payments" on page 140
- "Partial, Final, and Supplemental Payment Types" on page 140

See Also

- Payments are not the same as checks. See "Checks" on page 143.

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 using Total Incurred instead of Open Reserves, eroding reserves are not important. Only non-eroding Payments increase Total Incurred.

Payments Can Create 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 a payment is in *awaiting submission* status. This only applies for eroding payments, but not 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 141
- "Final Payments" on page 141
- "Supplemental Payments" on page 141

Partial Payments

A partial payment transaction is a transaction that usually pays for some, 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.

A final payment performs the following actions when its check is escalated by the Financials Escalation batch process:

- 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.

- 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.

Notes:

- 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 56 in the *Configuration Guide*.

- 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 is set to `true`, then you *can* make supplemental payments if no prior payments existed. In this case, the reserve line drop down menu in the New Check wizard displays 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 156.

Editing or Deleting Payments

You can edit or delete a payment as long as it belongs solely to ClaimCenter. That is, it has not been sent to be entered into an external accounting system. Editing and deleting are possible when a payment has pending approval, awaiting submission, or 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 158.

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, at any time after the payment is sent downstream. The user interface calls this process *recoding*. It is available on the Payments screen of the Transactions subtab of Financials. Recoding is simpler than deleting and reentering. After recoding a payment, its original reserve is increased by the recoded amount (offset), and a matching new reserve is created (onset) against the new reserve line. You can consider a check to be recoded when you recode its payments, but checks are unaffected by recoding - their amount is unchanged.

Transferring a Payment to Another Claim

You can move a payment to another claim at any time. The user interface calls this process *transferring*; it is available on the Payments screen of the Transactions subtab of Financials. You can also transfer a check. Such a check displays the original claim in the Memo field on the Check Details screen.

Voiding or Stopping a Payment

After a check is submitted to an external check writing application to be issued, its payments are also submitted. They can no longer be edited or deleted, so ClaimCenter provides 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/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 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. It would show a negative amount to offset the overpayment.

In ClaimCenter, you can create the following kinds of checks and payments:

- 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 (manual or electronic) 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 an amount less than zero.

You cannot create negative or zero dollar recovery reserves or recoveries. Also, you cannot create negative or zero dollar reserves in the user interface. You can enter reserve transactions or recovery reserve transactions that are less than zero through staging tables or financials APIs.

Making Payments with Rules

You must use the `setAsNonEroding()` and `setAsEroding()` methods on `Payment` to change whether automatic payments or other payments made using a Gosu rule erode reserves. Instead of you directly setting the field itself, ClaimCenter must handle the underlying offsets to the reserves' T-accounts. See also "Transaction Business Rules" on page 168.

Checks

ClaimCenter uses *checks* to make payments. You create and edit payments in the check wizard.

> **Note:** You can also use electronic fund transfers. See "Electronic Funds Transfer (EFT)" on page 148 for details.

ClaimCenter is always 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 within ClaimCenter to pay it. After the check issue date occurs, ClaimCenter sends a request to your check-writing application, which in turn writes the actual check. However, your external system can send an electronic funds transfer, wire transfer, or credit a credit card instead of issuing a check.

Payments versus Checks

The terms *check* and *payment* in ClaimCenter they refer to distinct things. A *payment* is a transaction you perform within 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, then sends to an external check-writing or financial management application. ClaimCenter records all of the salient details of the check. This includes to whom it was made out and for how much, and against which reserve line it 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 of 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

ClaimCenter creates checks 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 156 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, and 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.

- A *check* is 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.

- A *check set* is all the checks created by a single execution of the New Check wizard. This includes checks that will be issued at different times, such as a *recurring* check set. All of 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.

- A *check group* is all of 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* and *multiple* payees.

- *Joint payees* are 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* are unique payees who each receive 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.

This multiple payee example also illustrates *check groups*. In this case, all three checks are in one check group. The Grouped Checks section of a check detail screen lists them together. If these three checks were to recur 12 times, there would be 12 groups of three, and all 36 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.

Recurring Check Sets

You can create a check set that includes a series of checks that are issued 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.

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.

> **Note:** If you have enabled multicurrency in ClaimCenter, you cannot change the exchange rate of multi-payee checks in a recurrence. Otherwise, the exchange rate on the checks is locked in for the entire recurrence. Since 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 181.

Service Dates and Periods

One attribute of a check is its service date or 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. If that period of time was from August 1 - 14, then 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, in the event that 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 then records the payment and sends a request to your check writing system. But it can happen that your company must 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. This can cause confusion in the application's financial records.

You can account for checks written outside of ClaimCenter by creating a *manual check*. This is a check record you create within ClaimCenter to acknowledge a check that you write outside of ClaimCenter. After a manual check reaches its issue date, ClaimCenter changes its status to `notifying` and sends this message (rather than a print request) to its external check-writing application.

Working with Checks

This section explains 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 159 defines for which states these operations are available. To modify a check, use the New Check wizard and select the check.

Deleting Checks

You can delete any check until its status becomes requesting. You can also delete checks in rejected status if their reserve line is in a claim or exposure that is still open. If you have written recurring checks, you can delete any or all in the series that have not been sent downstream.

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. There are two ways to edit a check in a recurrence:

- If you click the **Edit** button on the **Check Details** screen, your changes apply only to that check.
- If you click the **Edit Recurrence** button in that screen, 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 lets you use an existing check or check set as a template to create a new check or check set. You can quickly clone an existing check set—single or recurring—and then use the New Check wizard to make changes.

One typical use for cloning a single check is if 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 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 COLI (cost of living increase) 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.

Some notes on cloning checks:
- Cloning creates a new check set for the same claim.
- Cloning creates a new check group (that is, 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.

Recoding Checks

You cannot recode a check. However, you can move a check's *payments* to make a payment against a different reserve line at any time. This process is called *recoding* a payment. To learn more about recoding, see "Modifying Recovery Records" on page 151.

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 void and then reissue the incorrect check instead of voiding and recreating the entire check group.

Some notes on reissuing checks:
- You cannot change the *amount* of a reissued check.
- You must not void or stop the check you want to reissue 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 receives a check in the correct amount, but the wrong claim is charged. For example, consider an attorney who represents insureds on behalf of the carrier in third-party litigation. She can represent quite a few insureds. In the process of paying her legal fees, it is possible to write a check against the wrong claim. It makes sense to transfer a check from one claim to another, rather than voiding it, only to recreate it in another claim.

You can transfer the check, with these limitations:

- The check must be written to a single payee - not joint payees.
- The check must have already been sent to the check writing application (have requesting status at least).
- The check cannot be a member of a check group that has multiple payees.
- The check cannot be recurring.

Voiding or Stopping Checks

The integration with the external check writing system determines the exact definition of *voiding* versus *stopping payment* on a check. The user interface will display a **void** or a **stop** button to tell you which is possible. Traditionally, the primary distinction is that you typically stop payment on a check if the check itself is no longer in your physical possession. Otherwise you void it.

IMPORTANT   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 will be 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 156 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

Setting the **Report As** field to **Reportable** in the New Check wizard asks ClaimCenter to withhold income tax from checks it writes (to Vendor payees only).

See Also
- "Configuration Parameters" on page 604 in the *Configuration Guide* for information on deductions
- "Deduction Plugins" on page 235 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 142.

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 its payments. See "Bulk Invoice Check Approval" on page 196.

Electronic Funds Transfer (EFT)

You can perform financial transactions electronically. These are known as electronic funds transfer or EFT. In ClaimCenter, you work with EFTs mainly in the context of a contact. The following are ways to add bank data to a contact.

New Person

A contact can have one or more EFT accounts, one of which can be marked as primary. Navigate to **Address Book** → **Actions** → **New Person**.

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 is duplicated in ContactCenter so that contact information is kept in sync. 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 **Check Payment** wizard, you can select EFT as a payment option. Doing so allows you to select from one of the registered EFT accounts for the payee. The selected account data is copied over to the check object to maintain an audit trail in case the contact is re-synced with ContactCenter 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.

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.
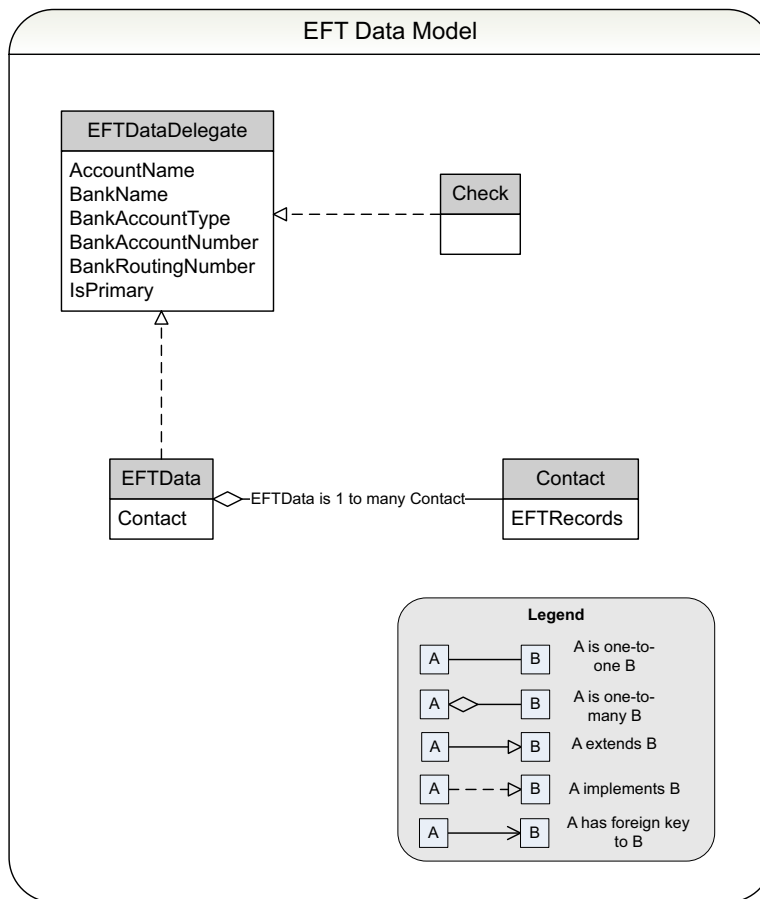
Diagram Specifics

- 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` to `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.

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.

A recovery can be considered a negative payment. ClaimCenter reports *Total Recoveries* that have been received. No approval is required to accept (create) a recovery. Note that they cannot have pending approval status.

Although recoveries do decrease a carrier's liabilities, they never increase reserve levels. You can let ClaimCenter calculate the difference between reserves and recoveries, or have an external accounting system manipulate these amounts to obtain any measure of claim liability you want.

ClaimCenter does deduct received recoveries from its *Net Total Incurred* value, which can give a more useful single value representing the total claim liability. You can also create a *recovery reserve*, indicating the amount of recoveries you are expecting. For more information on *Net Total Incurred*, see "Total Incurred" on page 136.

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 act in the reverse direction. 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 defined by their unique reserve line.

Although permissions are needed to view, create, edit, or delete recoveries and recovery reserves, they are assigned to all roles. You can even configure ClaimCenter to suppress recovery reserves.

This can be set in Studio, by setting the UseRecoveryReserves configuration parameter to False.

Recovery reserves are related to one reserve line. Unlike other transactions, recovery reserves have an additional attribute, *recovery category* (similar to cost category, but not part of the reserve line), which can further define them.

Recovery Reserve Offsets

After a recovery is received, it decreases the Open Recovery Reserve (Total Recovery Reserves minus Received Recoveries) associated with that reserve line. This is analogous to Payments decreasing Open Reserves.

If a recovery reserve does not exist, a received recovery generates the matching recovery reserve. The system then creates an offset which increases the Total Recovery Reserve. Note that this is not the Open Recovery Reserves, as Total Recovery Reserves and Total Recoveries have increased by the same amount.

This is analogous to payments which exceed reserves creating offsets which increase their matching Total Reserves. There is no parameter analogous to AllowPaymentsExceedReserves for recovery reserves. You can always receive money, to reduce a claim's cost.

If a received recovery is voided or stopped, this recovery reserve offset is also rolled back. The Total Recovery Reserve decreases by the previous offset amount and the Open Recovery Reserve remains unchanged. Again, this is analogous to what happens when payments exceed reserves.

Total Recovery Reserves	Open Recovery Reserves	Recoveries	Net Total Incurred
Claim is opened; no recoveries are expected			
$0	$0	$0	$0

Total Recovery Reserves	Open Recovery Reserves	Recoveries	Net Total Incurred
An unexpected recovery check is received			
$500	$0	$500	$-500
Receive recovery check is stopped			
$0	$0	$0	$0

Modifying Recovery Records

To make corrections to recovery records, you can do the following in ClaimCenter:

- *Recode a Recovery*
- *Transferring a Recovery*

Recode a Recovery

Recoding a recovery is similar to transferring a recovery, but with a slight difference. You are assigning (recoding) to the correct reserve line on the *same* claim. This means that clerical mistakes can be corrected.

Recoding:

- Creates an *offset* recovery on the same reserve line.
- Creates an *onset* recovery on the new reserve line.
- Sets the original recovery's status to *pending recode*.

  Note: Offset recoveries cannot be recoded. Recoveries with the following statuses cannot be recoded: *transferred*, *pending transfer*, *recoded,* and *pending recode*.

If the configuration parameter useRecoveryReserve is set to true, then if a recovery has a zeroing offset recovery reserve. The recoding process creates a recovery reserve in the negative amount of that zeroing offset. It also has 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 returns from the downstream system.

Multicurrency and Recoding a Recovery

You can recode a recovery using transaction currency that is using different transaction, claim, and base currencies. The following example shows how to recode a recovery using another currency.

To Create a Recovery

This example first creates a recovery so that you can change the transaction currency to another type.

1. Navigate to a claim's **Financial Summary** screen.

2. Using the **Actions** menu, select under the **New Transaction** section, **Other → Recovery**.

   The **Create Recovery** screen shows.

3. Select **Payer**, **Reserve Line** and **Currency** from the drop down menus.

   The **Currency** drop-down list is actually the transactional currency field. It defaults to the claim currency, or if there is none, then to the base currency. Changing this value to a currency other than the claim or base currency makes the selected currency the transactional currency. In this example, the transactional currency is in Euros, which is different from the claim currency, which is in US dollars.

4. Enter an amount and click **Update**.

Notice in the example that the Exchange Rate is using either the claim or base currency which is in US dollars.

Recoding a Recovery

To build on the previous example, you can change the reserve line so that it can be recoded.

1. After clicking **Update** from the previous set of directions, select the recovery you created from the **Financials Transactions** screen. This displays the **Recovery Details** screen.

2. Click **Recode** to open the **Recode Recovery** screen.

3. Change the **Reserve Line** by using the drop down menu, and then click **Recode** again.

Your changes are reflected on the **Financials Transactions** screen. The status is *Pending Recode*. In the **Amount** column, the transactional currency is listed on the top with the claim or base currency listed on the bottom of the column.

Transferring a Recovery

Transferring a recovery means that someone made a recovery amount on the wrong claim, and you need to associate it to the correct (and different) claim. It does not matter if the claims are closed.

Transferring a recovery does the following:

- It creates an *offset* recovery on the same reserve line
- It creates an *onset* recovery on the new claim and reserve line
- It sets the original recovery's status to *pending transfer*

If you set the configuration parameter `useRecoveryReserve` to `true`, then:

- 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 returns from the downstream system.

Multicurrency and Transferring a Recovery

How do you know which exchange rate is used when you transfer a recovery?

- If the selected claim 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 selected claim has a *different* claim currency from the original, and the claim's currency is the *same* as the recovery's currency, then no exchange rate information shows.

- If the selected claim has a *different* claim currency from the original claim currency, and the claim's currency is *different* from the recovery's currency, ClaimCenter displays that exchange rate information. The entered information is applied as the transaction-to-claim exchange rate for the *onset recovery*.

To Transfer a Recovery

1. Navigate to a claim's **Financial Transactions** screen.

2. Change the filter to **Recoveries** to help identify which recovery is to be transferred and click the amount in the **Amount** column.

   The **Recovery Details** screen shows.

3. Click **Transfer**. This action displays the **Transfer Recovery** screen.

4. Find the targeted claim or enter the number.

   If you decide to search, you can select from the active database or an archived one and enter a variety of parameters in which to narrow your search. View the search results at the bottom section of the screen.

5. Select the targeted claim and click **Select**.

   This action returns you to the **Transfer Recovery** screen.

6. Enter the **Reserve Line** from the drop down menu. (You might have to create a new one.)

7. Enter the **Exposure**, **Cost Type**, and **Cost Category** and click **Transfer**.

   Your changes are reflected in the **Financials Transactions** screen. The status is *Pending Transfer*.

If the **Transfer** button is disabled, then check for the following reasons.

- An offset recovery cannot be transferred.

- Check that the recovery does not have the following statuses: *transferred*, *pending transfer*, *recoded,* and *pending recode*.

- You must have the edit recovery permission.

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 section explains 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

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**, notice a table of all the claim's transactions of one type. To define the transaction type that you see, choose one from the drop-down menu: **Payments**, **Reserves**, **Recoveries**, or **Recovery Reserves**.

You can sort each table of transactions by any column by clicking that column title. To view the details of any transaction, select its amount.

The drop-down menu shows a **Custom** option, which is not intended for your use. Rather, when you select a transaction from a table of transactions, this view becomes **Custom**.

The Summary View

If you select **Summary**, you will see a condensed version of all transactions and checks. To further organize the **Summary** tab display, choose one of these from the drop-down box in the upper left:

- **Claimant**: Organize this display 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 the Exposure display, but with no claim expenses (like a car appraiser's cost) shown.

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 select **Checks**.

3. Notice a table of all checks written on the claim, sorted by **Check Number**, and showing **Pay To**, **Gross Amount**, **Issue** and **Send Date**s, **Status**, and **Bulk Invoice** number.

You can sort each table of transactions by any column by clicking that column title. To view the details of any transaction, select its amount.

You can also view checks by selecting a payment from **Transactions** and clicking **View Checks**.

Creating New Transactions or Checks

To create a new check or transaction:

1. Navigate to a claim and open it.

2. Select **Actions** → **New Transaction**.

3. Select **Payment**, **Reserve**, **Recovery**, **Recovery Reserve**, **Check**, or **Manual Check** to start the wizard that creates the transaction or check.

Other Ways to Create New Checks and Recoveries

You can also 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. Select a **Reserve** and click **Create Check**.

Alternately, you can create a check through the **Actions** menu by navigating to **New Transactions** → **Check**.

You can similarly create recoveries against a particular payment or recovery reserve.

1. Navigate to a claim and open it.

2. Click the **Financials** menu item and select **Transactions** → **Recovery Reserves** or **Payments**.

3. Select a transaction and click **Create Recovery**.

Alternately, you can create a recovery through the **Actions** menu by navigating to **New Transactions** → **Other** → **Recovery**.

> **Note:** You can also create a check through the quick check option.

Modifying Transactions or Checks

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 have no such effect. 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 "Summary of Financial Calculations" on page 165.

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
Eroding Payment is scheduled for $300 at the end of the month; requires approval							
$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
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. These 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 156.
- **Check Status** – Defines when a check is written, approved, issued, cleared, or canceled."Approval Status" on page 156 "Lifecycles of Checks" on page 159.
- **Transaction Status** – Defines when a transaction passes through statuses similar to those of a check."Approval Status" on page 156 "Lifecycles of Transactions" on page 158.

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 which run when a specific status change occurs.

Approval Status

Both checks and transactions always carry one of these *approval statuses*:

- **Unapproved** – Entered (or being entered) into ClaimCenter by someone who cannot have approval authority.
- **Approved** – Given permission to remain in ClaimCenter.
- **Rejected** – Not given permission.

All financial entities (transactions and checks) move from unapproved to approved when their transaction status changes from pending approval to awaiting submission.

Transaction Status and Check Status

Transaction status and check status are similar. They appear in the user interface and Gosu can write rules based on 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 lives, checks and all transactions have the same lifecycle. While being created, they are in *draft* status. After they are first saved, they become *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. This means that 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 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 151 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 tables that follow describe them.

These unusual events are:

- **Recode** – Move a payment/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, 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

- "Check Integration" on page 203 in the *System Administration Guide*.
- "Payment Transaction Integration" on page 212 in the *System Administration Guide* for details of these statuses and the allowed transitions between them.

Voiding or Stopping a Check

Traditionally, you void a check that you can physically rip up, and stop payment on it when it is no longer in your possession. ClaimCenter does not always know whether to void or stop a check (except a manual check), and so provides both options. You can also void recoveries.

After you stop or void a check that is part of a check group, you stop or void all checks within that check's check group. Any checks that are part of other check groups, even other check groups that are within the same check set, are not affected by the stop or void.

After you ask to stop or void a check in the user interface, you cannot know its actual status. The downstream system can have already issued the check and it can even have been cashed. In all cases, ClaimCenter assumes that your action was successful, and creates an offsetting transaction (an *offset*). This reverses the check amount. If the downstream system then tells ClaimCenter that the check was indeed issued or cashed, ClaimCenter responds by creating yet another transaction (an 'onset') which reverses the offset. Voiding or stopping a final check returns its reserve, which the final check zeroes, to its original value.

In the case of a check transfer to another claim, ClaimCenter creates an offset and 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 new claims.

Lifecycles of Transactions

The following diagram and table summarize all transaction statuses and how they relate to approval status:

Transaction Status Flow Chart

NOTE on automatically generated transactions: These do not require approval, so DRAFT always flows to AWAITING SUBMISSION.

NOTE on payments of manual checks: These go directly to SUBMITTING - never to AWAITING SUBMISSION
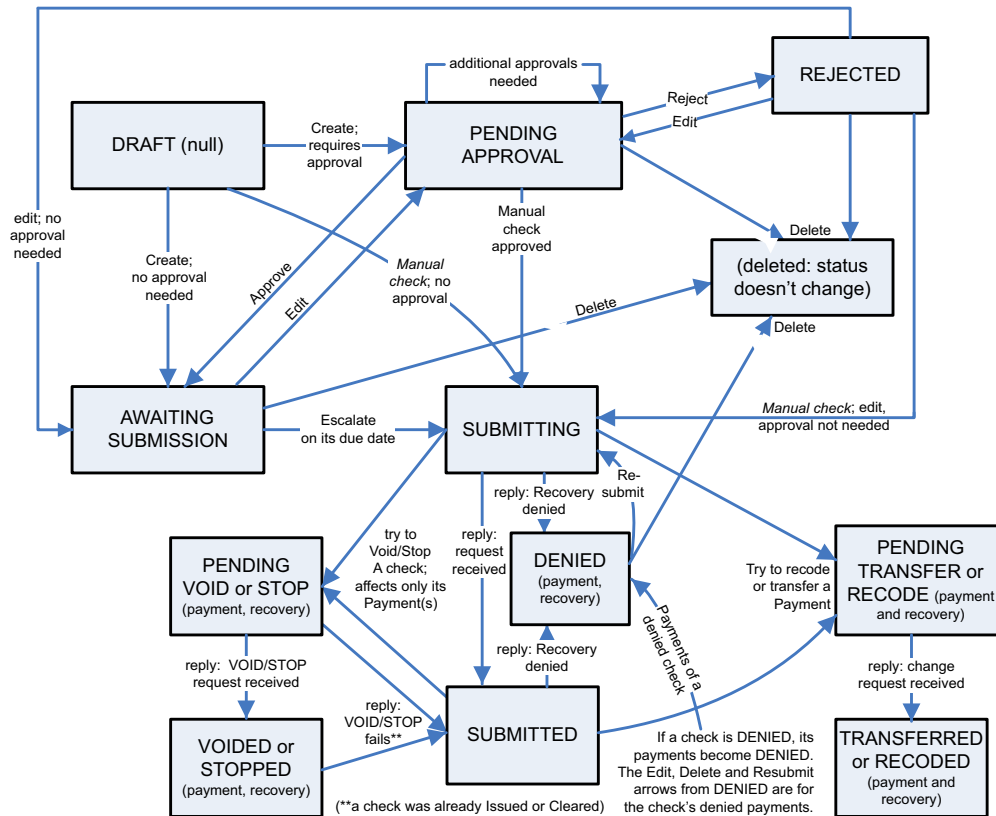
Approval Status	Transaction Status	Delete, Edit?	comment
unapproved	null (draft)	yes	When finished, moves to pending approval.
unapproved	pending approval (P,R)	yes	On approval, moves to awaiting submission.
approved	awaiting submission (P,R)	yes	In queue, unsent, to downstream system (transaction date 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 (P, Rec)	no	The messaging plugin sends a request downstream to void the check. Remember this is not in the base configuration and you must set this up.
approved	voided (P, Rec)	no	Downstream reply that the transaction is voided.
approved	pending stop (P)	no	The messaging plugin sends a message downstream to stop the check. Not in the base configuration—you must set this up.
approved	stopped (P)	no	Downstream acknowledgement that a stop occurred.

Approval Status	Transaction Status	Delete, Edit?	comment
approved	pending transfer (P/R)	no	Notify downstream system to move to another claim.
approved	transferred (P,R)	no	Downstream reply; transfer notification received.
approved	pending recode (P,R, Rec)	no	Move to another reserve line, notification sent.
approved	recoded (P,R)	no	Downstream reply; recode notification received.
rejected	rejected	yes	Through *pending approval*; edit/delete only if claim open.
approved	denied (P, Rec)	no	For recoveries only, a reply from downstream.

((P,Rc) = payments and recoveries only   (P,R) = payments and reserves only,   (P) = payments only

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 table.
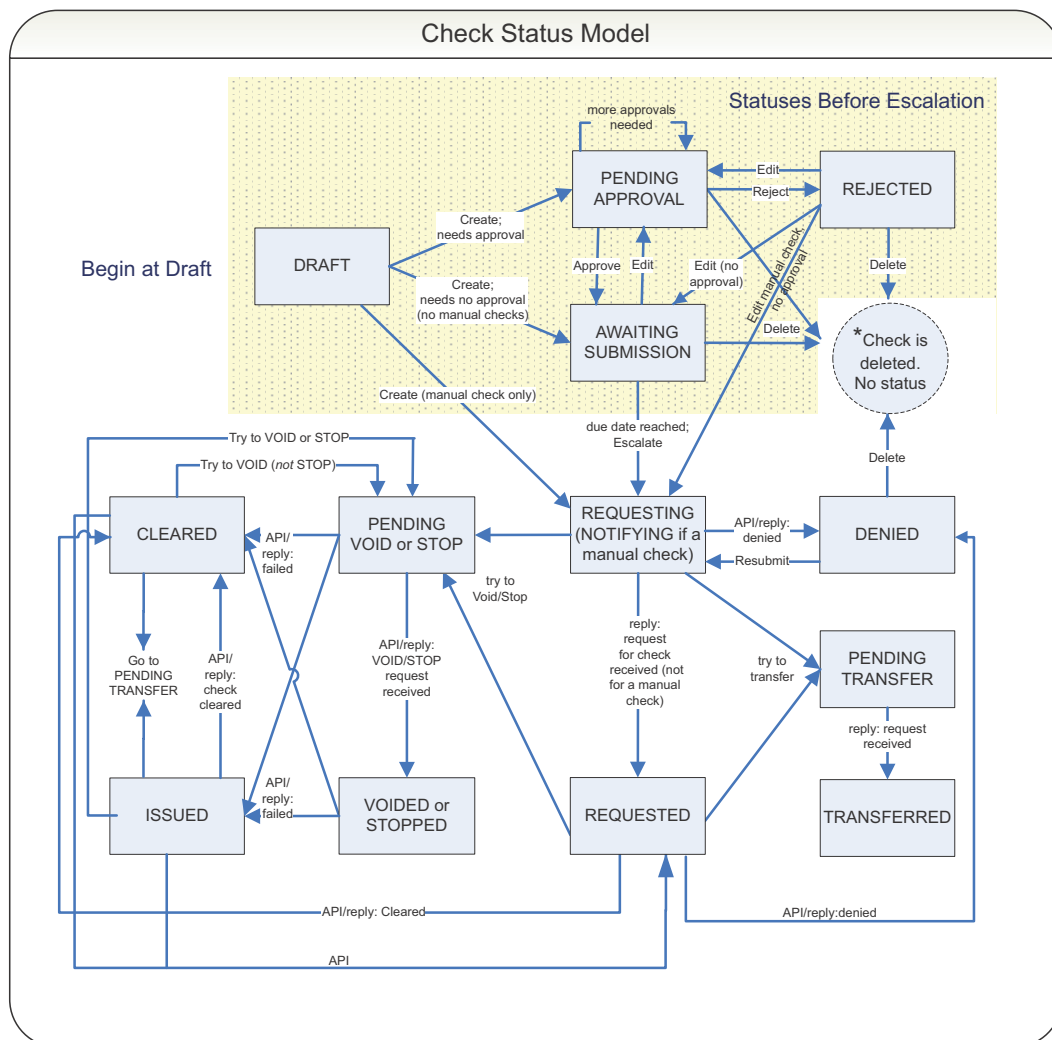
Notes

- Some statuses advance by either SOAP APIs or through the user interface which the diagram does not show explicitly. See "Financial Transaction Status and Status Transitions" on page 195 and "Check Integration" on page 203 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/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; 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
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
approved	voided *	no	no	notification to ClaimCenter - check voided
approved	pending stop *	no	no	stop attempt sent downstream
approved	stopped *	no	no	notification to ClaimCenter -check stopped
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
		* most integrations will use stop or void but not both		** not many integrations find this useful

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 it is with a normal check.

> **Note:** In the diagram, *reply* indicates that a transition changed from the downstream system. The plugin `IClaimFinancialsAPI` can also change the status of the check where *API* is noted in the diagram.

Downstream Denials of Recoveries and Checks

While it is easy to understand check and recovery status changes while these entities are within ClaimCenter, after they been escalated to a downstream system, their lifecycles become more complex. In particular, when a check writing system refuses to issue a check or accept a recovery check it receives, it notifies ClaimCenter of this denial. ClaimCenter must respond to this denial.

The following provides an example for using a downstream denial of a check (or receipt of a recovery check). All check writing systems must now compare all payee names on the Office of Foreign Assets Control (OFAC) watch list of payees who will not receive (or send) checks.

How to Deny a Check or Recovery

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. They can never reach requesting or requested status, they are denied from notifying status. Denial occurs when the downstream system sends ClaimCenter a denial notification. This can occur is several ways:

- The downstream system can use `denyRecovery(ID)` and `denyCheck(ID)` methods in the `IClaimFinancialsAPI` plugin to asynchronously notify ClaimCenter any time after receiving the recovery or check request.

- The `Recovery.denyRecovery(ID)` and `Check.denyCheck(ID)` 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

Recoveries are the only type of transaction that can be denied. Payments are also denied when the check that pays them is denied. It makes no sense for another system to reject a transaction involving reserves or recovery reserves. Reserves and recovery reserves are ClaimCenter constructs and are completely controlled by the application.

After a recovery is denied, the following happens inside ClaimCenter:

- The recovery's status is set to `denied`. The **Claim → Financials → Recovery Details → Transactions** screen displays **Status = 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 Recovery's claim/exposure is already closed, and
  - The Open Recovery Reserve value is zero for the Recovery's `ReserveLine`.

- Post-setup rules are executed for the recovery's `RecoverySet` entity and for the `RecoveryReserveSet` entity created to zero Open Recovery Reserves, if any.

- You cannot import or add a 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. This button is active only for denied recoveries. The new recovery then appears as any other recovery in this screen, with **Submitting** status.

- **Delete** the recovery 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 first need to 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. Manual checks can also be denied. It is not possible to deny a multiple-payee check. After a check is denied:

- Its status is set to `denied`. The **Claim → Financials → Checks → Check Details** screen displays **Status = Denied**.

- Each of its contributing payments is denied. A contributing payment is one that contributes to the gross check amount. This means that 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.

You cannot edit a denied check directly; however, you can do the following.

- **Resubmit** the check by using the **Claim → Financials → Checks → Check Details → Resubmit** button. This button is active only for denied checks. The new check then appears as any other check in this 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. This is configurable by using the method `GWCheckEnhancement.resetCloneFields`.
- **Delete** the check by using the **Claim → Financials → Checks → Check Details → Delete** button.

> **WARNING** If you use the *Deny Check* feature, you must exercise extra care in the allocation of your check numbers. Resubmitting a denied check uses the same check number. Cloning a denied check to edit and then resubmit clears out the check number, so that a new check number is allocated later. This too can have consequences as it can result in 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 would void the check if needed, but not deny it.

Denied Manual Checks

You can deny a manual check.

Payment Denial and Claim/Exposure Closing

After a check makes a final payment, ClaimCenter can close the associated exposure and/or claim if `CloseClaimAfterFinalPayment` and `CloseExposureAfterFinalPayment` are `true`. After such a check 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, then neither is reopened by the denial of the payment.
- If the claim and/or exposure remains closed after the denial of each payment, the system creates any necessary zeroing reserves to keep Open Reserves zeroed.
- If the claim and/or exposure is reopened due to the denial of a check, then 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` typelists.

Integration with Other Accounting Systems

ClaimCenter is usually integrated with an external financial application that writes its physical checks. As you make a claim-related disbursement, you create the check information inside ClaimCenter. If a check with a*waiting 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.

Your integration can also send other transactions and their status transitions, besides financial summary information to the same or another G/L accounting system. ClaimCenter uses transaction status and check status, with their restrictions on editing and deleting, to ensure that the information sent always matches its own. It also triggers when information is sent externally.

Transaction 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

- The *Checks and Payments Configuration* section of the *ClaimCenter Configuration Guide* describes scheduling these batch processes.

The Financials Escalation Process

The `financialsescalation` batch process moves checks whose send date has arrived to *Requesting* status. This generates the `CheckStatusChanged` event, which ClaimCenter can listen for and, when received, send a request to the check writing system. After a check has *Awaiting Submission* status and its issue date is today or earlier, this batch process escalates the check and its associated payments and reserves.

Specifically:

- T-accounts are updated (unless `taccountescalation` has already run and done this).
- If needed, offsetting reserves are created. This and any other associated reserve changes are given *Submitting* status. For example, if an eroding payment exceeds its available reserves, it requires an offset to keep its available 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 of them 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 fails, it auto-assigns. 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, then ClaimCenter creates an activity. It alerts you that the recurrence is ending soon.

The batch process `financialsescalation` by default runs daily at 12:01 a.m. and 5:01 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 any 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 the fields are set to `true`, the checks are escalated by the `bulkinvoicesescalation` batch process. This parameter allows some bulk invoice checks to be processed normally, while others are held, perhaps so other, newly arrived checks to the same vendor can be bundled with them.

The T-Account Escalation Batch Process

The `taccountsescalation` batch process transitions payments and reserves from `FutureDated` state to `AwaitingSubmission` state. Its purpose is to update all the calculations, such as total reserves, total payments, total incurred, and so forth, to reflect payments on checks scheduled to be sent today.

After the batch process runs, offsetting reserves are created if needed. These and any other associated reserve changes are given A*waiting Submission* status, which means that they can still be retired if their associated payments are retired or changed. For example, if an eroding payment exceeds its available reserves, it requires an offset to keep its available reserves from becoming negative. This is in regards to a future-dated payment that is scheduled to be sent today.

This 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 being issued. This gives the carrier time on the issue date of a check to make adjustments, while keeping summary financial values correct.

You can change the time the batch process runs in the `scheduler-config.xml` file. In the default configuration, this process runs every 30 minutes between the hours of 12:00 a.m. and 5:00 a.m. If the server is down during this window, manually run the process as soon as possible. The batch process is more useful for configurations in which financials escalation is configured to only run in the evening. In that way, on the day a check is scheduled to be sent, the financial calculations get updated in the morning. However, the check would still be editable until it was escalated in the evening.

The `taccountescalation` batch process does not affect a check's eligibility for escalation. It exists only to transition payments' `TransactionLifeCycleStates` from future-dated to awaiting submission status (AWS) if their check's scheduled send date has arrived, and thereby update the financial calculations. The `financialsescalation` batch process picks up payments based on their status, not their `lifecyclestate`, so `financialsescalation` is not really affected by whether `taccountescalation` ran.

> **Note:** `Taccountescalation` affects the *open reserves* financials calculation, but only by transitioning the Payment life cycle states.

See Also
- "Foreign Exchange Adjustments in Your Custom Financial Calculations" on page 179 for more details.

How to Use the Batch Processes

In the base configuration, the batch process `financialsescalation` runs twice a day, at 12:01 a.m. and 5:01 p.m. However, if your configuration does not run `financialsescalation` at 12:01 a.m, and the `taccountescalation` batch process runs earlier in the day, then there are inaccuracies. T-account entries and summary financial transactions would be incorrect from 12:01 a.m until noon. Also, another reason to run `taccountescalation` just after 12:01 a.m. is so that the financial calculations are correct for any rules which 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 until sometime during the last available working day, run the `taccountescalation` process as soon after midnight as possible. You must 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, then schedule `financialsescalation` just after midnight. You need not run `taccountescalation`.

The Bulk Invoice Escalation Process

A separate batch process, `bulkinvoicesescalation`, 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 12:15 a.m. and 5:15 p.m.

Summary of Financial Calculations

ClaimCenter maintains many running totals of a claim's financial transactions and updates them as transaction statuses change. The application refers to these running totals as financial calculations or *building blocks*. 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. It pre-calculates (denormalizes) them for quick retrieval from the database.

The following table lists the available calculations:

calculation	definition
TotalReserves	Sum of all *approved* reserves (excludes only `PendingApproval` and earlier statuses)
TotalReservesWithPending	`TotalReserves` + `PendingApprovalReserves`
OpenReserves	`TotalReserves` - all eroding `Payments` made today or earlier
RemainingReserves	`OpenReserves` - all eroding `Payments` to be made after today [can be <0*]
AvailableReserves	`RemainingReserves` - `PendingApprovalErodingPayments` [can be <0*]
TotalPayments	Sum of all approved payments with scheduled send date today or earlier
FuturePayments	Sum of all approved payments with a scheduled send date after today
TotalPaymentsWithPending	`TotalPayments` + `FuturePayments` + `PendingApprovalPayments`
GrossTotalIncurred	`OpenReserves` + `TotalPayments`, or equivalently, `TotalReserves` + Sum of all approved non-eroding payments
NetTotalIncurred	`GrossTotalIncurred` - `TotalRecoveries`
TotalIncurredNetRecoveries	`GrossTotalIncurred` - `TotalRecoveries` (the same as `NetTotalIncurred`)
TotalIncurredNetRecoveryReserves	`GrossTotalIncurred` - `TotalRecoveryReserves`
TotalRecoveryReserves	Sum of all recovery reserves (unlike reserves, they need no approval)
TotalRecoveries	Sum of all recoveries with `submitted` status (all recoveries received up to now)
OpenRecoveryReserves	`TotalRecoveryReserves` - `TotalRecoveries`
PendingApprovalErodingPayments	Sum of all eroding payments with `pending approval` status
PendingApprovalNonErodingPayments	Sum of all non-eroding payments with `pending approval` status
PendingApprovalPayments	`PendingApprovalErodingPayments` + `PendingApprovalNonErodingPayments`
PendingApprovalReserves	Sum of all reserves with `pending approval` status
ForeignExchangeAdjustments	The sum of all exchange rate adjustments, both those made to eroding and to non-eroding payments.
ErodingPaymentsForeignExchange-Adjustments	The sum of all exchange rate adjustments made to eroding payments.

calculation	definition
NonErodingPaymentsForeignExchange-Adjustments	The sum of all exchange rate adjustments made to non-eroding payments.

*to understand when reserves can be negative, see "Payments Can Create Negative Reserves" on page 140.

Financial Transactions Outside the User Interface

The application's double-entry accounting system means that you do not create or modify transactions directly. After 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. However, when you use Gosu methods in rules to directly create or modify transactions and checks, you are responsible for all this bookkeeping. For example, you can cause accounting errors by doing the following. Use `var reserve = new Reserve` to create a new reserve, and then set the amount of its line item, since you have not updated any T-accounts in this way.

Use the Transaction Pre-setup rule set for proper bookkeeping. This rule set is the *only* appropriate place for you to create, modify, or remove transactions by using your own rules. For more information, see "Transaction Presetup" on page 67 in the *Rules Guide*.

The Financials Data Model

The following table contains the key Financials entities in the data model that you see in the application. Refer to the ClaimCenter data dictionary to see other financial-related entities.

entity or field	description
Transaction	Represents a financial transaction for a particular claim or exposure. It is an abstract supertype, and the user interface uses its subtypes: Reserve, Payment, RecoveryReserve and Recovery. Every transaction is made against a single ReserveLine object. A transaction also contains a non-null array of TransactionLineItem entities.
TransactionSet	A collection of all transactions made at the same time, such as a check and all the payments it makes. TransactionSet is an abstract supertype, and the user interface uses its subtypes: ReserveSet, CheckSet, RecoveryReserveSet and RecoverySet. CheckSet is a subtype. The 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. Documents can be associated with a TransactionSet.
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 made or recoveries applied against one ReserveLine.
TransactionLineItem	An entity in every transaction. TransactionLineItem contains the amount, or part of the amount, of the transaction, besides a description of the amount, its line category. All transactions must contain at least one TransactionLineItem. If there is more than one, each TransactionLineItem is analogous to an invoice item.
TransactionOnsetOffset	This entity contains a foreign keys to the Transaction entity and represents the relationship between a transaction and its offset and onset. It is used for transferring and recoding checks and payments.
Line Category	Field in a TransactionLineItem that is a description of one of the payment's items. A check for the entire payment can list the LineCategory as the description of the items paid.
Payment	A subtype of Transaction representing money paid out. A payment can be eroding or non-eroding depending on whether it draws down the reserve of its ReserveLine.
Recovery	Records money that reduces a claim's liability, received from such sources as subrogation, salvage, other insurance, co-payments or deductibles. Recovery is a subtype of Transaction.
RecoveryReserve	Records an expected or submitted (received) recovery. RecoveryReserve is a subtype of Transaction.

entity or field	description
Reserve	Records a potential liability. `Reserve` is a subtype of `Transaction`. A `Reserve` is any transaction that designates money for payments. Typically, a reserve is set soon after a claim is made.
CostType	A `Transaction` field that categorizes the `ReserveLine` of an `Exposure` or `Claim`. The `CostType` typelist includes just `aoexpense` (adjusting and other expense), `claimcost` (actual loss payments to claimants or repairers), `dccexpense` (defense and cost containment legal expense) and `undefined`. `CostType` can also be `null`.
CostCategory	A `Transaction` field that categorizes an `Exposure`, `Claim`, or `CostType`. Its typelist includes many values that can be filtered to support many lines of business (LOBs).
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 written, unless it is a manual check not created by the application.
CheckGroup	The entity that groups all `Check` entities resulting from a single `Payment` and written at the same time by using the New Check wizard one time. A check group can contain just *one* issuance of a recurring `Check`. All `Checks` belong to a `CheckGroup`.
CheckSet	The entity that collects all checks resulting from a single `Payment` and written at the same time by using the New Check wizard once, including *all* issuances of recurring checks. `CheckSet` is a superset of `CheckGroup`. It is a subtype of `TransactionSet`. All `CheckGroup` entities belong to a `CheckSet`.
Deductible	This entity tracks the amount, the coverage, and the status of the deductible, such as whether it has been paid or waived. A main field on the `Deductible` entity is `TransactionLineItem`, which is a foreign key to `TransactionLineItem`.

Transaction Line Items and their Line Categories

Transactions are always made against a single `ReserveLine`, which is defined by a unique `CostCategory` and `CostType`, both of which can be `null`. `CostType` and `CostCategory` thus classify payments, not checks. Checks are not transactions. Typically, `CostType` is the primary division between claim costs and claim expenses, while a `CostCategory` makes a subcategory of a `CostType`. `LineCategory` plays no role in defining a `ReserveLine`, but can be used to provide additional information about the `CostCategory`.

`LineCategory` is a descriptive string associated with a `TransactionLineItem`, of which each transaction must contain one or more. Reasons for a transaction to contain multiples of `TransactionLineItem`, and thus multiples of `LineCategory`, include:

*   Writing more than one check to make a single payment (multiple payees).
*   Adding billing line item details item to a single check.

For example, consider a `ReserveLine` with `ExposureType` = VehicleDamage, `CostType` = Claim Cost, and `CostCategory` = Labor.

*   You can write two checks to make the payment, one for glass shop labor and another for body shop labor. Do this in one transaction by using the New Check wizard to create both checks, using its multi-payee feature. Glass shop labor and body shop labor become two `LineCategory` values.

    Note: You can also make two separate payments by using the New Check wizard twice.

*   If writing a single check, you can add the two labor `LineCategory` values as billing detail information.

The New Check wizard presents you with the transaction's `LineCategory` choices to enter on the check. The uses of `LineCategory` are not restricted to these examples.

`CostType`, `CostCategory`, and `LineCategory` are all typelists, and you can filter `LineCategory` by `CostCategory`, `CostType`, and also `CoverageType`. That is why these typelists look similar.

Reversing Transactions: Offsets and Onsets

Sometimes, transactions must be reversed. Examples include if a payment was applied on the wrong reserve line and must be corrected or if a check needs to be voided or stopped. In each case, at least one new transactions is created which affect the original one, to maintain a complete trail.

- **offset** – ClaimCenter creates a new payment with an amount equal to the negative of the original transaction's amount. This serves to effectively 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.

A special entity, called a `TransactionOffsetOnset`, is used to associate the newly created offset and onset transactions with the original transaction.

Reserve Groups Do Not Exist

Reserve groups are not in the data model. A reserve group is a convention used by **Show Group** in the **Edit Reserves** screen of the user interface. It shows you all the reserves that you made changes to. This group does in fact reflect the `ReserveSet`. The **Show Group** button is active even if you have not made any edits in a given visit to the **Edit Reserves** screen. If you make two changes, one that requires approval and another that does not, they are both grouped into one `ReserveSet`. They both show when you select **Show Group**.

Double-entry Accounting Entities

These data model entities are related to T-accounts.

`TAccount`	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: a debit account (such as `Submitted Reserves`, which holds the amount of a reserve) and a matching credit account (such as `Cash Out`). One double-entry bookkeeping event affects one debit and one credit T-account. For example, a payment debits `Submitted Reserves` and credits `Cash Out`.
`TAccountLineItem`	The entry of a specific amount of money, either crediting or debiting one T-account. A `TaccountTransaction` contains a pair of balancing `TAccountLineItem` objects. When a `TAccountTransaction` is created, it debits one `TAccount` and correspondingly credits another. Certain state transitions can additionally debit and credit another pair of T-accounts. These credits and debits are represented by `TAccountLineItem` objects.
`TAccountTransaction`	Contains the `TAccountLineItem` objects 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 (removed) from the `Pending Approval Reserves` T-Account and added (credited) to the `Submitted Reserves` T-Account.
`Taccttxnhistory`	Used to track historical transaction data in a T-account.

Transaction Business Rules

ClaimCenter contains sets of rules which affect most of its financial events. You can develop rules which cause ClaimCenter to model your company's particular financial practices. For more information, refer to the *ClaimCenter 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. Refer to *Rule Set Categories* in the *ClaimCenter Rules Guide*:

- Transaction Approval: rule set which checks whether a user has the authority to make the transaction. See "Transaction Authority Approvals" on page 169.
- Approval Routing: rule set which creates an activity to send a transaction to another user for approval. See "Transaction Authority Approvals" on page 169 for an example.
- Transaction Validation: rule set that checks if a transaction exceeds a preset monetary limit. See "Transaction Approvals" on page 169.
- Initial Reserves: rule set that sets a newly created reserve line's reserve. See "Setting Initial Reserves" on page 169.
- Transaction Post-Setup: rule sets which 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 which 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 Pre-Update: rules which run before any object is updated in the database. They run prior to the Transaction Validation rule set. See "Pre-update and Validation Rules" on page 98.
- Transaction Pre-Setup: rules which run just before any transaction set or check set is committed. See "Financial Transactions Outside the User Interface" on page 166.

Transaction Approvals

One of the most common financial validations concerns overstepping limits of liability on a policy's coverage. The Transaction Validation rule set contains this type of rules.

For example, carriers commonly sell vehicle insurance with standard limits, such as:

- A 200/500/100 package limits 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.

By 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 or policy's per-occurrence limit.

ClaimCenter provides these 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 (PIP) 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 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 whether 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.

See Also
- The *ClaimCenter Rules Guide* topics on *Triggers*, *Categories*, and *Advanced Topics* describe transaction business rules.
- The *ClaimCenter Configuration Guide* lists all sample rules as well as the rules in your implementation.

Financials Permissions and Authority Limits

This section lists all the security aspects of financial transactions. For a complete discussion of ClaimCenter security, permissions, roles, access control levels (ACLs), and so on, see "Security: Roles, Permissions, and Access Controls" on page 379.

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 the above permissions except the last one: adjusters, claims supervisors, managers, clericals, new loss processing supervisors, superusers, and user administrators. 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 use all these permissions. They are all defined for consistency. For example, you cannot edit a recovery (`recedit` permission). It is a received check, and you cannot change its information. Similarly, you do not edit a reserve or recovery reserve (`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 also set the maximum allowed transaction amount for any user:
- For a claim's and for any exposure's Total and Available Reserves.
- For any single payment.
- For a change in reserve amount.
- For a payment which exceeds its reserve.

If `false`, the `CheckAuthorityLimits` configuration parameter overrides these limits, and if the parameter `AllowPaymentsExceedReservesLimits` is `false`, it prevents all payments that exceed reserves.

See also
- "Authority Limit Profile" on page 403.

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.

chapter 16

Multiple Currencies

ClaimCenter supports the use of different currencies depending on your business needs. Enabling ClaimCenter to use multiple currencies (known as *multicurrency)* means that you can write checks, create reserves, and recovery reserves, make payments, and collect recoveries in more than one currency. The system knows the ClaimCenter default currency (defined further in this section), but accounts for these transactions in the currencies in which they were made.

This topic discusses how multicurrency works in ClaimCenter, the role of exchange rates, and the different types of multicurrency in ClaimCenter.

This topic includes:
- "Multicurrency Overview" on page 171
- "Multicurrency Displays" on page 174
- "Multicurrency Financial Summaries" on page 175
- "Exchange Rates" on page 175
- "Foreign Exchange Adjustments" on page 178
- "Bulk Invoices Use Multiple Currencies" on page 180
- "Multicurrency Data Model" on page 181

See Also
- "Configuring Currency" on page 623 in the *Configuration Guide*
- "Working with Money and Currency Data Types" on page 304 in the *Configuration Guide*
- "Exchange Rate Integration" on page 236 in the *Integration Guide*

Multicurrency Overview

The application's financial transactions have always been conducted in a single (default) currency. But you can use more than one currency in ClaimCenter to:
- Write checks, payments, reserves, recoveries and recovery reserves in any other (transaction) currency.

- Track these transactions as a part of the usual ClaimCenter financials summary screens and calculations.
- Integrate these transactions into the application's financial totals and summaries.

Every instance of ClaimCenter continues to use a single default currency, but many tasks can be performed using another transaction currency. In particular, you can:

- **Create checks, and receive recoveries** in any currency.
- **Create reserves and recovery reserves** in any currency. All of them, no matter their currency, still contribute to the aggregate reserves and recovery reserves. These always appear in units of the claim currency.
- **Search** for checks and recoveries in any particular currency or in all currencies.
- **Create bulk invoice payments** and write their associated checks in any currency.
- **View financial summaries** which include *all* transactions, independent of their currency.
- **Adjust** the actual amount, in the claim and/or default currency, of a check and its payments.
- **Set the Preferred Currency** field on a contact, which tells ClaimCenter the default currency to use after writing a check to that contact.
- **Enter exchange rates** manually if needed, or automatically get them from an outside provider.
- **Periodically update exchange rates** obtained from an outside provider.

Enabling Multicurrency and Defining the Default Currency

In the base configuration, currency is set to a single default. To change it to using multiple currencies you must configure it. See "Working with Money and Currency Data Types" on page 304 in the *Configuration Guide* to learn how to do this.

Definition of Currency Types

ClaimCenter supports a single main, or *default* currency, as well as policy-based currency and transaction currency. They are defined as follows:

- **Default currency** – Main or base currency for the system. It is the same as the *Reporting* currency. The terms: server currency, reporting currency, main currency, and default currency, all refer to this default currency. The `ReportingAmount` field is on the `Transaction` entity. It returns the reporting amount of a transaction, which is the equivalent of the transaction amount in the reporting currency.
- **Claim currency** – Currency associated with the claim. It is used when performing financials calculations (which can span transactions of different currencies). It is also known as *policy currency*, but this topic refers to it as *claim* currency. However, the terms can be interchanged. The `ClaimAmount` field is on the `Transaction` entity. The amount is determined by summing the claim amounts of all `TransactionLineItems` that belong to the transaction. Since policy and claim currency are considered the same, see the section "Claim Currency and Policy Currency" on page 173 to learn why they are similar.
- **Transaction currency** – Currency of the transaction amount, which is the primary amount for the transaction, from which other amounts are calculated. For payments, this is the currency in which the actual payment was made. ClaimCenter has a list of all of the currencies in the `Currencies` typelist, along with their current exchange rates. However, you must configure what currency you want to see in the typelist. The `TransactionAmount` field is on the `Transaction` entity. It can differ from the claim currency.
- See "Exchange Rates" on page 175.

Every multicurrency transaction can have three amounts in each of those currencies associated with it. Financials calculations are tracked in the claim currency using the claim amounts. The claim inherits the currency from the policy. See "Multicurrency Data Model" on page 181 to understand the relationships.

Example

ClaimCenter calculates the amount of a financial transaction in the *default* currency using the appropriate exchange rate. It then stores both the amount in the transaction currency and the amount in the default currency.

This is seen, for example, in carriers with *snowbird* policyholders. Those are insureds who spend a certain season of the year in a different country (such as Canadians spending the winter in the state of Florida). The carrier writes all (or most) of their policies in one country (and therefore in one currency), but covers losses in a few other countries on occasion.

Another Example

A London based carrier has a satellite office in Paris. Since the carrier is located in England, ClaimCenter is configured with a *default* currency in GBP (United Kingdom Pounds). Policies that are written in England are in GBP. However, the Paris office writes and handles policies and claims in EUR (Euro). Therefore, ClaimCenter must handle claims in both GBP and EUR. If a Parisian policy holder drives to the Czech Republic and has an auto accident, then the financial *transactions* on the claim can be paid in Czech currency CZK (korunas). (Carriers using ClaimCenter can create certain transactions in a different currency.) ClaimCenter handles and stores amounts for financial transactions in all three currencies (default, claim, and transaction).

ClaimCenter makes currency available as search criteria. This applies to checks, recoveries, and bulk invoices. See "Multicurrency Searches" on page 175.

Claim Currency and Policy Currency

ClaimCenter supports policy currency, which is based on the policy's currency. In ClaimCenter, the `Currency` field on the entities `Policy` and `Claim` have a value that is not equal to the system's default currency. The initial value for the `Policy Currency` field is set up in the policy search adapter. Verified policies from the policy search adapter have their `Currency` property set. For unverified policies that are created through the FNOL wizard, you can select a currency other than the default currency. The `Claim` entity also has a `Currency` field. Changes to the policy's currency field are always copied to the `Claim Currency` field.

> **Note:** Policy currency *is the same* as claim currency.

If there are any transactions on a claim, then you cannot change the claim currency. If the claim currency were changeable while there were transactions, the claim amounts for the transactions, and the financials calculations would be in the wrong currency. However, until there are transactions on the claim, you can edit the policy currency in the user interface.

Preferred Currency on Contacts

The `Contact` entity has a `Preferred Currency` field, which contains the currency in which that contact would prefer to receive checks. You can assign a *Preferred Currency* to a contact after you create or edit it. After you specify the payee while writing a check, ClaimCenter changes the check's currency to the *Preferred Currency* of the payee. The currency selector drop down menu is enabled so that you can override this change. The following points are all configurable:

- For single payee checks, ClaimCenter changes the check currency from the default to the Preferred Currency.
- For joint payee checks, ClaimCenter makes the same change based on the first joint payee.
- For multi-payee checks, ClaimCenter only considers the primary payee, not secondary payees. All the checks in this check group use the same currency.

Checks, Payments, and Recoveries

The initially-selected currency when creating a check is determined first by the payee currency and then by the claim currency.

Reserves and Recovery Reserves

The system creates and stores reserves and recovery reserves in the claim currency. This means that in the user interface, you see the policy currency which includes all calculated values in the Financials Summary screen.

Multicurrency Displays

ClaimCenter implements the multicurrency feature with the following display features, which show and change currencies and exchange rates. Each financials page uses different combinations of these displays.

Types of Multicurrency Displays

If `MultiCurrencyDisplayMode` is `MULTIPLE`, you see the following in the user interface:

- If a transaction uses any currency besides the claim currency, the display shows both currency amounts. The amount in the claim currency appears in smaller type below the transaction amount in the claim currency. Both amounts are formatted according to their currency.

- The **Policy** screen is where you select the policy currency with a drop down menu of all of values of the Currency typelist. As with any policy attribute, if you edit the currency of a verified policy, the policy becomes unverified.

- If searching for checks or recoveries within a monetary range, ClaimCenter presents **From** and **To** text fields formatted in the currency chosen for the search. See "Multicurrency Searches" on page 175.

- If writing a check or bulk invoice check in a secondary currency, you can select an automatic-selected (market) exchange rate or enter your own custom exchange rate. See "Market and Custom Exchange Rates" on page 176.

- If creating a reserve, recovery, or recovery reserve, a popup shows the exchange rates. You can view or change the currency and exchange rate with the other display elements described in this list.

IMPORTANT   Using multiple currencies requires you to also correctly set the data types for those currencies. See "Working with Money and Currency Data Types" on page 304 in the *Configuration Guide*.

Pages that Use the Multicurrency Feature

The following pages of the user interface include support for multiple currencies. They all use some of the displays described in the previous section.

The New Check Wizard and Multicurrency

You can create all types of checks in any currency. Each of the these 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. Use this to think about other check currencies. It does not display the **Preferred Currency** of secondary payees.

Step 2 – Sets the check's currency to a payee's **Preferred Currency**. See "Preferred Currency on Contacts" on page 173. 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 currencies.

> **Note:** The **Auto First and Final** wizard also uses multicurrency.

Other Pages that use Multicurrency

Pages that create checks and transactions—payments, reserves, recoveries and recovery reserves—display a currency drop-down menu. Use this menu to add the transaction amount in any currency.

You can sometimes add a transaction in another currency to one of these pages, but in the default currency. For example, if you received a recovery in another transaction, you can add it in the default currency. A popup calcu-

lator helps you select the correct value. You can also override the exchange rate it provides. Also, multicurrency features such as the exchange rate are not enabled when using the default currency.

Multicurrency Searches

Because you can create checks and recoveries in any currency, you can search for them independently of their currency (in all currencies), or any single currency. Enter parameters to control these searches:

* **Search** tab → **Recoveries** → **Optional Parameters**
* **Search** tab → **Checks** → **Optional Parameters**

Searches for both checks and recoveries contain a currency selector in their **Optional Parameters** sections. Use them to select a currency for these searches. This drop-down menu contains all the typecodes in `Currrency`. Additionally, the search screen offers **From** and **To** text boxes for you to specify the search range.

Single Currency Searches

If you specify a currency, your search is restricted to items in that currency, and the **From** – **To** fields are used to specify amounts in that currency. Single currency searches return the sum of all items found. ClaimCenter labels the list of single currency search results as follows:

> **The results of this search can be incomplete because a specific currency is being used to limit the search.**

You can configure this message for both recoveries and checks by using the following display keys.

```
JSP.RecoverySearch.Recoveries.Warning.SingleCurrency
JSP.PaymentSearch.Payments.Warning.SingleCurrency
```

Multicurrency Financial Summaries

Most ClaimCenter features, such as the **Summary** pages, financials calculations, and aggregate limits, operate in the claim currency. The **Financials Summary** screen of each claim, reflects use of the claim currency. ClaimCenter calculates these aggregate amounts in the claim currency.

For more information, see "Foreign Exchange Adjustments Affect Financial Calculations" on page 179.

If there is no policy currency, ClaimCenter uses the default currency.

> **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. This 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. This is because they do not take foreign exchange adjustments into account, so Remaining Reserves would no longer equal the difference between Total Reserves and Total Payments.

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.

ClaimCenter uses a table of exchange rates to calculate the claim amount from the transaction amount and to perform similar currency conversions. ClaimCenter uses this table in conjunction with an `IExchangeRateSetPlugin` plugin, described later. If you create transactions, you can determine the exchange rate in one of two *modes*, described in the next topic.

Market and Custom Exchange Rates

If you create transactions, you can determine the exchange rate in one of two *modes*:

- **Automatic mode** – The system gets the rate based on data in the tables, using the exchange rate from the application's table of most current market rates. This mode is selected by default.
- **Manual mode** – ClaimCenter shows a text field where you can enter a custom rate. Initially, the 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.

If you select a currency other than the claim currency, or the default currency for a bulk invoice, ClaimCenter enables you to switch between modes. You can do so by selecting the appropriate radio button in the user interface.

Plugin for Market Exchange Rates

ClaimCenter typically obtains current, market-based exchange rates from a web service to an external third-party system through the plugin `IExchangeRateSetPlugin`. These exchange rates are typically stored in ClaimCenter with effective dates.

The implementation of the plugin, and how often it runs to import an exchange rate set, is based on your business needs.

For example, the plugin could:

- Call a web service.
- Process and import a document with a list of rates. This document might be provided by an internal currency management department.

The Exchange Rate (`ExchangeRate`) batch process invokes the plugin `IExchangeRateSetPlugin`, which adds a new set of market exchange rates in ClaimCenter. Running this batch process loads the market rates.

In the base configuration, this batch process has been commented out in the `scheduler-config.xml` file.

```
<ProcessSchedule process="ExchangeRate">
  <CronSchedule hours="2"/>
</ProcessSchedule>
```

The batch process might invoke the plugin as follows:

- Every day, for the latest market rates.
- Periodically, based on your business requirements.

An implementation of the `IExchangeRateSetPlugin` plugin interface is required to provide an `ExchangeRateSet` containing at least one `ExchangeRate` from each currency in the `Currency` typelist to the system default currency. For every currency in the `Currency` typelist, there must be one `ExchangeRate` in the returned `ExchangeRateSet` whose base currency is that currency and whose price currency is the system default. If N represents a currency, then the minimum is N times one ($N \times 1$) 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 `ExchangeRates` to construct an exchange rate between every currency pair, which becomes the active market `ExchangeRateSet`.

In the following illustration, the ExchangeRateSet entity contains two currencies: US dollars and Euros. It also has effective and expiration dates—EffectiveDate and ExpireDate fields.
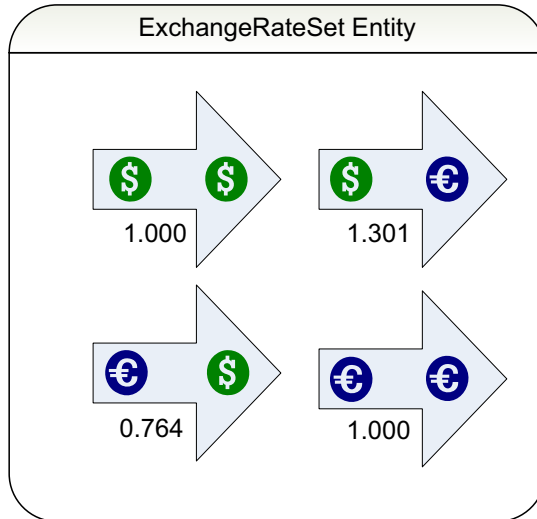
Multicurrency and Active Market Rate Sets

ClaimCenter must always have an *active market rate set* if it has been configured for multicurrency. Guidewire defines an *active market rate set* if the MarketRates field is set to true on the ExchangeRateSet entity and it has the current date. The current date is between the effective date (EffectiveDate field) and expired date (ExpiredDate field).

To determine which ExchangeRateSet is the active market set, the system first searches for ExchangeRateSet entities with the MarketRates field set to true. It then sorts on the most recent effective date that has not expired.

Note: If the MarketRate field is set to false, it indicates a custom rate.

WARNING You must run the exchange rate batch process at least once to load the market rates. Otherwise, ClaimCenter displays an error if you try to create a multicurrency check. This error condition also occurs if the current market rate set expires and no new set has been loaded. To avoid this issue, Guidewire recommends that you do not set the expiration date, enabling the system to always get the last known market rate set.

See Also

- "Foreign Exchange Adjustments" on page 178.
- "Multicurrency Data Model" on page 181 for a diagram showing the relationships between the entities.
- "Exchange Rate Integration" on page 236 in the *Integration Guide*.
- "Batch Processes and Distributed Work Queues" on page 134 in the *System Administration Guide*.

Importing Multiple Currency Transactions

Use the following methods to import financial transactions into ClaimCenter.:
- IClaimFinancialsAPI.addClaimFinancials
- IClaimFinancialsAPI.addClaimFinancialsWithValidation

A call to either of these methods results in a new TransactionSet whose transactions all have the same currency and exchange rates. For details, see "Claim Financials Web Services" on page 200 in the *Integration Guide*.

Foreign Exchange Adjustments

Sometimes a check is written in a currency other than that of the claim currency, and no custom rate was 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 differ from the previously calculated amounts.

For example, the default (or reporting) currency and claim currency is 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, then the carrier's USD 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 (to $140 in the example). This adjustment changes some, but not all, summary calculations. They do not affect recoveries, for example. See "Foreign Exchange Adjustments Affect Financial Calculations" on page 179 for details.

> **Note:** You cannot make these adjustments on reserves, recoveries, or recovery reserves.

How to Make 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 of the check's payments except for offsets, recoded payments, 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 - $130 = $10 adjustment. If the payments of the check had claim amounts of $39 (30% of the total) and $91 (70% of the total), then the adjustment would be distributed between them. Three dollars applies 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 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:

- Be on an escalated check that has not been canceled or transferred.
- Not have been recoded.
- Not be an offset payment.

- Not be a 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 before the application of the new one.

Refer to the Guidewire Studio Gosu API reference for additional details and examples of these methods.

Foreign Exchange Adjustments Affect Financial Calculations

ClaimCenter treats all foreign exchange adjustments as non-eroding, and most calculated values—most importantly Open, Available, and Remaining Reserves—do not change if you apply an adjustment. However, Net and Gross Total Incurred and Total Paid do change. To continue the example, total incurred and total paid values increase by $10, and the aforementioned reserves calculations remain unchanged.

See "Summary of Financial Calculations" on page 165 for definitions of all calculated financial values.

Foreign Exchange Adjustments in Your Custom Financial Calculations

You can create your own custom financial calculations that include foreign exchange adjustments. For example, you could define a calculation like 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 how they affect 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.domain.financials.FinancialsCalculationUtil` provide financial expressions that can be used to define new calculations. To get detailed information, refer to the Guidewire Studio Gosu API Reference:

- `getForeignExchangeAdjustmentsExpression`
  - Total foreign exchange adjustments for both eroding and non-eroding payments.
- `getErodingPaymentsForeignExchangeAdjustmentsExpression`
  - Total foreign exchange adjustment for eroding payments only.
- `getNonErodingPaymentsForeignExchangeAdjustmentsExpression`
  - Total foreign exchange adjustments for non-eroding payments only.

Example

A British motorist injures an American, who is walking down a street in Europe. This accident sets in action the following events:

1. The American opens a claim. Anticipating that the claim will be paid in Euros, the adjuster creates an initial reserve of 80 Euros but decides to create the claim in US dollars. 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 1200 Euro bill for medical treatment, and increases reserves up to 1280 Euros, a $1600 claim amount.

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. The claim adjuster opens a recovery reserve for 750 Pounds, based on the current Pound/$ exchange rate of 2.0. The adjuster sends a subrogation request for this amount to the British driver's insurance company. The claim amount for the recovery reserve is $1500.

5. By the time the check 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, will 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.

6. The American insurance company receives and deposits a subrogation check for 750 Pounds. 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, an exchange rate of 2.04. However, the claim amount of the recovery transaction is not adjusted.

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) *Recovery attempt for 750 Pounds started; recovery reserve opened for this amount*								
2.0 $/Pound	$88	$1512	$1512	**$1500**		$1600	$1600	
5) *1200 Euro check clears bank for $1560; adjustment made*								
1.30 $/Euro	$88	**$1560**	$1512	$1500		$1600	$1600	$48
6) *750 Pound Subrogation check received and recovery of $1515 entered*								
2.02 $/Pound	$88	$1560	$1512	**$10**	**$1515**	$1600	**$85**	

Note: entries in **bold** are changed by the action in the line above them.

Notes:

- * Total Eroding Payments is not a real calculation and is only used in the table for illustration.
- This example shows that foreign exchange adjustments are made on payments *only*, not recoveries.
- Step 5, where the foreign exchange adjustment was applied, did not affect Open Reserves or Total Eroding Payments.

Bulk Invoices Use Multiple Currencies

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 201 for details.

Multicurrency Data Model

The following table and diagram summarize key entities related to multicurrency.
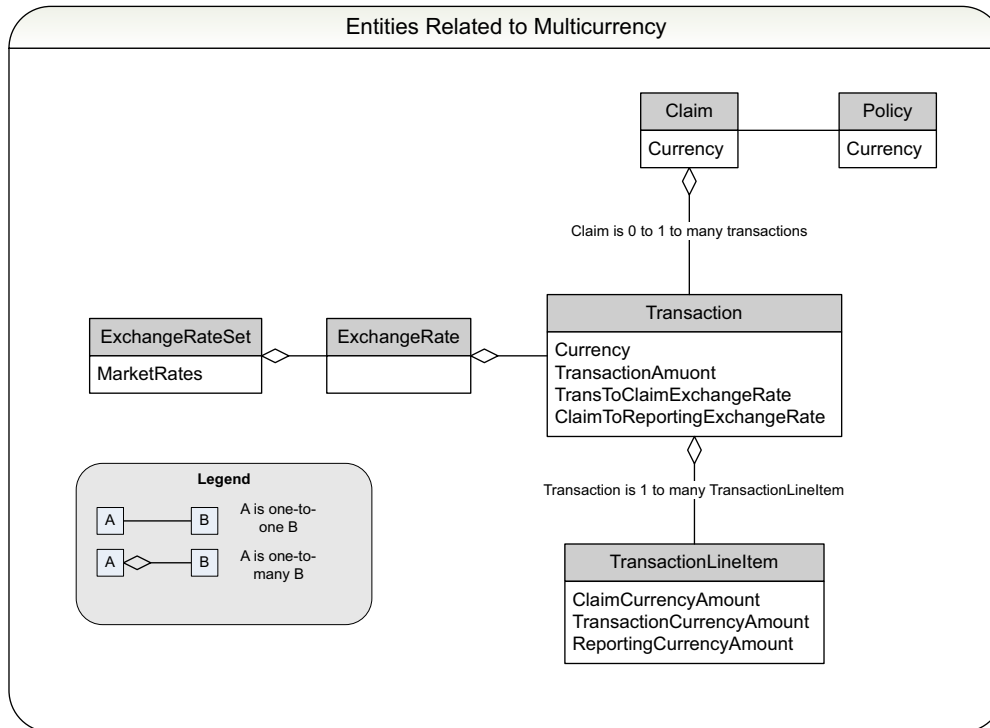
- The currency of the claim always equals the currency of the policy.
- There is a foreign key from `Transaction` to `Claim`.
- `TransactionLineItem` stores amounts in all three of the currencies that affect a transaction: transaction, claim, and reporting. The `TransactionLineItem` table itself only stores the amounts. The currencies are stored, respectively, on the `Transaction` and `Claim` entities, and statically in the system as configured in config.xml. The `ReportingAmount` is from the application's default currency. ClaimCenter stores this currency as a configuration parameter in the `config.xml` file.
- The transaction-to-claim and claim-to-reporting exchange rates are stored in the corresponding fields in `Transaction`.

Entity	Description
Check	`Check` contains an array of `Payments`. `Payment` is a subtype of `Transaction`, so every `Payment` stores a currency and two exchange rates. All payments on a check must have the same currency and exchange rates. For this reason, the currency for a payment can also be referred to as the *Check currency*. The `Check` table does not store a currency or exchange rates, but `Check` has virtual properties to get the currency and exchange rates for its payments.

Entity	Description
CheckPortion	Determines the amount for which a secondary check, such as a check on a multi-payee check that is not the primary check that will be written. `CheckPortion` can indicate that a secondary check receives a percentage of the sum of the payments or a fixed amount.
	Checks with a `CheckPortion` do not have any payments, but just receive a percentage or fixed amount of the Payments in the primary Check of the `CheckGroup`. `CheckPortion` cannot have its percentage and fixed amount fields both populated.
	Key fields include: • `FixedTransactionAmount` – If set, the amount in the transaction currency that is allocated to this secondary check • `FixedClaimAmount` – If set, the amount in the claim currency that are allocated to this secondary check • `FixedReportingAmount` – If set, the amount in the reporting currency that are allocated to this secondary check • `Percentage` – If set, the fraction of the amounts of the payments that are allocated to this secondary check
Deduction	This represents a deduction from a check, usually for tax purposes.
	Key fields include: • `ClaimAmount` – In the claim currency • `TransactionAmount` – In the transaction currency • `ReportingAmount` – In the reporting currency
Transaction	Represents a financial operation. It has the following subtypes: `Payment`, `Recovery`, `RecoveryReserve`, and `Reserve`.
	Key fields include: • `Currency` – The transaction currency. • `TransToClaimExchangeRate` – The exchange rate between transaction and claim currencies that is in effect for this `Transaction`. • `ClaimToReportingExchangeRate` – The exchange rate between claim and reporting currencies that is in effect for this Transaction. This value is not shown in the user interface in the base configuration.
TransactionLineItem	`TransactionLineItems` provide a means to split the amount of a transaction into multiple categories such as Doctor, Hospital, Legal, and so forth. Every transaction has one or more `TransactionLineItems`, and the amount of the transaction is the sum of all its line items' amounts.
	Key properties include: • `Deductible` – The Deductible represented by this `TransactionLineItem`, used when deductible handling is enabled. • `TransactionAmount`, `ClaimAmount`, `ReportingAmount` – Store the amount in the three currencies. `TransactionAmount` is also accessible through the `Amount` virtual property for single currency implementations.
ExchangeRate	Represents an exchange rate between a pair of currencies. This exchange rate can be a market rate, in which case it will exist in an `ExchangeRateSet` with rates between every currency pair. This exchange rate 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`.
	Key fields include: • `BaseCurrency` – The *from* currency, as in GB pounds. • `PriceCurrency` – The *to* currency, as in Euro. • `Rate` – As in 1.301.
ExchangeRateSet	Represents a set of exchange rates, along with supplemental information about those rates, including the dates the set goes into effect and expires.
	The `MarketRates` field, when `true`, indicates that the exchange rates are market rates. When `false`, the set contains only one, user-entered (custom) rate.
	Key fields include: • `EffectiveDate` – Sets the date and time for the rate set to be in effect. • `ExpireDate` – Sets the date and time for the rate set to be no longer effective. • `MarketRates` – If set to `true`, the rate set is included in the search for the latest market rates.

chapter 17

Deductible Handling

You can define a *deductible* as 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 would be if you were in an auto accident and you notified your insurance company. Your agent said that they would cover the entire cost of replacing the hood of your car after you contributed 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 through configuration.

This topic introduces you to how ClaimCenter uses deductibles.

This topic includes:
- "Deductible Handling Overview" on page 183
- "Working with Deductibles" on page 184

Deductible Handling Overview

Typically, these deductibles are applied to the payments before making out the check (on the coverage level). The deductible amount is normally defined in the policy. After you select a policy in the FNOL 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, and the actual check to the insured is in the amount of $500. $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:
- Some policies have a higher deductible based on the claim incident. Drivers in Great Britain can pay a higher deductible if they are under a certain age, for example.

- Deductible calculations are often made based on the fault rating of the insured *if* the insured can prove that the insured's fault was a certain percentage. For example, if the insured's fault was 30% and the other party was 70% at fault, then the insured would pay only 30% of the deductible.
- In some cases, the deductible can be negotiated with the claim's 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:** ClaimCenter does not support deductibles applied across multiple partial payments.

Working with Deductibles

This section describes how to work with deductibles and contains the following sections:
- "Viewing Deductibles" on page 184
- "Applying Deductibles" on page 185
- "Editing Deductibles" on page 186
- "Waiving Deductibles" on page 186
- "Setting Up Deductibles" on page 186
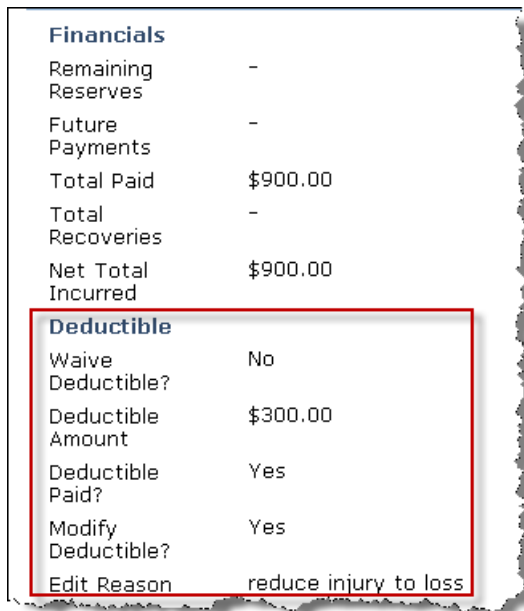
Viewing Deductibles

How do you know if a deductible has been applied to a claim? There are several places in the user interface where you see it.
- On the **Summary** screen, you can see this information in the **Financials** section.
- On the **Exposures** screen (for example in an auto policy).

  In this example taken from the **Exposures** screen of the first vehicle, you can see that not only has the deductible been applied, but it was modified per the comments.

- On the **Subrogation** screen.

Continuing with the previous example, the adjuster has now determined that the accident was not the insured's fault. On the **Subrogation Financials** screen, notice that the $300 deductible has been applied. It will be returned to the insured as soon as the carrier gets that amount from the party who was at fault.

The deductible amount only displays with a reserve line if the insured incurred it. This applies only for exposure level reserves. Hence, the Claim-Level reserve lines display no deductible amount. However, if you choose to have any deductibles apply to Claim Level reserves, you can configure it in Studio.

Applying Deductibles

Apply deductibles in the following personal auto wizards:

- New Check wizard (NCW), in step 2 of 3
- Quick Check wizard
- Auto First and Final wizard

You apply (or pay off) deductibles as payments are made against the appropriate exposures. On the payments step of the check wizard, after choosing a reserve line whose exposure has an unpaid deductible, you can optionally click **Apply Deductible**. If you do decide to apply the deductible, then ClaimCenter automatically creates a transaction line item whose value is 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. No further payments on this exposure can have a deductible applied to it. In the base configuration, there is no support for deductible payments over multiple payments. Therefore, you must apply the entire amount as a negative transaction line item to a reserve that is associated with an exposure that has a deductible on it. ClaimCenter validates the first check that the deductible is applied against. If the deductible amount is greater than the amount of the check, then ClaimCenter issues a warning. **This payment cannot be added because it has a deductible line item whose amount exceeds the sum of the other line items' amounts.**

Editing Deductibles

A deductible can be overridden (edited) if it has not been paid or waived. In the user interface, the *Overridden* flag is known as *Modified* and you access it by a radio button. Selecting **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*, then ClaimCenter recalculates the claim deductible amount through the DeductibleCalculator and it becomes uneditable again.

This section describes how to change the deductible amount to a different number from what is indicated on the policy.

1. Navigate to the **Exposures Details** screen and click **Edit**.

2. Ensure that a coverage is selected.

3. In the **Deductibles** section, select the **Modify Deductible** radio button.

4. Enter a deductible amount and edit reason.

5. Update your work.

Waiving Deductibles

A deductible can be waived if it has not been applied to any payment. This is done in the **Exposures Details** screen, where the deductible's *Waived* flag can be set to *Yes*. This field is not editable if the deductible has already been paid (although if something causes it to become unpaid, then the waived field is again editable). If you waive a deductible, then the **Apply Deductible** button does not appear in the check wizard after selecting related exposures. You must also have the correct permission of *Edit Deductible*.

> **Note:** Waiving a deductible is usually done by more experienced adjusters. They are often waived in no-fault states if the insured is not at fault.

1. Navigate to the **Exposures Details** screen and click **Edit**.

2. Ensure that a coverage is selected.

3. In the **Deductibles** section, select the **Waive Deductible** radio button.

4. Enter an edit reason.

5. Update your work.

See Also

- "Configuring Deductibles" on page 633 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 (or *unoverridden* in the database). 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 application, deductible handling has been automatically set up. This is done by the following parameters having been set to true in the config.xml file:

- UseDeductibleHandling parameter enables deductibles to be applied in the system.
- AllowMultipleLineItems parameter must also be set to true. The reason for this parameter is since deductibles are applied through TransactionLineItems, the AllowMultipleLineItems config parameter must be set to true in order for deductible handling to be enabled.

However, if you set the config parameter `UseDeductibleHandling` to `false`, then:

- 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.

If you set the config 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 bulk invoices feature to record an invoice containing items for multiple claims and then pay it with a single check. The following examples illustrate how you can use the bulk invoices feature.

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:

- Electronically record the invoice.
- Assign each invoice line item to the correct claim.
- Create a single payment for each of the invoice's line items.
- 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 invoices feature, you enter the payments for each claim into one screen to create one bulk invoice and send one check.

This topic includes:

See Also
- See "Bulk Invoice Integration" on page 221 in the *Integration Guide*.

Bulk Invoice Screens

Access the bulk invoice initial screen by selecting the **Desktop** tab and click **Bulk Invoices**. The bulk invoice feature consists of this screen, with its list of bulk invoices, and a **Bulk Invoice Details** screen. This screen contains information about a single bulk invoice, including the list of its line items.

The Main Bulk Invoice Screen

The main **Bulk Invoice** screen (accessed from the **Desktop**) contains a tool bar of buttons and a list of all existing bulk invoices with their statuses. You can view and edit existing bulk invoices, create new ones, or further process a bulk invoice. Use the buttons on this screen to:

- **Delete** a bulk invoice (select its checkbox and click **Delete**).
- **Create** a new bulk invoice (click **Create New**).
- **Validate**, **Submit**, **Stop** or **Void** a bulk invoice to further process it.
- **Refresh** the screen. This checks whether an invoice's status has changed.

These buttons are available if you have the correct permissions and the operation is possible on the selected bulk invoices.

The Bulk Invoice Details Screen

The upper section of the screen contains areas pertaining to the bulk invoice as a whole, while the lower section contains a list of line items.

Bulk Invoice Details Screen: Upper Section

The upper portion of the **Bulk Invoice Details** screen contains the following sections as well as two buttons in edit mode:

- **Update** – Save the bulk invoice to the database in its current state, even if incomplete.
- **Cancel** – Undo any changes since you last clicked **Update**.

The **Invoice** section contains these fields:

- **Invoice Number** – A number assigned to the invoice being entered. Typically this number 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** – You must select either **Enter individual amounts** or **Distribute Amount Evenly**. If the latter, a total amount will be divided evenly among all the line items. Otherwise, you must enter individual amounts for each line item. **Distribute Amount Evenl**y is useful if your bill contains the same charge for many similar police reports.

- **Distribute Amount Evenly** – If Split Equally is yes, then this field must contain a value. This value is the total amount of the invoice which will be split equally amongst all the invoice items. If this is not selected then this field is not used.

If multicurrency is enabled, this field also appears:

- **Currency** – The currency that this bulk invoice uses. A bulk invoice has a single currency that is applied to all bulk invoice items and their corresponding checks (when created or updated).

If multicurrency is enabled, the following fields also appear when the currency selected is not the default currency:

- **Exchange Rate Mode** – If Automatic (default), the current market exchange rate is used. If Manual, the user can enter a specific rate in the next field.
- **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** – A description of the origin of the exchange rates being used for this bulk invoice.
- **Date Entered** – The date that the exchange rate being used for this invoice was entered.

The **Status** section consists of the following fields:

- **Status** – Status of the bulk invoice. See "Lifecycle of a Bulk Invoice" on page 198.
- **Date Approved** – If the bulk invoice was approved, set when the reviewer approves the bulk invoice.
- **Total Approved Amount** – The total of all approved items.
- **Issue Date** – Date the bulk invoice was issued.

The **Invoice Item Details** section contains the following fields:

- **Default Cost Type** and **Default Cost Category** – Filter the available reserve lines for each item. Also used when entering a new reserve line.
- **Default Payment Type** – Assign Supplemental, Final, or Partial to the payment type of each line item.

The **Check Details** section contains these fields:

- **Payee*** – Required, and can be selected from contacts in the address book.
- **Pay to the Order of*** – Required, defaults to **Payee**, can be selected from address book, can be multiple names.
- **Check Number** – The number of the check that pays the bulk invoice. This number is propagated to the item checks.
- **Delivery Method** – Mail, hold for hand delivery by adjuster, or no check if a manual check was written.
- **Recipient*** – To whom the check is sent. Defaults to Payee.
- **Mailing Address** – Where the check is to be sent; defaults to the Payee's address.
- **Report As** – Whether the check amount is reportable to an income tax agency, such as the IRS.

The **Payment Instructions** section, containing the following fields:

- **Payment Method** – How to pay (by EFT, manual check, or check), from the `PaymentMethodType` typelist.
- **Send Date*** – The date to send the bulk invoice check to the downstream check writing system.
- **Check Instructions** – Special instructions, from the `CheckHandlingInstructions` typelist.
- **Memo** – Add this free-form text to the check when it is written.

The bulk invoice's **validation status** appears at the bottom of this portion of this screen. You must write your own validation by configuring the `IBulkInvoiceValidationPlugin`. In the base configuration, ClaimCenter marks all bulk invoices valid when you click **Validate**.

Bulk Invoice Details Screen: Lower Portion

The lower portion of the **Bulk Invoice Details** contains a table of line items. Each Line Item corresponds to an invoice line item of the original bill. After creating a new bulk invoice, this table is empty. Use **Add** or **Remove** to create line items:

- **Add** – Open a new blank row so that you can enter the details of another Line Item.
- **Remove** – Delete all line items whose check boxes have been checked.

You can use following fields to create a line item:

- **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 claim's reserve line against which to make the payment. All the claim's reserve lines show in a drop-down list, after being filtered 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 the claim's exposure from this drop-down menu. See "Defining a New Reserve Line" on page 193.

    Note: A newly created reserve line uses the Cost Type and Cost Category in the **Default Cost Type** and **Default Cost Category** drop down menus.

- **Payment Type** – Either Supplemental, Final or Partial; can be different for each Line Item.
- **Amount** – Enter this value unless you have chosen to **Distribute Evenly**, in which case the split amount appears.
- **Deductions** – Income tax withheld, which ClaimCenter computes if required.
- **Service Date** – See "Service Dates and Periods" on page 145.
- **Description** – An optional field for your use.
- **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, see "Lifecycle of a Bulk Invoice" on page 198.

Creating a Bulk Invoice

The following diagram is an overview of the bulk invoice process.

Overview of the Bulk Invoice Lifecycle
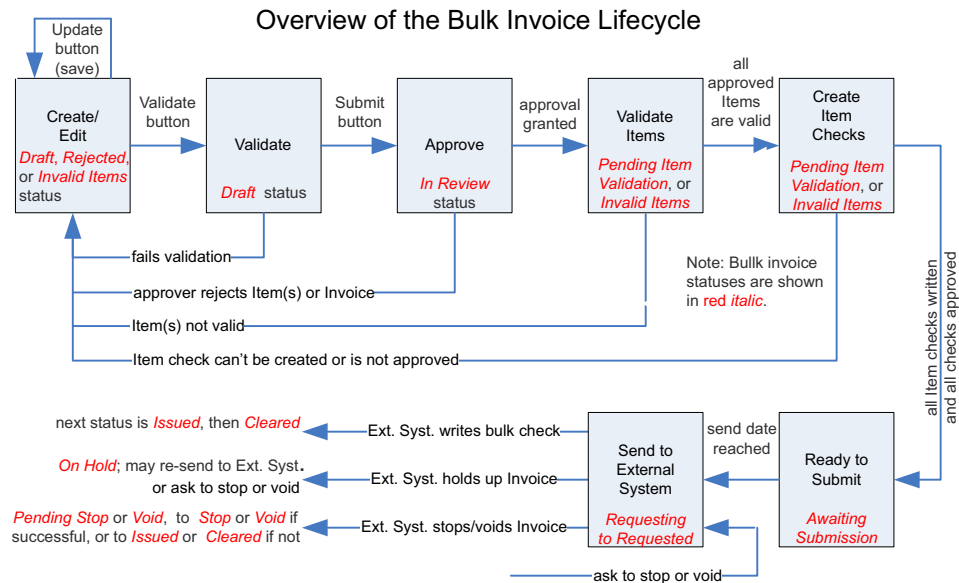
Note: Validation is usually performed by the Bulk Invoice Validation plugin.

After reaching the bulk invoice overview screen by selecting **Bulk Invoices** from the **Menu Items**, the **Create New** button opens the **Bulk Invoice Details** screen in edit mode.

Enter your information. You cannot save the bulk invoice until these required fields are entered. See the "Bulk Invoice Details Screen: Upper Section" on page 190 for more information on each field.

Entering Bulk Invoice Line Items

Begin by entering the claim number of the claim against which the bill's invoice item is to be charged. If the claim is valid, ClaimCenter displays a list of all its reserve lines, filtered by the **Default Cost Category** and **Default Cost Type**. Setting the **Default Cost Type** and **Default Cost Category** restricts the available reserve lines.

Defining a New Reserve Line

If assigning an item to a reserve line that does not yet exist on the claim, it is created in the claim during Line Item Validation.

1. Click **New** in the **Reserve Line** drop down list.

2. Select the **Exposure**, unless you want the reserve line to be at the claim level.

3. Select a **Cost Type** and/or **Cost Category** in the **Default Cost Type** or **Default Cost Category** drop down lists.

4. Save by clicking **Update**. The current values define the reserve line.

Notes:

• To create reserve lines with different Cost Types and/or Cost Categories, use one set of defaults. Click **Update**, then select a new set of defaults.

- Creating a new reserve line does not create a reserve for it, and doing so can cause the Line Item to fail its validation, if the payment exceeds its reserves.

Editing a Bulk Invoice

After clicking **Update** to save a bulk invoice, it appears in the list of bulk invoices with *Draft* status. You can select and continue editing it by clicking **Edit**.

You can re-edit a bulk invoice after it has left *Draft* status, but not reached *Requesting* status. However, any of these changes returns the bulk invoice to *Draft* status:

- Editing **Payee** or **Total Amount**.
- Adding or deleting a line item.
- Editing to a line item's claim number, any part of its reserve line (exposure, cost category or cost type) its payment type, or if it is eroding.

In addition, during Line Item validation, you can only edit line items which have failed this validation.

Total Amounts

ClaimCenter calculates and stores both the **Total Amount** of all the line items, and the **Total Approved Amount**, which is the amount of the bulk invoice check. Both these amounts have two values: the value in the default currency, and the value in the currency of the bulk invoice.

Validating a Bulk Invoice

Bulk invoices undergo two validations. Bulk invoice validation occurs if you click **Validation** before it is submitted for approval. The second validation, line item validation, occurs automatically upon approval, or immediately after submission if approval is not required.

The purpose of the first validation is to ensure that the bulk invoice conforms to your company's business practices. You can configure this by implementing the `IBulkInvoiceValidationPlugin`.

Many times edits invalidate the bulk invoice, thus requiring a repeat of this step. See "Editing a Bulk Invoice" on page 194.

ClaimCenter also performs other validation checks internally, including whether each claim number is valid and that exposures are at the Ability to Pay validation level.

Approving a Bulk Invoice

There are two approval processes that a bulk invoice must pass before being sent downstream.

- Bulk invoice approval, after bulk invoice validation.
- Check approval after Line Item Validation. See "Bulk Invoice Check Approval" on page 196.

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 Item Validation* and all its line items not marked *In Review* or *Rejected* by the approver receive *Approved* status. All *Rejected* and *In Review* Line Items remain in the bulk invoice with this status. See "Orphan Line Items" on page 196.

If a bulk invoice and a particular item are approved, but that item's check is subsequently rejected, then the bulk invoice item's status becomes *Not Valid*. This status reflects the fact that the approval of the bulk invoice item is to be done in bulk invoice approval rules and activities. This means that you need to fix the item, remove it, or manually reject it for the same reason the item's check was rejected.

Example of Bulk Invoice Approval

The following example uses rules to create approval activities for a bulk invoice:

First, add a rule to the *Bulk Invoice Approval* rule set:

```
Condition:
  { the BulkInvoice PaymentType starts with "RENTALCARCOST" or with "METRO"
    and there is no BulkInvoice approval date already assigned
  }
Action:
  { log "this Bulk Invoice needs approval"
    and flag that this bulk invoice needs approval
    and print message: "this system imported bulk invoice needs approval."
  }
```

Second, add a rule to the *Bulk Invoice Approval Assignment* rule set:

```
Condition: True
Action:
  define variables fooMetro, barMetro, and so on.
  if the BulkInvoice PaymentType starts with "RENTALCARCOST"
    then { set the group to fooRental and the user to barRental
    and log that this invoice has been assigned for approval to this group and user
    }
  else if the BulkInvoice PaymentType starts with "METRO"
    then { set the group to fooMetro and the user to barMetro
    and log that this invoice has been assigned for approval to this group and user
    }
```

Bulk Invoice Approval Rules

The only rule in the base configuration is one that requires approval for all bulk invoices. However, it is disabled so no approval is required.

If you have added approval and approval assignment rules, the approver sees an approval activity for the bulk invoice when 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 the activity list 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*. Items so marked are ignored. See "Orphan Line Items" on page 196. You can optionally add a comment to the marked items explaining 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 using buttons of the same name on the same screen. Clicking Cancel removes all flags from all line items.

See Also

- Bulk Invoice Approval in the *ClaimCenter Rules Guide*
- Bulk Invoice Integration in the *ClaimCenter Integration Guide* to create rule sets to select an approver and define this approval process

Validating Invoice Line Items

The application's next step in creating a bulk invoice is Line Item Validation. It begins 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 *Allow Payments Exceed Reserve Limits* is set in the `config.xml` file.
- Must have a valid Payment Type.

If any line items fail this validation, their status becomes *Not Valid*. The bulk invoice itself is given Invalid Invoice Items status and cannot be processed further. You must first either edit or remove them. Editing or

removing a Line Item returns the bulk invoice to *Draft* status for reapproval. See "Editing a Bulk Invoice" on page 194 and a repeat of this Line Item Validation.

Placeholder Checks

After a line item passes its 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 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. This means that you cannot edit or delete these checks from the Check Detail screens.

Transfer and Recode

A placeholder check can be transferred to a different claim, which creates a new invoice item against the new claim. The payment on a placeholder check can be recoded to another reserve line, which updates the invoice item's reserve line. If you make that change after the bulk invoice has been sent to a downstream accounting system, ClaimCenter notifies it.

Repeated Line Item Validations

If Line Item Validation occurs more than once, some line items will have been previously validated and already possess a placeholder check. In this case, the existing check will be updated to reflect any editing changes. If the check has already been approved, it will not need reapproval. If a Line Item becomes invalid after having been previously validated, its check is retired.

Orphan Line Items

If the bulk invoice approver marks any line items *Rejected* or *In Review,* then those line items do not participate in Line Item Validation. You can edit them 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. To be paid, you must either copy them to another bulk invoice, or write checks directly from their claims. Alternatively, you can edit the bulk invoice. But such an edit invalidates the bulk invoice and moves it back to *Draft* status.

Writing a Bulk Invoice Check

After the bulk invoice check's send date is reached, the check will be sent to the downstream check-writing system to be issued. The Bulk Invoices → Bulk Invoice Details screen is where you enter the values to be written on the check in the Payment Instructions and Check Details sections.

> **Note:** You must write a message transport plugin to listen for the `BulkInvoiceStatusChange` event so that the check can be sent downstream. See "Bulk Invoice Integration" on page 221 in the *Integration Guide*.

Bulk Invoice Check Approval

Every check created by the bulk invoice must pass thorough the same approval process as all other checks. If a check cannot be created or approved, the bulk invoice itself cannot be sent downstream. The offending line item must be removed or edited. If the line item is edited, it must be re-approved.

Escalating a Bulk Invoice

Escalation is the last step in the creation and approval of a bulk invoice. It involves two batch processes.

- The `bulkinvoicesworkflow` batch process transitions the bulk invoice to *Awaiting Submission* status after its checks are approved.

- After it reaches its send date, the `bulkinvoicesescalation` batch process gives the bulk invoice *Requesting* status. Integration code sends it to the downstream accounting or check writing system. You can edit the bulk invoice until it receives Requesting status, although most edits will invalidate it and return it to *Draft* status. Stopping, Voiding, and placing the bulk invoice *On Hold* are the only actions possible after it has been escalated. The `bulkinvoicesescalation` batch process escalates the placeholder checks for the items, causing the items to go to *Submitting* status. Individual placeholder checks can be excluded from this process by clearing their `PendEScalationForBulk` property. This causes them to be escalated as normal checks by the `financialescalation` batch process.

For more information on these batch processes, see the *ClaimCenter System Administration Guide*.

Stopping or Voiding a Bulk Invoice

The integration with a downstream system allows you to try to stop or void a bulk invoice. This moves the bulk invoice and its items into *Pending Stop* or *Pending Void* status. The downstream system calls the `IBulkInvoice` API after the cancellation is complete so that the bulk invoice is moved into *Stopped* or *Voided* status.

Placing a Bulk Invoice on Hold

The downstream system can also stop processing a bulk invoice and notify ClaimCenter through the `IBulkInvlice` API. In this case, you can void or stop it, or resubmit it. This is after correcting the problem found by the downstream system.

Lifecycle of a Bulk Invoice and its Line Items

Every bulk invoice has a lifecycle described by its statuses. The **Bulk Invoice** screen shows the status of each bulk invoice. Individual line items also have their own, similar life cycles and statuses. Status changes cause events that can be used to trigger a custom rule or action.

- A bulk invoice is first created. This process can take place over a period of time, and you can save incomplete bulk invoices with the Update button. They have *Draft* status.
- The bulk invoice itself must next be validated (using the Validate button). This does not change its status.
- If the bulk invoice must be approved, clicking **Submit** sends it 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 no approval is required, clicking **Submit** immediately starts line item validation and processing.
- 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 137 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 their associated checks are created and approved or rejected, the Bulk Invoice Workflow Monitor picks up the bulk invoice. This monitor moves the bulk invoice from *Pending Bulk Invoice Item Validation* status to either *AwaitingSubmission* status or *InvalidInvoiceItems* status.
- If ClaimCenter moves the status to *Awaiting Submission*, the bulk invoice remains at 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.

Lifecycle of a Bulk Invoice

Note: Some statuses advance by either SOAP APIs or through the user interface, which the diagram does not show explicitly. See "Financial Transaction Status and Status Transitions" on page 195 and "Check Integration" on page 203 in the *Integration Guide* for details.

Bulk Invoice Statuses
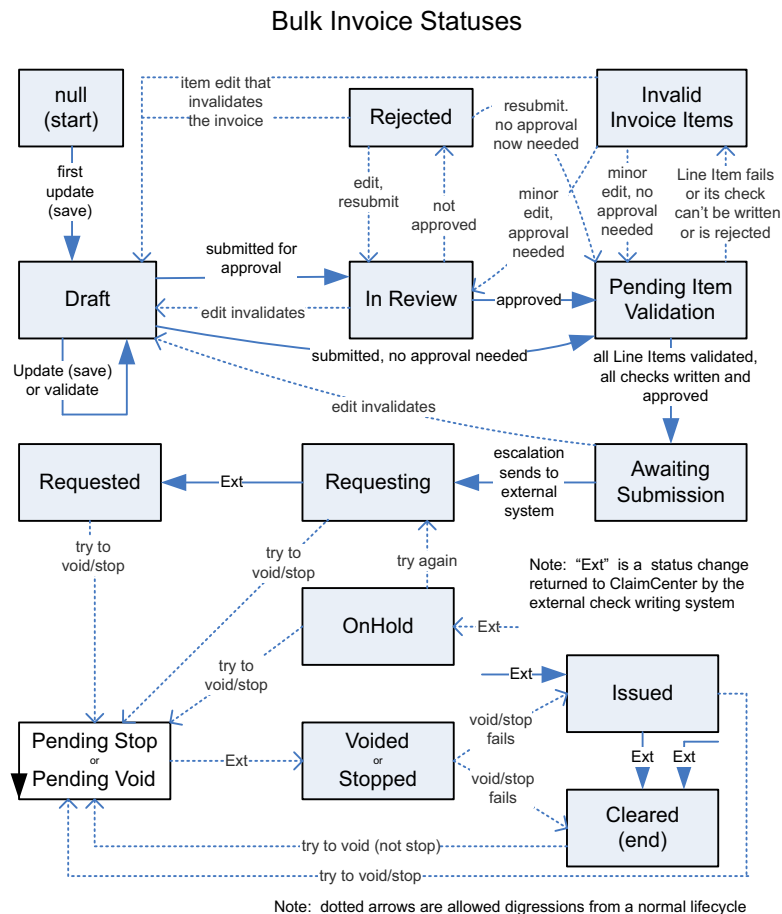
Bulk Invoice Status	Can delete or edit	Description
null	yes	Creation started but never saved (**Update** button never used).

Bulk Invoice Status	Can delete or edit	Description
draft	yes	Initially edited, or re-edited after saving, after being invalidated by edits by the approver. Or after edits to correct Line Item validation errors, or after edits while awaiting submission to the downstream system.
inreview	yes	Submitted for approval and is waiting for it from the assigned approver.
rejected	yes	Rejected by the assigned approver.
pendingbulkinvoice itemvalidation	no	Approved (or not needing it); all its line items are now being processed.
invalidbulkinvoiceitems	yes	At least one line Item failed processing, its check could not be written or was rejected.
awaitingsubmission	yes	Awaiting the date to be submitted to the downstream system.
requesting	no	Submitted (sent) to the downstream system.
requested	no	Downstream acknowledgement that bulk invoice was received.
issued	no	Downstream system notification that the bulk invoice check was issued.
cleared	no	Downstream system notification that the bulk invoice check cleared.
pendingvoid	no	The messaging plugin sends a message downstream to void the bulk invoice. Remember this is not in the base configuration and you must set this up.
voided	no	Downstream system reported that the Void request succeeded.
pendingstop	no	The messaging plugin sent a message downstream to stop the bulk invoice. Remember this is not in the base configuration and you must set this up.
stopped	no	Downstream system reported that the stop request succeeded.
onhold	no	Downstream system found problems and notified ClaimCenter.

Statuses of Bulk Invoice Items
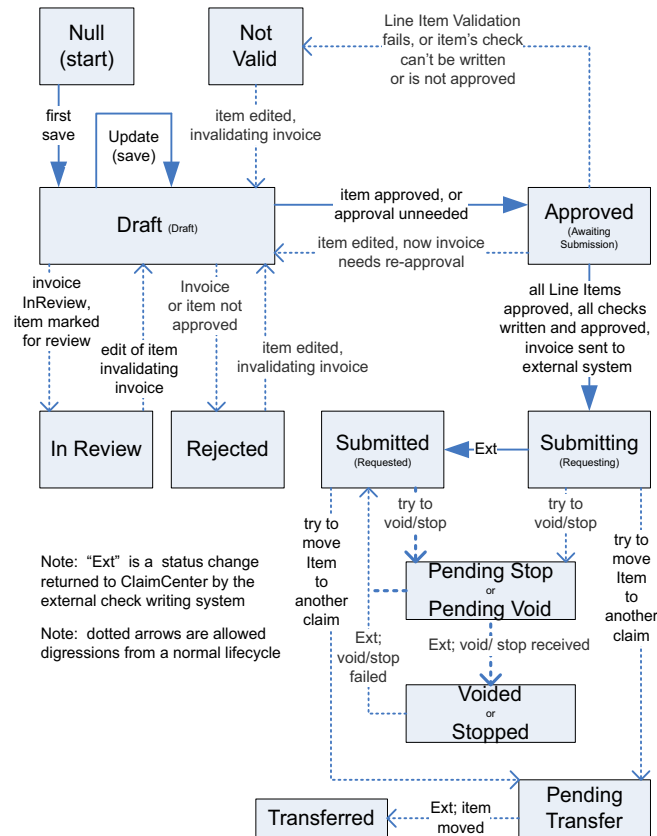
Lifecycle of Bulk Invoice Line Items

Statuses can be:

Bulk Invoice Item Status	Invoice Status	Delete or Edit	comment
null	null	yes	Bulk invoice created but never saved (Update button unused).
draft	draft	yes	Being initially edited, or reedited after being invalidated by edits after Line Item Validation rejects it (or another Line Item)
inreview	any	yes	Approver gives Item this status. It will not be processed further unless reedited. See "Orphan Line Items" on page 196.
rejected	any	yes	Same as in review.
notvalid	any	no	Failed Line Item Validation/Processing.
approved	any	yes	Passed bulk invoice approval and passed Line Item Validation.
submitting	requested	no	Submitted (sent) to the downstream system.
submitted	requested	no	Downstream acknowledgement that submission received.
pendingtransfer	requested or later	no	Notify downstream system to transfer Item to another claim.
transferred	requested or later	no	Downstream acknowledgement that transfer request received.
pendingvoid	pendingvoid	no	Message sent downstream to void the invoice.
voided	voided	no	Downstream acknowledgement that void request received.
pendingstop	pendingstop	no	Message sent downstream to stop the invoice.
stopped	stopped	no	Downstream acknowledgement that stop request received.

Bulk Invoice Events and Acknowledgements

Bulk invoices generate all the standard events (`BulkInvoiceAdded`, `BulkInvoiceUpdated`, `BulkInvoiceRemoved`) besides the specialized `BulkInvoiceStatusChanged` event. The `BulkInvoiceStatusChanged` event is generated every time the bulk invoice's status is updated, as well as when it is first created. This is exactly the same as the events generated for all financial transactions and checks.

Viewing Bulk Invoices From the Desktop

Notice the **Desktop** view of the **Bulk Invoice** link. Since you can use the **Search** tab to search for bulk invoices, use the Desktop view to view bulk invoices that are currently being worked on or processed. You can also create a new bulk invoice from this screen too.

See Also

- "Bulk Invoice Search" on page 50 for details.

Bulk Invoices and Multicurrency

Bulk invoices can be written in any single currency, not just the default currency. The entire bulk invoice and its check use this single currency, as do all its invoice items.

The Currency used by a Bulk Invoice

A bulk invoice has a currency, and that currency becomes the *transaction* currency for each of its invoice items' checks. The bulk invoice also has an exchange rate from its currency to the reporting currency. The items for a bulk invoice can be attached to different claims, with different currencies.

A claim's currency can differ from the default 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.

The two exchange rates for each check are selected 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* – A market exchange rate for 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.	The system uses market rates, since you are not prompted for an exchange rate.	The system 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's transaction-to-default rate is a market rate, then it can be selected from that rate's market rate set.
- If the bulk invoice's rate is a custom rate, then it can be selected from a market rate set with a date near that of the custom rate's effective date.

After the system updates the checks, this process repeats and the exchange rates and amounts are recalculated.

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 Financials Permissions and Authority Limits

This section lists all the security aspects of bulk invoice transactions.

User Permissions

These user permissions pertain to bulk invoices: view, create, edit, and delete.

In the base configuration, these roles have all above the above permissions: Adjusters, Claims Supervisors, Managers, Clericals, Customer Service Representatives, New Loss Processing Supervisors, and Superuser.

Authority Limits

Bulk invoices have no special authority limits, but all transaction authority limits apply and set the following maximums:

- For a claim's and for any exposure's total and available reserves
- For any single payment
- For a change in reserve amounts
- For a payment which exceeds reserves

The `CheckAuthorityLimits` configuration parameter can prevent all these from occurring.

Bulk invoice checks are subject to the same rules that apply to normal ClaimCenter checks. If you configure ClaimCenter to not allow payments to exceed reserves, this will also affect bulk invoices. In this case, be sure that reserves are set high enough before creating the checks of a bulk invoice, or set to true the parameter `AllowPaymentsExceedReservesLimits`.

See also
- "Authority Limit Profile" on page 403

Bulk Invoice Web Service API

ClaimCenter includes a web services API interface called `IBulkInvoiceAPI` that allows integrations to submit and manipulate bulk invoices directly from external systems. For example, an associated rental car company could directly submit bulk invoices to ClaimCenter from their systems using this API. In addition, `IBulkInvoiceAPI` methods can create and submit bulk invoices, as well as add, update, and delete bulk invoice items. For details, see "Bulk Invoice Integration" on page 221 in the *Integration Guide*.

The Bulk Invoice Data Model

The data model uses these entities to support bulk invoices.

Entity	Description
BulkInvoice	The top level `BulkInvoice` entity. It corresponds to the incoming invoice or bill to be paid. It has a unique ID (which can correspond to the invoice), some data fields (such as payee and a scheduled send date) and a non-null array of `Bulk Invoice` Items.
BulkInvoiceItem	Describes one line of the Bulk Invoice. 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, besides the amount and the *PaymentType* (Supplemental, Final or Partial). It is associated with a single claim.
bivalidationalert	Encapsulates one alert generated by a bulk invoice validation. The customer's implementation of the `IBulkInvoiceValidationPlugin` returns an array of these objects, or null if the validation is successful. Each alert consists of a message and an alert type (from the `BIValidationAlertType` typelist).
reservelinewrapper	Provides a level of indirection between a `BulkInvoiceItem` and its `ReserveLine`. This is necessary when a `BulkInvoiceItem` is created for a non-existent reserve line, and so cannot be committed to the database. The `BulkInvoiceItem` has a non-null foreign key to `reservelinewrapper`. There is a second FK from the wrapper to the actual reserve line that is null if the reserve line does not yet exist. The user interface displays the wrapper's reserve line so you never see this.

The bulk invoice feature uses these typelists.

Typelist	Description
BulkInvoiceStatus	The bulk invoice status. Controls which actions are possible for the invoice, such as edit, submit, void, and so on.
BulkInvoiceItemStatus	The status of a single `BulkInvoiceItem`. As with the `BulkInvoiceStatus`, this value controls which actions are possible for a given Invoice Item.
BIValidationAlertType	The alert type for an alert returned from the `IBulkInvoiceValidationPlugin`. The only entry provided is `unspecified`. However, you can extend this list with alert types germane to the tests you execute in your validation plugin.

ClaimCenter Components

chapter 19

Assigning Work

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 "What Work is Assignable" on page 208 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. A powerful feature of ClaimCenter is that it can make assignments automatically, based on rules which model your business practices. ClaimCenter also provides the ability to assign work manually, that is managers and supervisors can freely select to whom they assign work.

This topic includes:

- "Assignment Models the Way A Carrier Distributes Work" on page 207
- "What Work is Assignable" on page 208
- "How Work is Assigned" on page 208
- "Assignment Methods" on page 212
- "Queues" on page 214

Assignment Models the Way A Carrier Distributes Work

ClaimCenter mimics the way assignment is manually determined in an organization: An executive learns of a task and determines that it belongs to one of the executive's departments. The department manager decides that a certain team will work on the assignment. The team supervisor either selects one of the employees or assigns the work to a queue from which employees take the work items. Assignment is complete. The employee assigned the work is now its owner and is responsible for its completion.

This example shows that individuals, or users, are ultimately assigned work, but 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, facilitating work assignment.

Each of those decisions is made independently and the logic of each is easy to describe. Each assigner only needs to know how to direct the work to the right group or person within her authority.

ClaimCenter takes a similar approach. For every main work item assignment rules model this step-by-step process to assign a person responsible for performing the work. The assignment logic passes down through the group hierarchy to find the correct group, 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 written make assignments by considering these factors. There are automatic methods which 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.

What Work is Assignable

Work is assigned to both a group and a user (or queue). Work falls into these main areas, each corresponding to a main ClaimCenter entity:

- An *activity* (see "Working with Activities" on page 219) is 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.
- A *claim* can be assigned based on its attributes (such as its segmentation type), number and type of exposures, and geographic location.
- An *exposure* can be assigned to the claim owner, or can be assigned to someone else based on exposure attributes.
- A legal *matter* is often assigned to the claim owner or to a user with a special role or a custom user attribute, like a legal expert.

You can not make any other default entities in ClaimCenter assignable. However, extension entities (ones you create) *can* be made assignable (see "Assigning Other Entities" on page 212).

Viewing Your Assignments

View all claims you are assigned work by substituting the **All open owned** or **New owned (this week)** filters in the **Desktop → Claim** and **Desktop → Exposure** screens. The **Desktop → Activities** screen shows all activities. Note that you cannot view all matters to which you have been assigned. To view all matters related to a specific claim:

- Open a **Claim → Parties Involved** menu item → **Users** button → your matters (if any) appear in the **User Details** table
- Open a **Claim → Litigation** menu item → all matters (assigned to anyone) appear in the main table

How Work is Assigned

Global and default rule sets define how assignments are made (see "Global and Default Rule Sets Govern Assignment" on page 209). You can assign work to an owner - the person responsible for completing it - by:

- Explicit, or manual assignment.
- Automatic assignment, which can mean:
  - The assignment engine runs the global and default rule sets.
  - You call the rule set directly, using Gosu in a `.pcf` file. See "Assignment Without the Assignment Engine" on page 211
  - You write your own version of automated assignment; see "Dynamic Assignment" on page 211.

Global and Default Rule Sets Govern Assignment

For historical reasons, ClaimCenter contains both a global and default rule set for each assignable entry. 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 asks for auto-assignment.

Multiple Default Rule Sets

Although each entity has a single global rule set, different subentities can have their own default rule set.

For example, after the global rule set has selected a group, the group's default rule set runs to finish assignment. It targets first to the group or one of its a subgroup, and then to 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.

The Assignment Engine

The assignment engine is the normal method ClaimCenter uses to execute the global and default rule sets (the global rule set 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 done 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:

- A default rule assigns a user. In this case, assignment is done 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 "The Default Owner" on page 209 and "Assignment" on page 52 in the *Rules Guide* for more information.

The 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 assignment 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. "Assignment" on page 52 in the *Rules Guide* describes 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 have already 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.
- *Group* - you choose the group; 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, can assign work from a queue to others.

To assign work manually, you can select a specific owner or use a search tool select the assignee from the list that the user interface 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 displays on a supervisor's calendar. Selecting 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 allows you make assignments based on workload.

There is also a new ability to 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:

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 using a 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, choose the auto-assignment option.

Auto-assignment results in one of the following outcomes, 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 to 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 (use an **Administration** or **Team** screen for this change).
- Set the user's Vacation status to "On Vacation (Inactive)" so they do not receive automated assignments (use either of the same screens).
- Choose **inactive** in the user's User Profile (but this also disables access to the ClaimCenter, and the user receives no assignments at all - not just by round-robin assignment).

   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 is referred to as "cascading assignment" because the new assignment for the top-level item cascades down to other related items. You do not necessarily have to write rule sets to do this. However, the ClaimCenter rule sets performs cascading assignment by default. It uses this logic to automatically cascade assignments:

- If a claim is reassigned, ClaimCenter:
  - Reassigns all open activities connected to that claim (not to any specific exposure) to the claim owner, unless they were already assigned outside the claim owner's group.
  - Reassigns all non-closed exposures to the new claim owner, unless they were already assigned outside the claim owner's group.
- 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 of the related work remains unassigned until the final claim or exposure owner is selected; they are then assigned to the new claim or exposure owner.

Assignment Without the Assignment Engine

You can make assignments without using the assignment engine to run the global and default rule sets. You do this by writing your own Gosu in PCF pages to call assignment rules and methods directly. This means, for example, that you can add an Assignment button to any saveable PCF page and complete the assignment when saving that page. See the example in the *Configuration Guide* for how to do this. 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 you own assignment logic, for both users and groups. It is intended to supplant round-robin assignment when this 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 (carriers can not want to have their group structure mirror their assignment logic).
- Automatic assignment which also considers a user's current workload.
- Automatic assignment which takes into account assignments made outside of round robin assignment.

In general, ClaimCenter provides an interface to let you 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.

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 by adding these final steps:

5. If the commit fails, roll back all changes made to the user's information, if possible.

6. 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 time 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 98 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 can also redefine the current group.
- Methods that assign work to subgroups and then 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 (address).
- Assignment based on both location and user attributes, such as `AssignUserbyAttributeandLocation()`, `AssignGroupbyLocation()`, and `assignUserByLocationUsingProximitySearch()`.
- 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" on page 52 in the *Rules Guide* for a detailed description of these methods.

Group Types and Load Factors can be Used 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 373.

Regions can be Used 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 "Regions" on page 375 for more details.

For example, a group can be defined as belonging to a region consisting of all ZIP codes between 90000 and 90999. This is also besides belonging 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()` rule considers regions in 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.

Security Zones can be Indirectly Used 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. "To Create or Edit an Access Profile" on page 386 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 sometimes 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.

Contacts, besides users, can have roles.

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, then 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 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, chooses 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 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 and/or exposure owner, some activities are best performed by a specialist, such as a field inspector or a 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. This is because 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 to give to the next rule. `CurrentGroup` is the way such assignment rules communicate. After the global assignment rule set finishes, the current group is available (unless global assignment rules finish assignment) to the rules in the current group's default rule set. It 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 display 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 now complete.

The `assignActivityToQueue()` method assigns an activity (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 so assigned. However, queues can be used to assign claims, exposures, or 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 is an example that illustrates how to use a queue to assign first notice of loss (FNOL) claims. After you import a FNOL, ClaimCenter triggers the rule sets in the table below. These rule sets generate review activities and place them on a queue. A group member then grabs 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	in this rule set	which performs this action
Assign FNOL claim to an intake group	Global Claim Assignment	Choose the 'current group' which will make the final claim assignment.
Assign claim to the group supervisor	Default Group Claim Assignment	'Park' the claim with 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	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.

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 by administrators and supervisors.

Claim Segmentation

Claims are segmented into logical groupings so that multiple users can handle different parts of a claim.

This topic includes:

Automated Claim Setup

After the initial claim information is entered into ClaimCenter, these automated processes set up the claim so it can go to its new owner, ready to be worked on:

- Claim Segmentation
- Assignment of Work
- Workplan Generation

For claims generated within ClaimCenter, these setup rules run on exiting the New Claim wizard. If the claim does not pass the final validation at the New Loss level, then all setup rule actions are reversed. For imported

claims, these setup rules again run prior to you saving the claim. It must then pass validation at the New Loss level.
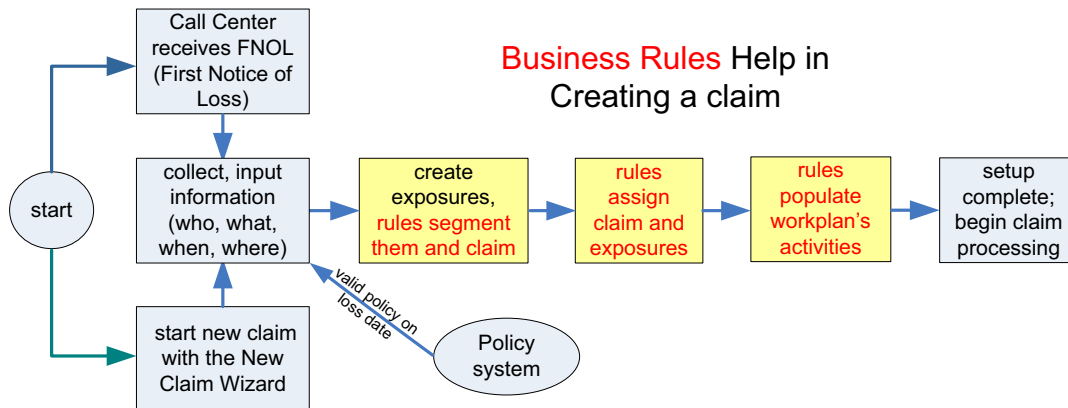
Claim Segmentation

Segmentation allows insurers 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 (multi-car, single car, injuries, glass only)
- segments that describe the loss location (close to field office)
- strategies based on policyholder type (normal, preferred, sensitive or questionable)

These pair of categories, together 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 guidance. The system assigns based on claim attributes and adjuster profiles, including adjuster skills, current workload, or any other available information. Besides assigning new claims to adjusters, the ClaimCenter rules assign individual exposures within the claims and assign activities associated with the claims. See "Assigning Work" on page 207.

Workplan Generation

The claim's workplan is its collection (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 display 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, for example, to resolve 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, the Rule Engine 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 means examining the fields on the exposure. For example, for an injury: severity, body part injured, nature of injury, first 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. So 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.

Example of Segmentation Rules

The following is part of a rule set which segments personal auto and homeowner's losses:

```
If this is an auto claim, then use this list of vehicle child rules to find the exposure's segment:
    If this has glass damage only, then segment as "auto glass" [exit]
    Else if this was a collision, consider collision segmentation rules (run these grandchild rules):
        If there are injuries, then segment as "injury accident" [exit]
        Else if there are more than two cars, segment as "multi-car accident" [exit]
        Else if there are two cars, segment as "two car accident" [exit]
        Else segment as "single car accident" [exit]
    Else consider these auto non-collision segmentation rules (another set of grandchild rules):
        If there are third-party exposures, segment as "non-accident liability" [exit]
        Else, if the cause of loss is theft, then segment as "theft" [exit]
        Else, segment as "non-accident vehicle damage" [exit; auto exposure segmentation is complete]
If this is a homeowner's claim, then go through this list of child rules to segment homeowner's claims:
    (the child rules that segment this type of claim are located at this point)
If all else fails (the exposure is still unsegmented), segment this as exposure as "unknown" [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
glass only, low, medium, or high complexity	fast track
single car, pedestrian, two-car, multi-car	normal
minor or severe injury	investigate

Strategy is Similar 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 *normal* 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 "normal"
If claim segment is "auto glass" or "auto/low", then set strategy to "fast-track"
```

You can imagine 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, then you can assign a strategy based on the age of the auto. You can make decisions based on both of 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 use different approaches to handle them based on the strategy value. You can 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 giving work to the best group and most capable user. A rule that examined the segment and loss location parameters can decide whether to assign the exposure to a local or regional office. This is based on both the severity, as described in the segment, and the location. However, the segment can also determine other claim-related actions:

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 "glass only", set the reserve level to a very low level.
  Else if the exposure's segment is "multiple injuries", set a much higher reserve level.
  Else if "single injury" segment value, set another reserve value, and so on.
```

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's segment of *multiple injuries* 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 give the allowed values for both claims and exposures. You can extend them both.

chapter 21

Working with Activities

ClaimCenter describes 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 forth are considered to be *activities*.

Activities are the application's central organizing concept for tracking the completion of all varieties of tasks. Dividing a claim's work into activities, then making list of these activities to track them to completion, defines everything that must be done to settle every claim.

The Claim Segmentation process, described at "Claim Segmentation" on page 215, creates an initial set of activities for a new claim. Additional activities can be added to the claim at any time. Many people can be assigned activities on a single claim. Assigning activities divides a claim into units of work and divides the work units among your users. Tracking work by using activities make it easier for claim owners to perform all necessary claim-handling tasks and identify missed tasks. Supervisors and managers can track assigned work and identify problem claims, such as those with many overdue or escalated activities.

This topic includes:

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 location. This topic contains the following topics:

- **Activities are Tasks**, the atomic units of work into which claims can be divided. Activities are created, assigned, and completed.

- **Displaying Activities** can be done for each claim, each user, group, or team in ways that help claim handlers and managers.
- **Activity Patterns** are templates used to create activities. Special patterns can be created for specific types of work, such as approval or email creation.
- **Activity Calendars** display activities, especially those overdue or escalated, owned by one or more users for all their claims.
- **Activities and the Data Model**, and how holidays and business days are defined.

Activities are Tasks

Activities are tasks necessary to process claims. Each activity is a single task that can be assigned to a person for completion. Not all work can be completed by using ClaimCenter directly. However, ClaimCenter tracks the assignment and completion of activities to ensure that the claim is correctly handled.

Activities store information about what needs to be done, who does it, and the facts about what was completed. Activities themselves do not actually store the results of the work. Some examples of activities are:

- Externally stored signed agreement document
- A note within ClaimCenter summarizing the activity's investigative results
- A new reserve set up, or a settlement plan created.

What an Activity Contains

The following elements, when combined form an activity:

- **Subject** – The activity name.
- **Short Subject** – A shorter name for use as a calendar entry. The length of it is 10 characters.
- **Description** – Visible after looking at the **Activity Detail** pane.
- **Target Date** – due date, after which the activity appears in red.
- **Escalation Date** – date at which ClaimCenter generates other activities to deal with the lapse.
- **Class** – Whether the activity is a **Task** and has a due date or an **Event**, like a court date, which does not.
- **Category** – activities grouped for display purposes. After you create a new activity, you view categories of activity patterns. After making your selection, you see all the patterns in that category.
- **Priority** – `urgent`, `high`, `normal`, or `low`, used for sorting a list of activities.
- **Mandatory** – whether it can be skipped or not. if skippable, an activity is just a suggestion.
- **Calendar Importance** – `top`, `high`, `medium`, `low`, `not on calendar`, for calendar display of the activity.
- **Claim loss type** – `auto`, `cargo`, `property`, `workers' compensation`, or `General Liability`, for which the activity can be used.
- **Available for closed claim** – Whether it can be added to a closed claim.
- **Externally Owned** – Whether it is to be done by an outside group or user.
- **Document Template** – Name of the template used by a correspondence activity to generate a document.
- **Recurring** – Whether the activity repeats. If so, completing one activity creates a new one.
- **Displaying Activities** – Name of the template that provides default values for the activity.

It is the activity template associated with the activity that gives the initial, or default, values for these attributes.

Creating Activities

Because activities are central to the claim process, they can be created in a number of ways:

- Users create activities for themselves or (with authority) other users with the user interface.
- ClaimCenter uses rules to create activities while:

- Generating workplans.
- Responding to escalations or claim exceptions.
- Handling manual assignments.
- Obtaining approvals, investigating fraud, and other events.
- Externally, using API calls.
- Batch processes can generate activities.

Automated Activity Generation

During a new claim's setup process, 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. The claim's segmentation often indicates which activities are appropriate, so an auto claim might produce one set of activities, while a property claim would produce several different activities.

ClaimCenter also automatically creates other activities after it needs to convey information or requires someone to make a decision. For example, 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 it was.

The workplan rule sets for claims, exposures, and matters generate activities in this way.

See also
- "Automated Claim Setup" on page 215

Batch Processes Can Help Create Activities

Several batch processes can identify claims and activities for which you might want to create new activities. These include claims which have reached their escalation date and those which have not been looked at for a long period. Useful batch processes include:

batch process	what it finds	parameter name and (default)
idleclaimexception	claims with no activity for a defined period.	IdleClaimThresholdDays (7) in config.xml
activityescalation	activities that reached their escalation dates	Escalation Days or Hours (set in the Activity Pattern)
claimexception	claims with exceptions (new, since last run)	none

For more information about scheduling batch processes, see the "Scheduling Batch Processes and Distributed Work Queues" on page 143 in the *System Administration Guide*.

To Create Activities

You can create activities for yourself and for other users.

1. Navigate to **Claim** → **New Activity** menu action.

2. Select activity type and enter the activity details.

   Select activity type: Choose the general activity type and then the specific activity type (Activity Pattern) from the menus that appear after you select the **New Activity** menu action. If the specific type of activity is not present, then create a new one by creating a new activity pattern. See "Creating and Editing Activity Patterns" on page 227.

   Enter activity details: See "What an Activity Contains" on page 220 for the meaning of individual fields.

3. Assign the activity and click **Update** to save.

Use the **Assign To** drop-down list to choose yourself or **Use automated assignment** to have the application use rules to assign the activity. See "Automated Assignment" on page 210 for detail. You can also search for other users not in this list with the nearby Find icon.

Assigning Activities

An activity must always be assigned to a user after it is generated. Many activities, including those generated after a new claim creation, are assigned to you if you become the owner of the new claim. You can assign activities you create to yourself or another. 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 assign your activities, but can also place automatically generated activities on a queue. From this queue, you can assign activities to yourself or others. For example, you can:

- Select **Queues** from the **Desktop** tab and choose a queue.
- Filter the queue's list of activities to locate those of interest and set their checkboxes.
- Assign the selected activities:
  - Choose **Assign Selected To Me**.
  - Choose **Use automated assignment**. to select another user using the assignment rules.
  - Select another user from the **Assign** drop-down list.
  - Search for another user with the **Find** icon, and select from among those found.

You can also not select an activity, but simply choose **Assign Next in Queue to Me**.

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. Navigate to: **Claim** → **Workplan**.

2. Select an activity.

3. Click **Assign To** and assign the activity.

4. Click **Update** to save your work.

Completing or Skipping Activities

To avoid having a finished activity marked overdue and escalated, you must mark it as such. After it is completed, ClaimCenter changes its status to Complete, logs this fact, and creates an entry in the claim History. See "Claim History" on page 83.

To mark an activity as complete:

- Locate and check the activity in either a **Workplan** activity list or the **Desktop**'s activity list.
- Check the **Activity Detail** pane, and if the activity has been done, select the **Complete** subtab.

Some activities can recur and are so labeled. To schedule the next occurrence while completing the current one:

- Select the activity, then select its **Activity Detail** display.
- Enter the new dates and any other information, then select the **Complete and Create New,** then the **Update** subtabs.
- Edit the dates and any other part of the next activity occurrence which is present, and click **Update** again.

Activities not created as **Mandatory** are skippable. To skip a non-mandatory activity, locate the activity in the **Workplan** or **Desktop** activity list and set its checkbox, and then click **Skip**.

A skipped activities is treated similarly to a completed activity. ClaimCenter changes its status to **Skipped**, logs this fact, and creates an entry in the claim History.

> **Note:** You cannot resurrect a completed or skipped activity. Create a new one instead.

To Complete a Review Activity

If adjusters schedule payments that exceed their authority, ClaimCenter creates approval activities that are assigned to their 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 a review activity:

1. Select the activity from your **Desktop** or **Workplan** list.

2. Review the payment in the activity's **Activity Detail** pane.

3. Enter the reason you are going to approve or deny the payment in the **Approval Rationale** box.

4. Select either **Approve** or **Reject** to complete the activity.

ClaimCenter generates an activity for the original issuer of the payment if it is rejected. It also logs the decision and notes it in the claim History.

To Complete a Correspondence Activity

Sending a letter is an activity. To start, select a form letter. The **Activity Details** screen has a panel in which you can add information to the form letter, such as the addressee and address, before editing the body of the letter.

To Work With Documents in Activities

Documents related to activities appear in the **Documents** section of the **Activity Detail** screen. You can view, edit, or send these documents directly from the originating activity. In this section you can:

- **List Claim Documents** – A **Search** option replaces the claim Documents screen'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. This is different than a document being related to an exposure or matter. Documents can be related to only one entity but they can be linked to many entities such as notes and financials.

See also
- "Working With Documents" on page 346.

Activity Escalation

After an activity reaches its **Due date**, the date appears in red, and a star symbol appears in the **Desktop Activities** list. If it later reaches its **Escalation date**, it triggers escalation rules that can help the activity be expedited. For example, a rule can create a new activity for the supervisor of the escalated activity's owner, asking that supervisor to intervene.

The Activity Escalation rule set contains the rules that determine the actions to take after an activity reaches its escalation date. The `activityexception` batch process, which 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**, navigate to **Actions → Statistics**. The **Statistics** card at the bottom of the screen displays statistics about your activities and claims, and, if you are a supervisor, about your team's activities as well. Supervisors can see details of 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 cannot always see the latest numbers.

Displaying Activities

Activities are central to claim handling, and ClaimCenter enables you to work with them in a number of ways:

- To see a list of all your activities for all claims, select **Activities** from the **Desktop** tab. You can then see:
  - Activities that are overdue or will become overdue at today's end.
  - Activities that are open and are due in the next week.
- To see a list of all the activities of one claim, including those owned by others, open that claim and select **Workplan**. See "Workplans List all Activities of one Claim" on page 224.
- To see a list of all activities belonging to your group, open the **Team** Tab and select **Activities**.
- To find specific activities, select **Activities** from the **Search** tab 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, selecting one displays its **Activity Detail** in a new workspace window at the bottom of the user interface.

Workplans List all Activities of one Claim

All activities are associated with a specific claim (or a bulk invoice). The *workplan* is a table of all activities related to one claim. The workplan table of a claim summary contains this information:

- **Due** – Indicates the activity's targeted completion date. The due date is red if it has gone by.
- **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.
- **Subject** – The title of the activity.
- **New** – Highlights whether the assigned activity has been changed by someone else since the last time you opened it. This could mean it is a truly new activity in the workplan, or it has been reassigned to you by someone else, or someone else has edited the activity recently.
- **Assigned To** – The owner of the activity.

The **Workplan** contains buttons, or subtabs, that help in managing the activities. There are subtabs to:

- **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** – Show the latest list of activities.

Desktop List of Activities

The desktop list of activities shows all your activities for all claims. In addition to the information contained in the **Workplan**'s table of activities, the Desktop activities table contains these additional entries for each activity:

- **Overdue** – A star symbol that indicates that the activity is past its due date.
- **Escalated** – A symbol that indicates that the activity is past its escalation date. Activities have escalation dates assigned either automatically by ClaimCenter or by the adjuster. This is not the same as the activity being past its due date.
- **Claim number, Insured, Claimant, Exposure, LOB, State** – Information about the claim with which the activity is associated.
- **External** – Whether the activity is owned by a user without access to ClaimCenter.
- **Status** – Whether open, complete, skipped, or cancelled.

Searching for Activities

Use the main **Search** tab to view many lists of activities, including those:

- Attached to a specific **Claim Number**.
- Belonging to one **Group** and its subgroups.
- Belonging to s specific person.
- Created by a specific person.
- That have an **External Owner**.

You can also filter any of these lists to see just the activities:

- With a particular **Status, Subject, Priority, Due date,** or **Creation date**.
- In a specific time period, like due in the last 30 days.
- With a **Late Completion** date or **Pending Assignment** or **Now Overdue**.

Use these lists to reassign activities.

Team Activity Lists

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.

Activity Detail Screen

Clicking the name of any activity displays its details. The fields it shows are described in "What an Activity Contains" on page 220.

Activity Filters

You can create your own displays by using filters provided by the application. The *PCF Reference Guide* describes these and other filters that affect lists. You can also create compound filters by combining them.

Activity filter	Selects for
getStatusFilter(state)	Activities with the given activity state (open, skipped, completed, and so on.)
OpenFilter	Open activities
CompletedFilter	Completed activities
SkippedFilter	Skipped activities
getClosedLastNDaysFilter(days)	Activities whose close date was in the last N days

Activity filter	Selects for
getDueInNDaysFilter(days)	Activities whose due (target) date is within the next N days
DueTodayFilter, OverdueFilter	Previous filter, with days = 1 or 0, respectively
ExternalFilter	Activities that are externally owned (NotExternalFilter exists also)
ReviewFilter	Assignment review activities (NotReviewFilter exists also)
ApprovalFilter	Approval activities (NotApprovalFilter exists also)
EscalatedFilter	After the escalated flag is true (NotEscalatedFilter exists also)
AssignedFilter	Activities whose assignment status is assigned
MyFilter	Activities assigned to the currently logged in user

The main places to look for lists of activities is from the **Desktop** tab or the **Workplan** of any claim. The **Search** and **Team** tabs also display lists of activities, and so do calendars.

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 after it is needed as part of an auto claim.

Activity patterns contain many default characteristics for each activity, such as the activity's name, its relative priority, and its 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 Date**. Users and rules can override these defaults.

An activity pattern and an activity created from the pattern can have the same name. The pattern suggests its own name as the default activity name. You can think of a pattern as an entity, and the corresponding activity as an instance of it.

You can view the list of available activity patterns by selecting the **New Activity** menu from a claim screen. Administrators can view, create, and edit patterns by using the **Activity Patterns** menu action of the **Administration** tab. You can manually create activities based on these patterns. Rules and external systems, using API calls, can do the same.

Activity Pattern Types and Categories

Every activity pattern has both a **Type** and **Category** attribute. A **Category** attribute classifies patterns into related groups. Each typecode of the ActivityCategory typelist is an activity pattern **Category**, and relates each **Category** attribute to a specific **Type**.

Each activity pattern also has a defined **Type**. You can add an activity pattern *only* with a **General** type, and only if you have administration permissions. General activities, patterned after the concept of a diary, are the work for a claim that is assigned to a person and has a deadline. An example is getting a vehicle inspected has a general activity pattern type.

Internal Activity Pattern Types

The base application defines a number of internal activity pattern types. 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.
- **FNOL** – Activities for reviewing first notices of loss (FNOLs) that are newly received by ClaimCenter.
- **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 permission, you can edit or create new activity patterns by clicking the Activity Patterns menu action exposed in the Administration tab, and then selecting Add Activity Pattern. There, you must specify:

- **Subject** is the activity's name, which is shown in both lists of activities and in lists of patterns.
- **Short Subject**, which names the activity in a calendar entry, or after the full subject name is too long. There is a limit of 10 characters.
- Either a **Class**, which determines if the activity is a Task and has a due date (target date) or an Event, which does not. For example, trial dates are events—they occur on a given date, but cannot become overdue or escalated.
- **Type** of pattern. All patterns 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 contains these types.
- **Category**, which the user interface uses to filter available activity patterns in its New Activity drop-down list. The activityCategory type list contains them. For example, the Interview category includes the patterns Get a statement from witness, Make initial contact with claimant, and Make initial contact with insured.
- **Code**, the name used to refer to the pattern in Gosu. The code length is 30 characters.
- **Priority**, which allows ClaimCenter to sort activities into urgent, high, normal, or low in a list of activities.
- Whether it is **Mandatory** to complete the activity, or if it can be skipped.
- **Calendar Importance**. Top, high, medium, low, or not on calendar—indicates the priority.
- **Claim loss type**. Auto, cargo, property, workers' compensation, or General Liability—for which the pattern is allowed.
- **Automated Only** indicates whether the pattern can only be used by rules, or if you can create an activity based on it. If you want to remove an activity pattern, set this value to true instead of deleting it. Setting it to true prevents you from creating new activities from this pattern, but does not break existing rules that use this pattern.
- **Available for closed claim** is true if the activity can be added to a closed claim.
- **Externally Owned** indicates if the activity can be owned by an outside group or user. 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 your control.
- **Document Template**, if any, appears from the activity and is useful if the activity is to send a letter or other document.
- **Recurring** indicates if the activity recurs on a regular schedule, and the period of recurrence.
- **Description** of the activity, visible after looking at the activity's details.

In addition, each activity pattern provides two default dates and the means to calculate them:

- **Target Date** is the due date, after which ClaimCenter displays the activity in red.
- **Escalation Date** is the date at which ClaimCenter sends alerts that the activity is overdue, or even generates other activities to deal with the lapse.
- These variables determine the **Escalation Date**:
  - **Escalation start point** is the activity creation date, loss date, or notice date.
  - **Escalation days** are the days between the start and escalation date.

- **Escalation hours** are the hours between the start and escalation date.
- **Include these days** are all days or only business days.
- These values similarly calculate the **Target Date: Target start point**, **Target days**, **Target hours**, and **Include these days**.

See "Activities and the Data Model" on page 230 for information of how to define holidays and weekends after calculating dates.

The same user interface screen allows assignment of a newly created activity, either to a specific user or by calling auto-assignment rules.

Activity Patterns use Holidays After Creating and Assigning Activities

Activity Patterns generate activities in several ways:

- Users can manually generate activities from the **New Activity** menu action of the **Claim** tab. The user selects the desired activity by selecting its correspondingly named activity pattern. The patterns shown are organized by their **Category**. During manual activity creation, the user can also override all default values set by the pattern.
- Rules can automatically create activities after:
  - Making a workplan during claim creation.
  - Responding to escalations, claim exceptions, or other events.
  - Assisting in manual assignment.
  - Obtaining approvals for other actions.
- External systems can also create activities through API calls.

Activity Assignment

An activity pattern does not control how an activity is assigned. There are several ways they can assist in 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, a user can select either 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

ClaimCenter contains a variety of calendars to help organize activities. They show activities in both monthly and weekly views. Access these calendars from either **Desktop** or **Claim**, and filter the listed activities in a number of ways. Supervisors can view activities from others. You can also filter the activities to show those related to legal matters.

Calendar Displays

From **Desktop**, click the **Calendar** menu item to display both the current monthly and weekly calendar. Select a calendar view to show:

- Calendars for the current week and month, or any other start date. Weekly calendars always start with the current date. The monthly calendar always starts on the previous Monday.
- All activities related to all claims and matters, all those unrelated to legal matters, or those related 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.

From Claim, display a calendar showing all activities and matter activities relating to just that one claim. Matter activities are grouped together with all other activities in this calendar. You can also view all the claim's activities, or just those assigned to you.

Calendar Information

If you need to obtain more details do the following.

In the monthly view

- Calendar items are truncated. Move your mouse over one to reveal the full name. If you click the name, the Activity Detail in the workspace opens to reveal more information.

- Calendar items are numbered. 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.

- If an activity has been escalated, it is listed in red.

- A supervisor's monthly calendar is likely to be cluttered, especially if looking at a large number of subordinates. Therefore, this calendar only shows the total number of open activities of each priority owned by each supervised group. These totals reflect all the activities of each employee. This means not just the ones the supervisor assigned, but also activities assigned to the supervisor's subordinates by virtue of their membership in other groups. This helps the supervisor get a better assessment of the total workload.

In the weekly view

- Calendar items are truncated. Positioning the cursor over one reveals its full name. Clicking the name opens the Activity Detail in the workspace.

- If an activity has been escalated, it displays in red.

- Each claim-related activity shown includes its name, claim number, and the insured name.

- If the calendar shows only trial dates, the detail shown includes the insured, the venue, the jurisdiction, and the names of the opposing attorneys.

- A supervisor's calendar list 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 comes from the value of the Calendar importance field of the activity pattern that helped create the activity. You can assign importances of Urgent, High, Normal, or Low. These values come from the Priority typelist. The calendar shows the priority of each activity it displays.

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

An important feature of manual assignment in ClaimCenter is the use of calendar information, which can help you make an assignment. In the standard search for potential assignees, workload information appears. This data is the same as the data on a supervisor's calendar. Viewing this data can help 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 section lists the main entities and typelists which relate to activities.

Main Entities Related to Activities

Entity	Description
Activity	The main entity. It has foreign keys to `Claim`, `Exposure`, `Matter`, `Note`, `Document` (array), `TransactionSet`, `ActivityPattern`, and `BulkInvoice` with which it is 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 (in the next table).
activityView	Displays activities efficiently as lists. It has these subtypes for these specialized views: • `ActivityDesktopView` – View in the Desktop tab. • `ActivitySearchView` – For search results and the claim summary screen. • `ActivityTeamView` – For the Team screens. • `ActivityUnassignedView` – For the Awaiting Assignment display. • `ActivityWorkplanView` – In the Workplan screen.
activityPattern	The template used to create activities. See "Displaying Activities" on page 224 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 related.
activityClass	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`, `complete`, or has been `cancelled` or `skipped`.
activitySubjectSearchType	Whether to search for an activity by its `activitypattern` or text it `contains`. Or for 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. It is used by activity patterns. ClaimCenter sorts list of activities by priority, then alphabetizes each priority group.

chapter 22

Outbound Email

Email is an important communication tool for adjusters and other users involved with the claim resolution process. From ClaimCenter, you can write and send emails. This includes 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 using contact information or manually
- Send emails from all claim screens
- Send attachments with emails
- Define activity patterns which allow sending 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 from a rule; the email can contain attachments

ClaimCenter sends emails only in the context of a specific claim, and can also store sent emails as documents attached to that claim.

This topic includes:

- "Working with Email in Claims" on page 231
- "How Emails are Sent" on page 233

Working with Email in Claims

There are multiple ways to send an email:

- From a claim-related screen, open the **Send Email** worksheet to send emails by selecting **Email** from the **Quick-Jump** box.
- Select **New Email** from the **Actions** menu.
- Perform an activity that involves sending an email.

The Send Email Screen

The **Email** screen is the worksheet from which you send emails. It has the same functionality of any email client - it allows you to specify recipients, the text body, subject, and attachments. You can also send and store the email from this screen. The **Email** screen is a worksheet; closing it returns you to the claim. Use the worksheet:

- "To Select an Email Template" on page 232
- "To Select Email Recipients" on page 232
- "To Add Attachments to an Email" on page 232
- "To Send an Email" on page 232
- "To Save an Email" on page 232

To Select an Email Template

An email template gives you a body and subject for your email. A template is not necessary. Instead type the subject and body directly into the **Send Email** screen. Click **Use Template** to enter the **Find Email Templates** screen that searches for templates. You can search by **Topic** or for one or more **Keywords**, or both.

Search for a Template by Topic or Keywords

The email template specifies topics and keywords on which you can search. Each template has a `<topic>` and a `<keywords>` attribute, for the template creator to specify one or more values. To configure searching, you must have already entered topics and keywords yourself; there is no drop-down or typelist from which to select.

If you click **Search,** the **Find Email Templates** screen displays its search results. Make your selection or conduct another search by clicking **Reset**. You can also click **Cancel** or **Return to Email.**

If you select a template, the Email screen opens with the template's body and subject in the text boxes at the right of this screen.

To Select Email Recipients

Each email must have at least one recipient. You can also add *cc* and *bcc* recipients. Click **Add** to add each recipient.

Instead of entering a name and email address, you can use click **Search** in this table. It displays a ContactCenter search screen, from which you can select any contact in your address book.

To Add Attachments to an Email

Clicking **Add** near the **Attachments** section of the **Email** screen displays the document search screen. You can select any document already associated with the claim. That is, the document must be present either in ClaimCenter or in the document management system to which it is integrated. All selected documents appear in a list directly under this button. Clicking **Remove** deletes documents from this list. You cannot attach documents that are not already present; they are not shown in this list.

To Send an Email

The **Send Email** button in the **Email** worksheet screen sends the email and closes the worksheet.

To Save an Email

If you mark the **Save as a New Document** checkbox in the **Email** worksheet screen, the email becomes a document stored in the document management system. This mixes emails with other documents.

Reaching the Send Email Screen

Access this worksheet from any claim screen and from some activities:

To Reach the Email Screen from a Claim

While in a claim, there are two ways to open the Email worksheet:

1. While in a claim, select **Email** from the QuickJump box.

2. While in a claim, select the **New Email** option from the **Actions** menu.

To Reach the Email Screen from an Activity

After you open any activity created with an activity pattern that specifies any email template, the activity includes a **Create Email** button. Clicking it displays the main **Email** worksheet screen. This **Email** screen is the same screen 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 using this screen.

> **Note:** An activity's activity pattern *must* specify an email template for the activity to contain a **Create Email** button. Add an email template to your activity patterns if you want activities created with them to display this button and be able to send email.

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.

Other Ways to Use the Email Feature

Send an Email from a Rule

Gosu contains the necessary methods for you to write rules that send emails and email attachments.

Create a History Event when an Email is Sent

Gosu also contains the methods you need to create a custom history event.

How Emails are Sent

ClaimCenter sends emails asynchronously using its messaging subsystem. After you call any one of the `EmailUtil.sendEmail()` methods, a message entity is created with the contents and other information from the email object. If the entity parameter is non-null, then the message entity is added to the entity's bundle and persisted when that bundle is created. If the entity parameter is null, then the message entity is persisted immediately.

You must also configure a `MessageTransport` class to hold the email messages and do the actual sending. See the following `<messaging>` XML section for details. Email messages are processed and sent one at a time, like any other message.

Since emails are sent 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.See "Monitoring and Managing Event Messages" on page 67 in the *System Administration Guide*. This means that the sender is not directly notified.

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 either accept scanned email and/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 configured this.

Incidents

ClaimCenter uses the `Incident` data entity to track key items related to a claim. Within ClaimCenter, you use an `Incident` entity subtype to capture specific information such as vehicles, property, and injuries involved on the claim. Another example of an incident subtype is `LivingExpensesIncident`, which you can use to track living expenses related to a homeowner's claim.

> **IMPORTANT** The insurance industry uses the term *incident* differently from Guidewire. Most commonly within 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 concept as well. The `Claim` entity contains a Boolean indicator, `Claim.IncidentReport`, that you can use to mark a claim as incident only. See "Incident Only Claims" on page 240 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. It is possible that 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. But, the CSR can capture details about the claim in an incident report.

2. An adjuster can decide 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

Typically, you gather information about incidents during the intake process. This information is useful in determining the indemnities—the claim costs—that you need 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 homeowner's 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:

- **As a way to capture information about the loss without having to create exposures.** Not having to create an exposure is useful if the person creating the claim does not have sufficient expertise to create exposures, such as a customer service representative (CSR). Additionally, an incident is useful if the user is unsure which exposures are necessary at the time the claim is created. For example, it might not be immediately obvious which policy coverage covers the loss.
- **Information about a lost or damaged item can be shared across multiple exposures**. Sharing information 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.

Use the ClaimCenter incident functionality:

- To gather injury, vehicle, and property damage data collection that is independent of exposure creation.
- To view all injuries, vehicles, or properties associated with a claim from a single screen.
- To understand 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 need the following permissions to work with incidents:

- If you have the *edit* claim permission, you can create and edit incidents.
- If you have the *view* claim permission, you can link an incident to an exposure, but cannot further edit the exposure.

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, meaning that a single claim can have multiple associated incidents.
- Incidents and exposures have a *one-to-many* relationship, meaning that 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 need to do so if 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.
- You do not need to do so if no claim or exposure will result from the incident. For example, if an incident describes damage to abandoned property, there might be no claimant.

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 as you create an exposure if no incident currently exists. For example, in the Personal Auto line of business, if you create an exposure after claim creation, 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.

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*.
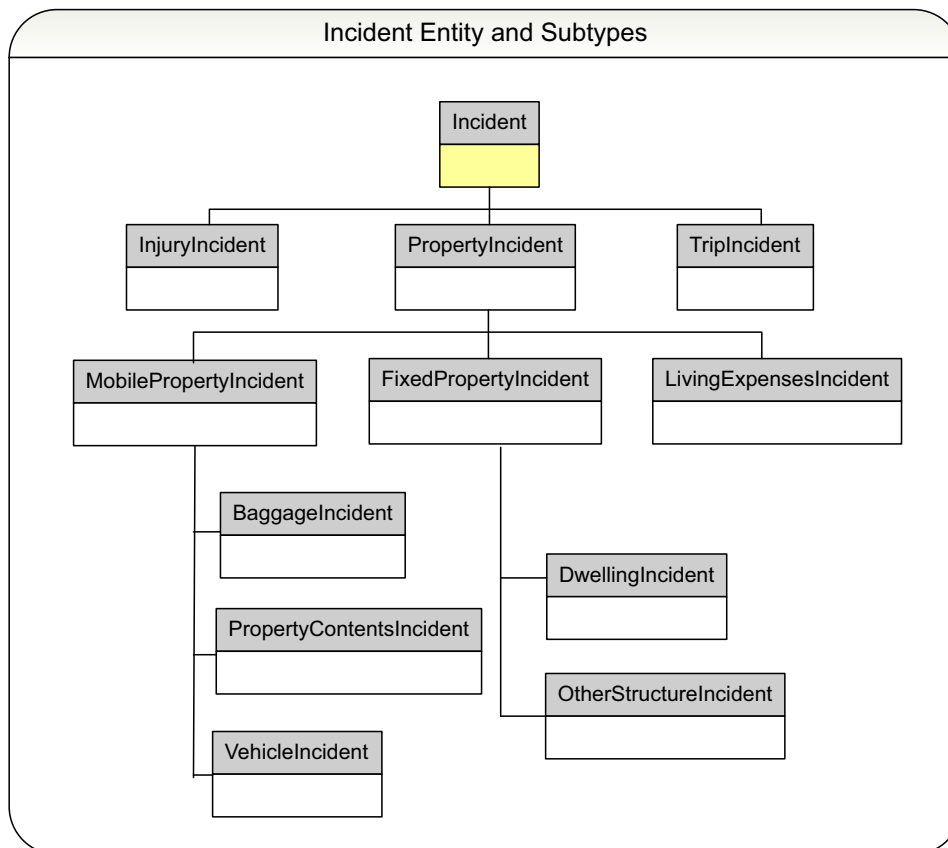
Every exposure type maps to the `Incident` entity or to one of its subtypes. In other words, every exposure has at least one underlying incident. As you create a new exposure, ClaimCenter needs to also create and initialize an incident. The link between `ExposureType` and `Incident` identifies the type of incident to create and initialize. The following table lists these relationships.

ExposureType	Incident subtype	Description
Baggage	`BaggageIncident`	Loss, damage, or delay of baggage. It also includes the lost of travel documents, such as tickets and passports.
Bodily Injury	`InjuryIncident`	Generic, for all LOBs, contains all injury-related data for workers' compensation (WC), auto, Personal PIP, and Medical Payments (MP).
Content	`PropertyContentsIncident`	Includes electronics, jewelry, furniture, and similar items.

ExposureType	Incident subtype	Description
Dwelling	DwellingIncident	Covers damage to a dwelling, such as a damaged roof or rooms in a building. It also includes property damaged by an earthquake.
Employer Liability	Incident	Used mainly for employer liability, both private and federal, associated with workers' compensation, and contains just description and loss estimate.
General	Incident	Generic, for use with all Lines of Business, and contains just description and loss estimate.
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—for example, theft or vehicle loss—or for moveable property such as a cellular phone.
PIP	InjuryIncident	Generic, primarily for PIP, not commercial losses.
Property	FixedPropertyIncident	Loss unrelated to an auto, 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 the insured missed a destination due to trip cancellation or delay.
Vehicle	VehicleIncident	Covers auto coverages related to vehicle damage.

Working with 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 (for example, 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 as such 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 by using the New Claim wizard

1. Create a new claim using the **New Claim** wizard.

2. Access the **Loss Details** screen.

3. Select an incident type from those shown at the right-hand 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**

4. 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 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-hand 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. Access the claim to which you want to add an incident.

2. From the **Actions** menu, select one of the following from the **New Exposure** menu:

   - **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, such as PolicyCenter, 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 from a verified policy tends to minimize any 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 for a personal auto claim:

- You can select one or more vehicles to include on the 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.

Incident Only Claims

In the base configuration, the **Loss Details** screen of the **New Claim** wizard contains an **Incident Only** radio button. Selecting or checking this option sets a Boolean `IncidentReport` property on the `Claim` entity. Set this indicator to `true` if you do not expect to ever have to make payments on a claim, for whatever reason.

IMPORTANT   It is important to understand that 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 as you add an exposure to a claim.

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chapter 24

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 241
*   "Working with Matters" on page 246

Legal Matters Overview

ClaimCenter contains tools that organize information for various types of conflict resolution, including:

*   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 matters, as described at "Negotiations" on page 40.

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 Budget Lines Screen or use the Evaluations page.

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, and 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.

- Look at all pending matters from the **Desktop**.
- Prevent deleting a user who has an open matter.
- Use Access Control Lists to divide matters into different security classes and define security for each one.

The Matters Screen

The matters screen shows the following information:

- Panels that describe the details of the matter. These panel vary by matter **Type**. Use **Edit**, **Update** and **Cancel** to change the information in these panes. Fro more information, see "Matter Types" on page 243.
- A **Calendar** button, which displays the Legal Calendar. See "Activity Calendars" on page 228.
- A **Status Line** table where you enter matter status milestones with Start Date and Completion Date. Milestones include Matter Filed, and others listed in the `MatterStatus` typelist.
- A **Secondary Attorney** table where you can add and delete contacts by using a contacts picker. There is an **Attorney** contact subtype.
- A **Planned Activities** table that shows all activities created by certain activity patterns.
- The **Latest Notes** relating to any matter on the claim. You see each note along with its Type and Name.

The following example is the **Matter** screen, showing the elements common to all matter types.

Matter Types

The **Matters** screen displays different information, depending on the matter type selected. There are several types of matters specified in the default `Mattertype` typelist. Each one tracks different types of information. The following table lists the types of matters that are in the default application, along with the sections, or panels. You can modify these types to include other information needed by your business model, and add other types. The General type includes all these panels:

Matter Type	Details	Litigation Details	Primary Counsel	Trial Details	Arbitration Details	Hearing Details	Mediation Details	Additional Details	Resolution
General	yes	yes	yes	yes	yes	yes	no	yes	yes
Lawsuit	yes	yes	yes	yes	no	no	no	yes	yes
Arbitration	yes	no	yes	no	yes	no	no	yes	yes

Matter Type	Details	Litigation Details	Primary Counsel	Trial Details	Arbitration Details	Hearing Details	Mediation Details	Additional Details	Resolu-tion
Hearing	yes	no	yes	no	no	yes	no	yes	yes
Mediation	yes	no	no	no	no	no	yes	no	yes

The Details Panel

This panel contains the basic information needed by any matter type. All fields are optional except **Type**:

- **Name** – The name of the matter.
- **Case Number** – Optional, enter if known.
- **Owner** and **Group** – To whom the matter is assigned.
- **Type** – **General** by default. Settings are **General**, **Hearing**, **Mediation**, **Arbitration**, or **Lawsuit**.
- **Plaintiff** and **Defendant** – Contacts you can enter manually or search for.
- **Related to Subrogation** – Often involves legal action. This field helps classify the subrogation.
- **Close Date** – ClaimCenter enters this date for you when you close the matter and erases it if you reopen the matter.
- **Reason Reopened** – After you reopen a closed matter, explain why you did so.

The Litigation Details Panel

This panel contains information used by **General** and **Lawsuit** matter types:

- **Court Type** – By default, **Federal**, **State** and **County** are the choices in the `Mattercourttype` typelist.
- **Court District** – By default, you can choose any state; the choices are in the `Mattercourtdistrict` typelist.
- **Legal Speciality** – **Personal injury**, **Motor vehicle liability**, **General liability** and **Workers' compensation** are the default choices available from the `legalspeciality` typelist.
- **Primary Cause** – For example, **Unreasonable Demand**. The choices, contained in the `PrimaryCauseType` typelist, also include:

  Blind Suit/First Notice, **Court Approval**, **Delay or insufficient claimant contact**, **Low settlement offer**, **Negotiations at Impasse**, **Claimant always intended to file**, **Statute of Limitations**, and **Valuation Dispute (1st party)**.

The Primary Counsel Panel

This panel contains information used by all matter types except **Mediation**:

- **Plaintiff Attorney**
- **Plaintiff Law Firm**
- **Defense Attorney**
- **Defense Law Firm**

You select these contacts either by searching through existing contacts, such as the **Attorney** contact subtype, or by entering a new contact. Use the picker icon by each entry.

The Trial Details Panel

This panel contains information used by **General** and **Lawsuit** matter types:

- **Trial Date** – Enter this date by using the calendar icon.
- **Trial Venue** – Pick an existing venue or add a new one by using the **Legal Venue** contact subtype.
- **Trial Room** – Enter a text field.
- **Trial Judge** – Pick an existing judge or add a new one by using the **Judge** contact subtype.

The Arbitration Details Panel

This panel contains information used by **General** and **Arbitration** matter types. The choices are analogous to **Trial Details**:

- **Hearing Date** – Enter this date by using the calendar icon.
- **Hearing Venue** – Pick an existing venue or add a new one by using the **Legal Venue** contact subtype.
- **Hearing Room** – Enter a text field.
- **Arbitrator** – Pick an existing arbitrator or add a new one by using the **Arbitrator** contact subtype.

The Hearing Details Panel

This panel contains information needed by **General** and **Hearing** matter types. The choices are analogous to **Trial Details**:

- **Hearing Date** – Enter this date by using the calendar icon.
- **Hearing Venue** – Pick an existing venue or add a new one by using the **Legal Venue** contact subtype.
- **Hearing Room** – Enter a text field.
- **Arbitrator** – Pick an existing arbitrator or add a new one by using the **Arbitrator** contact subtype.

The Mediation Details Panel

This panel contains information needed by **General** and **Mediation** matter types. The choices are analogous to **Trial Details**.

- **Mediation Date** – Enter this date by using the calendar icon.
- **Mediation Venue** – Pick an existing venue or add a new one by using the **Legal Venue** contact subtype.
- **Mediation Room** – Enter a text field.
- **Mediator** – Pick an existing arbitrator or add a new one by using the **Arbitrator** contact subtype.

The Additional Details Panel

This panel contains information that might be needed by all matter types except **Mediation**. All fields are optional:

- **Docket Number** – Enter a text field
- **Filing Date** – Enter this date by using the calendar icon.
- **Filed By** – Pick an existing contact or add a new one.
- **Service Date** – Enter this date by using the calendar icon.
- **Method Served** – Choose **Certified Mail** or **Sheriff**. Choices come from the `Mattermethodserved` typelist.
- **Response Due** and **Response Filed** – Enter these dates by using the calendar icon.
- **Ad Damnum** – Click **Yes** if there are any actual or anticipated costs so far.
- **Punitive Damages** – Click **Yes** if these are being claimed.

The Resolution Panel

The **Resolution** panel, shown in all matter types, tracks:

- **Resolution** – The outcome of the matter, using typecodes from the `Resolutiontype` typelist, categorized by loss type.
- **Final Legal Cost** and **Final Settlement Cost** – You must enter these costs directly.
- **Final Settlement Date** – Enter this date and also as the final entry in the **Status Line** table.

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 special 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. 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 for General, Hearing, and Lawsuit matter types. See the `Linecategory` typelist for the complete list. After you create exposures, use the cost category of Legal to make these line item categories available.

Payments and Matters

ClaimCenter not only allows you to estimate and track legal payments, but 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, choosing the **Litigation** menu item opens a table of all matters pertaining to that claim.

1. Open a **claim** and click the **Litigation** menu item.

2. Click a matter in the table to open it.

3. Click the **Details** tab.

You can create as many matters as you want with the **New Matter** button or through the **Actions** menu:

• Open a **claim** and choose **Litigation** → **New Matter** → **Details** tab

• Open a **claim** and click **Actions** → **New Other** → **New Matter** → **Details** tab

Assign each new matter you create by using the **Assign** button. Until you assign a matter to someone else, it is assigned to you.

To Close or Reopen a Matter

Click **Close** to close a matter. You are prompted to enter a reason selected from values in the `Resolution` typelist and an optional note describing the reason for closing the matter.

Use the **Reopen** button to reopen a closed matter. You are prompted to enter a reason selected from values in the `Matterreopenreason` typelist, as well as an optional note describing the reason for reopening the matter. Reopening a matter removes its **Close Date** from the **Details** panel and fills in the **Reason Reopened**.

To Use a Matter Type

You select a matter type by editing the **Type** field in the **Details** panel 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 this series of changes in several ways:

• 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.
- Open and close in turn a Negotiation, then a Hearing, then a Lawsuit, and finally an Arbitration matter type.

Organizing Legal Financial Information

The Budget Lines screen is a table that shows the following for each line item category of reserve lines with 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

Logging in as a user with administrative privileges, first set the `UtilizeMatterBudget` script parameter to `true`. Now, each time you open a matter, the Budget Lines tab appears. Select this tab to reach the Budget Lines screen:

To Add, Modify, or Delete a Line in the Budget Line Screen

The Budget Line table is initially empty. After you click Edit, you can:

- Click Add, then choose a Category to add a line with the line item category you have chosen.
- Enter an estimate to the line you add, or change estimates on the other lines while in this edit mode. This estimate is independent of the reserve amount of that reserve line.
- Delete a line from the table by selecting its checkbox and using 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 note payments made on reserve lines with the legal cost category. You must enter the category (line item). The Budget Lines table updates its Total Payments column when the check status becomes submitting or notifying. You enter the line item category on page two of the Check wizard and on page one of the Quick Check wizard.

Notes in ClaimCenter

One of an adjuster's important tasks is adding notes that track the progress of a claim and associate detailed information to the claim. Notes are a versatile and simple way to let all users keep a detailed record of all of the information, actions and thinking related to the processing of each claim. Notes cannot exist independently. They are always associated with a specific claim or one of the claim's parts.

With the Notes feature, you can:

* Create a note in most claim-related screens, including all claim, exposure, financial, and matter screens, and all **New Claim** wizard screens.
* Create notes without a note template.
* Use a note template to create specific note types.
* Attach a note to a single claim, or 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

Notes and documents have distinct functions in ClaimCenter, and the application handles them differently. The following table highlights the main differences. See "Document Management" on page 345.

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 Gosu.	Created by a user or Gosu, or come from an external document management system.
Stored only in the database.	Stored either in the database or 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

Following are the main pages related to notes:

- **Notes** – Main page containing a search screen in its upper portion, and the results of the last search in its lower portion. Select the **Notes** menu item while in any claim or the **New Claim** wizard to reach this main **Notes** page.
- **New Note** – Worksheet for creating notes. You can optionally use a template. You can also search for note templates. To access this worksheet, select **New Note** after clicking **Action**.
- **Activity Detail** – Worksheet to create notes related to an activity.

Other pages, including **Claim Summary**, display the latest notes related to the claim.

You can do the following with notes:

- "Searching for Notes" on page 250
- "Viewing Notes" on page 251
- "Editing or Deleting a Note" on page 251
- "Creating a Note" on page 251
- "Creating a Note in an Activity" on page 252
- "Creating a Note with a Template" on page 252
- "Creating a Note Template" on page 252
- "Linking a Document to a Note" on page 252

Searching for Notes

Use the **Search** panel at the top of the **Notes** screen to search for notes. Use the following filters or search fields:

- **Author** – The person who wrote the note. ClaimCenter attaches the name of the user; you cannot specify another name.
- **Contents** – You can search for a text string in the body of the note.
- **Date** – Search for an exact date, a preselected date range, or a range you enter yourself.
- **Topic** – Similar to the Subject of the note. What the note is about. It must be a typecode of the `Notetopic` typelist, such as FNOL, settlement, or general.
- **Related To** – A note created in an exposure or matter is related to that entity. This filter finds only notes related to a specific exposure, activity, matter, or claim contact. A note can be related to just one entity.

In the default implementation, you cannot search for these attributes: **Subject, Security type, Type,** or **Confidential**.

Viewing Notes

Use the Notes screen to see the most recent notes (up to 25), and the Search panel to find notes. If the note appears in a list, click it to see it. The most recent notes related to a matter, exposure, or activity are also visible on the **Exposure Summary, Matter,** and **Activity** pages. You can configure the **Notes** page to display more than the default. See "Configuring Notes" on page 253.

If you click **Author,** the detail page of that user shows. If the user who created the note no longer exists, the name shows but is not a link. To view the details of a note, click **Edit.** All the note's attributes display in the user interface.

Viewing Notes Related to an Activity

A note created in an Activity worksheet is linked to that activity. Clicking **View Notes** on the **Activity Detail** screen displays a search screen similar to the **Note Search** screen. However, these screens only display the notes linked to that particular activity.

Editing or Deleting a Note

If you have the correct permissions, **Edit** and **Delete** links show above each note.

1. Click **Edit** to start editing. You must have the `noteedit` permission to edit a note's attributes, besides the `noteeditbody` permission to edit its text.

2. Click **Update** to save.

See "Permissions Related to Notes" on page 252.

Printing a Note

1. To print a note click **Print** at the top of a note.

   Printing generates a PDF document on your computer that you can then print.

2. Print notes that you have the permission to view.

Searching for Note Templates

1. In the **New Note** worksheet, click **Use Template.**

2. In the **Note Template Search** screen, select template attributes to limit the search, and click **Search.**

   The search returns a list of templates matching your search criteria.

3. Click **Select** to choose your template.

Creating a Note

1. Click **New Note** from the **Action** button to obtain a **New Note** worksheet.

2. Fill in the required fields (**Topic, Related To,** and **Confidential)** and optionally the **Subject** and **Security Type** fields.

3. Enter the note text. Notes must always contain some text.

4. Click **Update** after you are finished with your note.

Creating a Note in an Activity

You can create notes while working on an activity in the **Activity Detail** worksheet.

1. Click **View Notes** in the **Activity Detail** worksheet to see **Activity Notes**. Notice the **New Note** section, identical to the normal **New Note** screen, where you can create a new note.

2. Optionally, select the **New Note** option of **Action** while in an activity to get the normal **New Note** worksheet.

   Note: Notes created in this worksheet are not associated with the activity.

Creating a Note with a Template

1. In the **New Note** worksheet, search for and select a note template. See "Searching for Note Templates".

   After you select it, the template's attributes and text populate the **New Note** worksheet.

2. Change any of this template information, and add other attributes and body text. Attributes and text that are part of the note template overwrite those you have already entered.

3. Select the template before entering anything yourself.

4. Click **Update** after you are finished.

Creating a Note Template

A note template is a single file containing attributes and values, and optionally, body text. These files are located in the `ClaimCenter/modules/configuration/config/resources/notetemplates` directory. There are several example files in that directory. The best way to create a new template is to modify a copy of one of these examples by using an editor.

   Note: Studio does not provide a special editor to help generate new templates.

Linking a Document to a Note

While creating or editing a document, 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, in this case `$ccDocLink(1)`. After you display the note body, 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 only link 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 as seen in the following table. Use these permissions to define different security types for documents and assign permissions to users that relate to these ACLs. "Access Control for Documents and Notes" on page 388 describes how to do this.

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

These are the system permissions which provide security to documents.

Permission Name	Purpose
viewclaimnotes	to view the Notes page of a claim or matter
noteview	to view notes

Permission Name	Purpose
`noteviewconf`	to view confidential notes
`viewprivnote`	to view private notes
`viewsensnote`	to view sensitive notes
`notecreate`	to add notes
`noteedit`	to edit the notes' metadata
`noteeditbody`	to edit the body of notes
`editprivnote`	to edit a private note
`editsensnote`	to edit a sensitive note
`notedelete`	to remove notes
`delprivnote`	to delete a private note
`delsensnote`	to delete a sensitive note
`notecreateclsd`	to add a note to a closed claim
`notedeleteclsd`	to delete a note from a closed claim

Confidential Notes

After you create a note, you can mark it as confidential. A confidential note that you create is visible only to you, your hierarchy of supervisors, and anyone who explicitly has permission to view all confidential notes.

All users have the permission to set the confidential field of notes they write. You can find, edit and delete confidential notes you write. However, the `noteviewconf` permission is required to see, and therefore edit or delete, a confidential note you did not write. ACLs are independent of this field.

Configuring Notes

The notes feature requires little configuration. `Config.xml` contains this single parameter:

- **MaxNoteSearchResults**: the maximum number of note search results to display before showing a warning in the user interface; the default is 25. The warning, but not the search results, appear if the limit is exceeded.

You cannot add and delete search filters in the `search-config.xml` file, as you can for other types of searches.

Notes Interfaces

There are two plugin interfaces associated with notes. They do not affect the main 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: Details of these interfaces are in the *ClaimCenter Integration Guide*:

- **INoteTemplateSource** – This interface, implemented in `gw.plugin.note.impl.LocalNoteTemplateSource`, is for retrieving note templates, `INoteTemplateDescriptor` objects, used to help create notes. The default implementation stores templates in the server file system, but this interface could also get them from a document management system.

- **INoteTemplateSerializer** – This interface, implemented in `com.guidewire.pl.plugin.note.internal.StandardNoteTemplateSerializer`, provides a way to customize reading and writing of `INoteTemplateDescriptor` objects.

Note and Note Template Metadata

Notes and their templates possess a number of characteristics, or attributes called the note's *metadata*. ClaimCenter uses this metadata to attach the notes to different claim entities and to search for notes or templates.

The following table contains a list of the metadata of notes and note templates:

Attribute Name	Definition of Attribute	How Set	Search for Note?	For Template?	Editable?
--- *This metadata is part of notes, but not note templates.* ---					
author	logged-in user name	cannot be set	yes	no	no
contents	the text of the note	on creation	yes - any string	no	yes
date	the date written	cannot be set	yes - and by range	no	no
related to	must exist and is unique	on creation	yes	no	yes
confidential	Boolean in note	on creation	no	no	yes
security type	in the `NotecurityType` typelist	on creation	no	no	yes
--- *This metadata is part of note templates and notes.* ---					
Topic	in the `Notetopic` typelist	on creation or by template	yes	yes	yes
Type	in the `Notetopic` typelist	by template	no	yes	no
Subject	defined in the template and given to its notes.	on creation, by template	no	no	yes
--- *This metadata is part of note templates, but not notes.* ---					
name	name of a note template	cannot be set	no	yes	no
keywords	to find templates only	part of template	no	yes	no
Line of business	to find templates only	part of template	no	yes	no

Metadata of Notes

The contents, date, author, related to, confidential, and security types are metadata unique to notes and are not a part of note templates.

Metadata that is Common to Note Templates and Notes

The following fields are set in the templates and are given to all notes made from them:
- **type** – A typecode of the `Notetype` typelist, such as diagram, action plan, or status report; you can add others.
- **topic** – The topic of the template and of notes created from it; a typecode of the `Notetopictype` typelist.
- **subject** – The subject of the template and of notes created from it.

Metadata Unique to Note Templates

Note template metadata are fields attached to note templates for organizing and searching for them and for notes written using these templates. Notes written in a note template inherit some of the metadata of that template. Some metadata is required, and you can add other search categories as keywords:
- **name** – A unique, readable name for the template.
- **lob** – A comma-delimited list of the line of business (LOB) codes for which this note is appropriate. Use this list to prevent finding the template when it is not appropriate for the current LOB.
- **keywords** – A comma-delimited list of keywords that can be used to find this note template. This is a way to extend searching for templates. Note Templates are somewhat constrained in functionality and therefore less widely used than Document Templates.

chapter 26

Holidays and Business Weeks

Holidays, weekends, and business weeks define the ClaimCenter business calendar. Holidays can vary according to zones, such as country. For example, some countries may have an accepted practice of working half 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 per zone. A large international company may need to track the different business days and holidays according to their locations to ensure that work is handled in a timely manner. The application's business calendar calculates these key 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 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. To determine how long it normally takes for international mail to arrive, consider the mail holidays of several countries.

This topic includes:

Specifying Holiday Dates

In the base configuration, ClaimCenter defines weekends and work days using configuration parameters in the `config.xml` file. However, you specify holidays through the user interface. Doing so this way, gives you more flexibility in defining them, 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 → Holidays** screen. All holidays you define in this screen are stored in the database and are editable. With administrator privileges, you specify:

- **Name**: There is no limit on what holidays can be defined, or what name you give them. But each holiday is only one day. So you must specify two holidays for Thanksgiving in the United States if the intention is for the company to not work on Thursday *and* Friday.
- **Date**: The dates of some holidays vary each year, so this screen allows annual updates.
- **Applies to All Zones**: This determines who observes the holiday. You can further select the type of zones such as state, county, or city in the United States if the holiday does not apply to all zones.
- **Types**: This is one way to categorize holidays. You can also define other types.

  Defaults include General, Federal, and Company.

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** 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 which 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 state, 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. In the application, with administrator privileges, click the **Administration** tab → **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 select **No** to **Applies to All Zones**, then you can further refine your choices on which zones apply.

To Edit a Holiday

1. To edit a holiday, including its **Date**, **Type** and **Zone**, select it from the **Holiday** screen.

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: Remember, you might need to change the **Date** of some holidays annually.

To Delete a Holiday

You can *delete* any holiday in the **Holidays** screen. Select its check box and click **Delete**.

See "Holidays" on page 408 for more information about adding, editing, and deleting regional holidays.

To Create a New Zone or Type

In Studio, navigate to the typelist that you want to modify.

- **Zone Type** is defined by the `ZoneType` typelist and includes the typecodes `ZIP code`, `City`, `County`, `State`, `Province`, `Postal Code`, and `FSA`. You can add other types to this typelist.
- **State** defines the states of both the United States and Canada that are in the `States` typelist.
- **Type** is 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 takes 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 which use Holiday **Type** and **Zone** to determine the correct number of business days.

Gosu Holiday Methods that Use Zones and Types

These methods compute business days taking into consideration holiday types or zones. These methods are defined in `gw.util.GWBaseDateEnhancement`.

Methods that use Holidays	This is what they do:
`getConfiguredHolidays()`	Return the array of all holidays of all types and zones.
`getConfiguredHolidays(tagCode : HolidayTagCode)`	Return the array of all holidays of this type.
`getConfiguredHolidays(location : Zone)`	Return the array of all holidays in this zone.
`addBusinessDays(date : Date, iDays : int, tagCode : HolidayTagCode)`	Adds `int` (signed) business days to Date, based on holidays of the specified type. Time of day is preserved.
`addBusinessDays(date : Date, iDays : int, location : Zone)`	Adds `int` (signed) business days to Date, based on holidays in the specified zone. Time of day is preserved.
`businessDaysBetween(fromDate : Date, toDate : Date, tagCode : HolidayTagCode)`	Returns number of business days between the given dates, omitting holidays of the specified type; ignores hours in dates.
`businessDaysBetween(fromDate : Date, toDate : Date, location : Zone)`	Returns number of business days between the given dates, omitting holidays in the specified area; ignores hours in dates.

Business Weeks

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. You can configure ClaimCenter to have the hours from Monday to Friday begin at 8 a.m and end at 7 p.m. For Saturday, you can configure the business hours to begin at 10 a.m and end at 2 p.m.

The `config.xml` file contains business calendar parameters. These parameters are applied system wide and are the default.

The business calendar parameters allow you to specify:

- For each day of the week, whether it is a business day.
- The time that each business day starts and ends.
- The day that is the end of the business week.
- The time that marks the start of a new business day.

However, you can configure business weeks to a more granular level which then overrides the configuration parameters. Do this in from the **Administration** tab → **Business Week**. (See "Working with Business Weeks" on page 259.)

Overriding the configuration parameters allows you to 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. In this example, you can define by zone how business weeks and hours are defined.

See also
- "Business Calendar Parameters" on page 41 in the *Configuration Guide*

Business Week Implementation

`BusinessWeek.eti` defines the table schema for the `BusinessWeek` entity. This entity stores data about whether Monday is a business day and its business hours, and the same for Tuesday and Wednesday and so on. You can also specify which zones a business week applies to, or whether it applies to all zones. This is accomplished through the user interface, specifically in **Administration** tab → **Business Weeks**. See "Working with Business Weeks" on page 259.

The `config.xml` parameters still remain, and are used when no `BusinessWeek` entity exists in the database. If at least one `BusinessWeek` is active in the database, then ClaimCenter uses `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, then 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 it has `AppliesToAllZones = true`, then any business calendar calculation uses 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. The first one with *California* zone and the second with *San Francisco* zone *and* a business calendar calculation specifies an `Address with State="California"` and `City="San Francisco"`. In that case, the *San Francisco* `BusinessWeek` is used. That is because matching is

first attempted on Zones of deeper granularity `ZoneType` and in t his example, City is a more granular `ZoneType` than State.

IMPORTANT If a `BusinessWeek` entity does not exist in the database, then ClaimCenter uses the business week parameters defined in `config.xml`.

Business Day Demarcation

The *BusinessDayDemarcation* field on Business Week is a time value (for example 5:00 p.m.) that is helpful when a time falls between the business hours of two days.

For example, if your business days start at 8:00 a.m. and end at 5:00 p.m. what happens when 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. Define the demarcation in the user interface which is described in the following section.

> **Note:** *BusinessDayDemarcation* cannot be set to fall during your defined business hours.

Working with Business Weeks

To define business weeks in the user interface, perform the following steps.

1. Navigate to the **Administration** tab and click **Business Week**.

2. Click **Add Business Week**. The **New Business Week** screen shows.

3. Enter a business week name, and indicate if it applies to all zones. If you select **No**, then you must define which zones this business week applies to.

4. You must define which day ends your business week and the business day demarcation. Also define for each day of the week, if it is a business day and 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 contains Gosu methods that calculate elapsed hours using these defined business hours. However, they do not consider holidays accurately.

Specifying holidays only considers dates, not hours. But you can write Gosu code for a task that is accomplished in hours, rather than in days.

ClaimCenter contains a set of Gosu business hour methods, completely separate from business day methods, which take holidays into consideration after calculating business hours.

For example, a carrier promises to respond to all inquiries and claims within two hours after receiving that 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 following methods compute business hours taking into consideration holiday types or zones. These methods are defined in `gw.util.GWBaseDateEnhancement`.

Methods for business hours	This is what they do:
`addBusinessHours(date : Date, iHours : int, tagCode : HolidayTagCode)`	Adds specified business hours to the date, incrementing it if needed while skipping all holidays of the specified type.

Methods for business hours	This is what they do:
`addBusinessHours(date : Date, iHours : int, location : Zone)`	Adds specified business hours to the date, incrementing it if needed while skipping all holidays in the specified zone.
`businessHoursBetween(fromDate : Date, toDate : Date, tagCode : HolidayTagCode)`	Returns the number of business hours between two dates, while skipping all holidays of the specified type.
`businessHoursBetween(fromDate : Date, toDate : Date, location: Zone)`	Returns the number of business hours between two dates, while skipping all holidays in the specified zone.

Notes

While certain methods appear to be similar, they can have different results. For example,

- The method `addBusinessDays()` is different from `addBusinessHours()`. For example, assume that 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., while adding nine business *hours* to the same date results in Tuesday 8:00 a.m.

- The same is true for the methods `businessDaysBetween()` and `businessHoursBetween()`. If the day is between 8:00 a.m. and 5:00 p.m., then calling `businessDaysBetween()` between Sunday 12:00 a.m. and Monday 12:00 a.m. has a value of 1. Calling `businessHoursBetween()` results in 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 contain these permissions.

Business Week Permissions

The following system permissions control whether you can view and edit the **Business Week** screen.
- `buswkview`
- `buswkmanage`

These permissions exist on the Superuser role in the base configuration.

chapter 27

Vacation Status

ClaimCenter assigns work (such as working on claims, exposures, or activities) to users either through assignment rules (such as by round robin) or by manual assignment. What happens if you are unable to work on claims because you are not in the office? How does the application redistribute your work load so that it can be done in a timely manner?

ClaimCenter provides a way for work to be handled, and that is 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 kept in the `VacationStatus` typelist, which contains these typecodes:

- **At work**: You receive new assignments. This is the default.
- **On vacation**: You continue to receive new work, but current work assignments appear to your designated backup, when your backup checks the **Vacation** Tab.
- **On vacation (inactive)**: This is identical to the prior status, **On Vacation,** with one exception. You are not assigned new work by an assignment rule that considers multiple assignees. For example, `assignToCreator()` assigns work, but `assignUserByRoundRobin()` does not.

These rules apply to claims, exposures, and activities of the person who is on vacation.

> **Note:** If you have administrative permissions, you can change vacation status and backup users through the **Administration** tab. More commonly, supervisors can redistribute work, change vacation status, and set backup user from the **Load and Vacation** screen. Navigate to **Desktop → Actions → Load and Vacation**.

Setting Your Vacation Status

Perform the following to change your status.

1. Navigate to **Desktop → Actions → Vacation Status**.

2. Select the status (**At work, On vacation, On vacation/inactive**) from the drop down menu.

3. To select a backup user for your work while on vacation, in the same location select your designated backup user from the drop down menu.

4. When you return from vacation, go back to the vacation status and select **At work** from the drop down menu.

Accessing the Vacation Tab

To view work assigned to you as a backup by another user currently on vacation, click the **Vacation** tab. It is not available if there is no work for you. This is where you can select any activities, claims, or exposures to work on.

Backup Users and Permissions

Ideally, the backup user has the same set of permissions as the person on vacation. In other words, you want them to have the same level of responsibility. For example, if the main user can work on sensitive claims, but you, as the backup user do not have those permissions, then you cannot work on those sensitive claims. So it makes sense to select a backup user from the same group. System permissions are *not* inherited from the main user to the backup user. Security zones also cannot be inherited. Another factor to consider is authority limits. If the backup user does not have the same or greater authority limits, the backup user cannot view any activities relating to needing authority limits to work on an activity. For example, if the backup user does not have the appropriate authority limit, then the user cannot see under the **Vacation** → **Activities** tab the activity to approve reserves.

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 if you attempt to do so.

Backup Users and Activities

Since a person is designated as a backup, the backup user gains the right to edit activities owned by the vacationing user. This means that they can update, complete, skip, assign, or link a document. If they have the same permissions, they can also view notes on an activity. However, the backup user cannot approve *approval type* activities unless they have the `actapproveany` permission.

Supervisors who go on vacation can assign their manager as their backup user, but the manager might not have the `actapproveany` permission. You can remedy this as follows:

- If you are the backup user and you have the permissions and authority limits to approve that type of activity, then you can reassign the activity to yourself. After this, in your **Desktop** → **Activities**, find the reassigned one, 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 you approval rights to *any* approval activity and is not restricted to being used in the backup role. Remember that 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 is an option, this choice may not best serve your business requirements.

Question Sets

Question sets are pre-defined sets of questions, used to help an interviewer obtain complete information. They regularize the information gathering, and creates a searchable record of the answers. In ClaimCenter, question sets are used:

- To help build a data base of recommendations for service providers.
- To help assess the risk that a claim is fraudulent.

This topic includes:

Service Provider Question Sets

An auto claim adjuster can have to choose a body shop from a list of providers. To help in this selection, the adjuster can rely on question sets which:

- Find out from the claimant how much value is placed on perfect or rapid body work, or if the claimant has previous experience from a particular provider.
- Find out the claimant's 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.

Fraud Question Sets and the Use of Risk 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 avoid using fax, email, or mail, and only communicate verbally?
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 difficulties?
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 their 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 full set of questions and the Risk Point feature ensures that all claims can be examined in a uniform and fair way.

Working with Question Sets

You create `QuestionSets` and their related entities by creating .xml files, then importing them through the application.

Importing Question Sets and Questions

With administrative permissions, you can import question sets from the user interface, specifically, from **Administration → Import/Export Data** and then select **Import**. For detailed information, see "Importing and Exporting Administrative Data from ClaimCenter" on page 121 in the *System Administration Guide*.

This adds the selected `QuestionSet` and its `Questions`, besides `QuestionChoices` and `QuestionFilters` to your installation. This can occur while the server is running.

Creating a Question Set and its Questions

Each `QuestionSet` consist of `Questions`, which can in turn point to the allowed set of answers (`QuestionChoices`) to the question. After creating `Questions`, realize that:

- Each `Question` must have a foreign key back to the `QuestionSet` it appears in.
- To be scored, the `QuestionType` field must be of type `choice`. Other types can be used but 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 of the question where it shows in its `QuestionSet`. The values start with zero, and count upwards.
- The `QuestionFormat` field is optional and can be `ChoiceSelect` or `ChoiceRadio` or `null` (and be `null` for `QuestionType` other than `choice`).
- Each `Question` 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 -->
    <Indent>0</Indent>                     <!-- not used, but will be to indent when displayed -->
    <Priority>12</Priority>       <!-- order in which this Question appears in the QuestionSet -->
    <QuestionSet public-id="generalquestionset"/>    <!-- points to Questionset it belongs to -->
    <QuestionType>Choice</QuestionType>            <!-- boolean, choice, string, or integer -->
    <Required>false</Required>        <-- if question must be answered or have non-null default -->
    <Text>Did the claimant present excessive documentation?</Text> <!-- actual question text -->
    <!-- If QuestionType=Choice, then ChoiceRadio displays an array of radio buttons, -->
    <!-- and ChoiceSelectBox displays answers in a select drop-down box. -->
    <!-- question.xml is a typelist containing all display choices -->
    <QuestionFormat>ChoiceRadio</QuestionFormat>
 </Question>
```

Similarly, a `QuestionSet` looks like this:

```
<QuestionSet public-id="AssignValue">
    <AvailabilityScript/>                                    <!-- this field is not used -->
    <Name>Repair Timeliness</Name>                          <!-- the name to display -->
    <Priority>0</Priority>      <!-- order in which this QuestionSet appears in user interface -->
    <QuestionSetType>autorepair</QuestionSetType>        <!-- typecode of QuestionSetType.xml -->
        <!-- this typecode is used to make sure only the appropriate QuestionSets are displayed-->
</QuestionSet>
```

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="question1
1"/> <!-- reference to question this is a choice for -->
    <Score>0</Score>                          <!-- the score assigned to this choice -->
 </QuestionChoice>
```

Creating a Conditional Question

The notion of follow-up questions becomes *conditional questions* in ClaimCenter. The use of conditional questions can tailor a single question set to quickly and accurately obtain information from a number of similar cases. Consider this partial sequence of questions that determine the place of loss:

- Question A1: "Was the loss at your home?"
  - If yes to A1, then conditional question A11: Is your home a house, condo, or apartment?
  - If answer to A11 is apartment, then conditional question A111: How many units in the building?
  - If answer to A11 is not apartment, then conditional question A112: Is the house or condo detached?
- If the answer to A1 is no, then question A12: Was the loss at your work or place of business?

Reuse of 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 QuestionSets

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.

Adding Question Sets to PCF Pages

To include a `QuestionSet` on a page, you need to use the `QuestionSetLV` page. See `SIDetailsDV` for an example on how to use it, as well as `ClaimImpl.java` which implements `AnswerContainerBase`.

Start by declaring the variable:

```
<Variable name="QuestionSets" type="QuestionSet[]" initialValue =
                             "util.QuestionUtils.getAppropriateQuestionSet(Claim)"/>
```

Next, pass the `QuestionSet` down to the list view:

```
<InputIterator value="QuestionSets" elementName="QuestionSet">
   <InputSet visible="QuestionSet.isQuestionSetAvailable(Claim)">
      <Label label="QuestionSet.Name"/>
      <ListViewInput  labelAbove="true" editable="true" def="QuestionSetLV(QuestionSet, Claim)">
         <Toolbar/>
      </ListViewInput>
   </InputSet>
</InputIterator>
```

You need to write extensions to your extending entity so that you can call `getOrCreateAnswer()` on the entity. This creates the answer and associates it with the entity involved. This is currently done in Java.

The `QuestionUtils.gs` class shows an implementation of the `QuestionSet` selection code:

```
public static function getAppropriateQuestionSet(claimInput : Claim) : QuestionSet[] {
   var result : QuestionSet[] = com.guidewire.cc.system.dependency.
                      CCDependencies.getQuestionSetFinder().findQuestionSetByType("siugen");
   if (claimInput.getLossType().Code == "AUTO"){
     result = concatArrays(result.com.guidewire.cc.system.dependency.   <!-- see next line -->
            CCDependencies.getQuestionSetFinder().findQuestionSetByType("siucar"));
   }
   else if (claimInput.getLossType().Code == "WC"){
     result = concatArrays(result, com.guidewire.cc.system.dependency.  <!-- see next line -->
            CCDependencies.getQuestionSetFinder().findQuestionSetByType("siuwork"));
   }
   return result;
}
```

This is an example of how to use `QuestionSetTypes` to decide what `QuestionSet` to show.

Question Sets Key Entities

These following entities relate to question sets:

Entity	Description
Answer	Answers to questions can be either text, logic, dates, or numbers. It 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	One of the question type values. Question choices can be scored.
Question	A query. ClaimCenter typically uses questions to gather information regarding fraud and service provider recommendations. Question types values can be boolean, choice, string, and integer.
QuestionFilter	A filter that controls the visibility of a question based on the answer to a previous question in a question set. Has a foreign key to `Question`.
QuestionSet	Question sets are groups of questions. Typically used in the risk qualification process or to develop supplemental underwriting information.
SubQuestion	In the user interface, this is the text that shows 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. Guidewire associates an array of `AnswerSet` entities, which corresponds to many sets of answers for the claim.

IMPORTANT While the `QuestionSetFilter` entity exists in the product, Guidewire recommends that you do not use it. It is reserved for future use.

chapter 29

Reinsurance

Reinsurance is the process of insurance companies insuring underwritten policies with other institutions in order to offset exposure. Carriers do this to offset some of the financial risks that insurance companies assume when they insure any kind of loss type. This relationship is called a reinsurance *agreement* or *treaty*, but is not a *policy*. However, the challenge for carriers is in correctly identifying claims that qualify for reinsurance since lack of identification results in leakage. While carriers have a separate process outside of ClaimCenter to handle the processing of reinsurance claims, ClaimCenter helps carriers identify those claims that qualify for reinsurance.

There is also administrative tasks for either an administrator or a reinsurance manager. See "Reinsurance Threshold" on page 416 for details.

This topic includes:

Reinsurance Overview

Whether a claim can be reported for reinsurance is based upon a claim's *total incurred* exceeding a specific amount determined by the carrier's *reinsurance treaty*.

ClaimCenter helps carriers identify potential losses in the areas of catastrophes and large individual losses. The application contains the necessary logic required for detecting and notifying insurance handlers, so that they can perform the necessary tasks on the claim file.

What sort of claims would be identified for reinsurance?

Example 1 - An Individual Loss Exceeds a Set Threshold

Your home was damaged by fire. There was over $2 million in damages. The carrier however, has treaty with a reinsurer to cover losses over $1 million.

Example 2 - Massive Aggregate Loss Due to Catastrophe

Now your home was unfortunately demolished by the last hurricane, Hurricane Carolina. The carrier again has treaty with a reinsurer to cover the cost over a certain amount.

Example 3 - Aggregate Loss Due to a Single Event

There was a fire in a shopping mall and several tenants sustained damages. All tenants have individual policies with the insurer, but none of the individual losses qualifies for reinsurance. However, the carrier has treaty with the reinsurer to cover losses on single event.

Reinsurance in ClaimCenter

How does it work in ClaimCenter? The application manages:

- Threshold data
- The reasons for reporting to the reinsurer

It can do this manually or automatically through rules.

Using Rules to Mark a Claim for Reinsurance

Rules (created in Studio) can analyze and determine when to report. These can be seen in the Transaction pre-update rules, claim pre-update rules, and assignment rules.

Most of the logic for determining if a claim is be reported for reinsurance is contained in the Transaction pre-update rules. Anytime a claim's financial information is changed, ClaimCenter performs the necessary calculations for checking whether a claim's gross total incurred has exceeded the respective reinsurance threshold value.

- The Claim Pre-Update rules set global conditions for when a claim must be marked for reinsurance when a specific injury has been associated with it. For example, if a claim has a fatality, brain injury, or amputation involved, the carrier might consider that claim for reinsurance.

- There is also a *Reinsurance Flagged Status* field on the `Claim` entity that tracks how a claim had been marked or unmarked for reinsurance. The application uses the Reinsurance Flagged Status rule to handle the case where you mark or unmark the claim for reinsurance. That is so it updates the Reinsurance Flagged Status.

- The Create Reinsurance Review Activity rule checks that anytime a claim is marked for reinsurance, a new reinsurance activity is created. It automatically creates the reinsurance activity when you manually updates the claim for reinsurance. When the system updates the claim for reinsurance, the transaction pre-update rules create the reinsurance activity.

- The Create Reinsurance Reason Note checks that a reason has been entered into the user interface. In order to log all reasons for change in the Reinsurance status, the system adds a note of Reinsurance Topic type.

- Assignment rules automatically assign activities by round robin to any user with the role of *Reinsurance Manager*. The Global Activity Assignment Rules are invoked when you create the *Review Claim for Reinsurance* activity and use the *use automated assignment* to assign the claim. This rule assign the claim to a reinsurance manager that belongs to a predefined reinsurance group and adds the reinsurance manager as a user on the claim.

Flagging a Claim

ClaimCenter can flag claims that might be eligible for reinsurance. You can see this on the **Summary** screen under the **Claim Status** section. Since the flagged status is only used to track how the claim was marked for reinsurance, the flag field is not editable and only visible in read-only mode.

Reinsurance Reportability

A claim is *Reportable* if it needs to be reviewed for reinsurance purposes by the Reinsurance Manager. You can see this on the **Claim Status** screen under the **General Status** section.

The Reinsurance Manager has Activities

Now that certain claims have been marked for reinsurance, the reinsurance manager is notified. See the following section *Reinsurance Manager* to understand that role and the duties associated with it.

Reinsurance Manager

Reinsurance handling is usually a specific role performed by an employee in a reinsurance specific group. ClaimCenter has the role *Reinsurance Manager*. This role is assigned the activities to help process the reinsurance claims. It exists to receive notifications that certain claims might be eligible for reinsurance handling. This role works with the reinsurer outside of ClaimCenter.

> **Note:** No financial information about the reinsurance claim returns to ClaimCenter.

Reinsurance Manager Tasks

After a claim is marked for reinsurance, the reinsurance handler (the Reinsurance Manager) performs a set of required tasks. Most of these are outside of ClaimCenter. It does not matter whether the claim was marked manually or through rules. After it is marked, the *Create Reinsurance Review Activity* rule creates the activity using the activity pattern code: `claim_reinsurance_review`. The activity is to review the claim for reinsurance. It then assigns it to you if you have the role of Reinsurance Manager. You can either see this activity or create it in the user interface under the Reminder category as *Review Claim for Reinsurance*.

Working with Claims for Reinsurance

If a claim has been marked for reinsurance, you can see it in the claim's **Summary** screen, under the **Claim Status** section.

Marking a Claim as Reinsurance Reportable

You can mark or unmark a claim to be reported for reinsurance.

1. Navigate to a claim's **Summary** screen and click **Claim Status**.

2. Click **Edit** and under the **General Status** section, and select **Yes** under **Reinsurance Reportable?**

3. You must now give a reason under the **Reinsurance Edit Reason**.

4. Click **Update** to save your changes.

This action creates a note which you can see on the **Summary** screen.

Associating Claims

You can relate claims to each other. This is useful so that the Reinsurance Manager can run reports to find examples of reinsurance-related associated claims and analyze them for reinsurance reportability. To do so, navigate to a claim's **Loss Details** screen and click **Associations**.

Reinsurance Data Model

Guidewire created the `ReinsuranceThreshold` entity as a reference table to store the related information for determining whether a claim can be reported for reinsurance. Reinsurance treaties are mostly applied at the policy type and coverage level, so depending on a claim, different reinsurance treaties might be applied. The primary determining factor for a claim to be marked for reinsurance is if their total incurred amount for the

included coverage types exceeds the threshold percentage notification value. This is the threshold value multiplied by the reporting threshold. The table can be edited in the **Administration** tab by selecting the **Reinsurance Threshold** link.

See "Reinsurance Threshold" on page 416 for details.

The following table contains some of the key fields available on the `ReinsuranceThreshold` table.

Field	Description
TreatyType	This is the reinsurance treaty type.
PolicyType	The policy type for which this reinsurance threshold is applied on a claim.
LossCauses	A list of loss causes for which this reinsurance threshold is applied on a claim.
CoverageTypes	A list of coverage types for which this reinsurance threshold is applied on a claim.
ThresholdValue	The dollar threshold value.
ReportingThreshold	The percentage of the threshold value at which a claim is marked for reinsurance.
StartDate	The start date.
EndDate	The end date.
ThresholdDescription	A general description of what the current reinsurance threshold is for.

Example of Usage

In this example, the following reinsurance threshold entry in the reference table is as follows.

PolicyType	CoverageTypes	ThresholdValue	Reporting Threshold
Homeowner's	Personal Property Damage, Dwelling Damage	$1,000,000	50

If a claim had a Homeowner's policy type, you would take the total costs for any damages related to personal property or dwelling and compare it to the threshold. The threshold value can be interpreted as, when the claim cost exceeds 50% of the $1,000,000, then the claim is marked for reinsurance. Therefore, if the accumulated costs for the coverage damages was above $500,000, then reinsurance kicks in for the claim.

Additional Fields on the Claim Entity

There are additional fields on the `Claim` entity.

- `ReinsuranceReportable`: In order to track which claims can be covered by reinsurance, there is a `ReinsuranceReportable` boolean field on the claim. Use this field, to search and retrieve all reinsurance claims.

- `ReinsuranceFlaggedStatus`: A claim's reinsurance reportable field can by modified in two ways: automatically by the system through rules or manually. The field `ReinsuranceFlaggedStatus` keeps track of how the claim was marked for reinsurance. This means that you could implement the logic required for ensuring the user's input is not overridden by the the system. For example, if a claim's gross total incurred has not reached the threshold and a user had manually specified that the claim not be reported for reinsurance. In that case, if claim's gross total incurred ever exceeds the threshold, the expected behavior would be that the system would not mark that claim to be reported for reinsurance.

  The possible states for this field are:

  - `SystemFlagged:` Reinsurance reportable set by ClaimCenter
  - `UserFlagged:` Reinsurance reportable set by the user
  - `UserUnflagged:` Reinsurance reportable unset by the user

chapter 30

Subrogation

Subrogation is the legal technique in 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 a first-party insurer pays their insured for accident costs for which a third-party is liable. The insurer then has the right to pursue a recovery effort from the third-party or the third party's insurance company. In other words, the insured 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 enable 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 273
- "Enabling Subrogation" on page 279
- "Subrogation Data Model" on page 280

> **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 the following main activities:
- "Starting a Subrogation" on page 274
- "Assigning the Subrogation" on page 275

The following figure is a conceptual overview of a subrogation process:
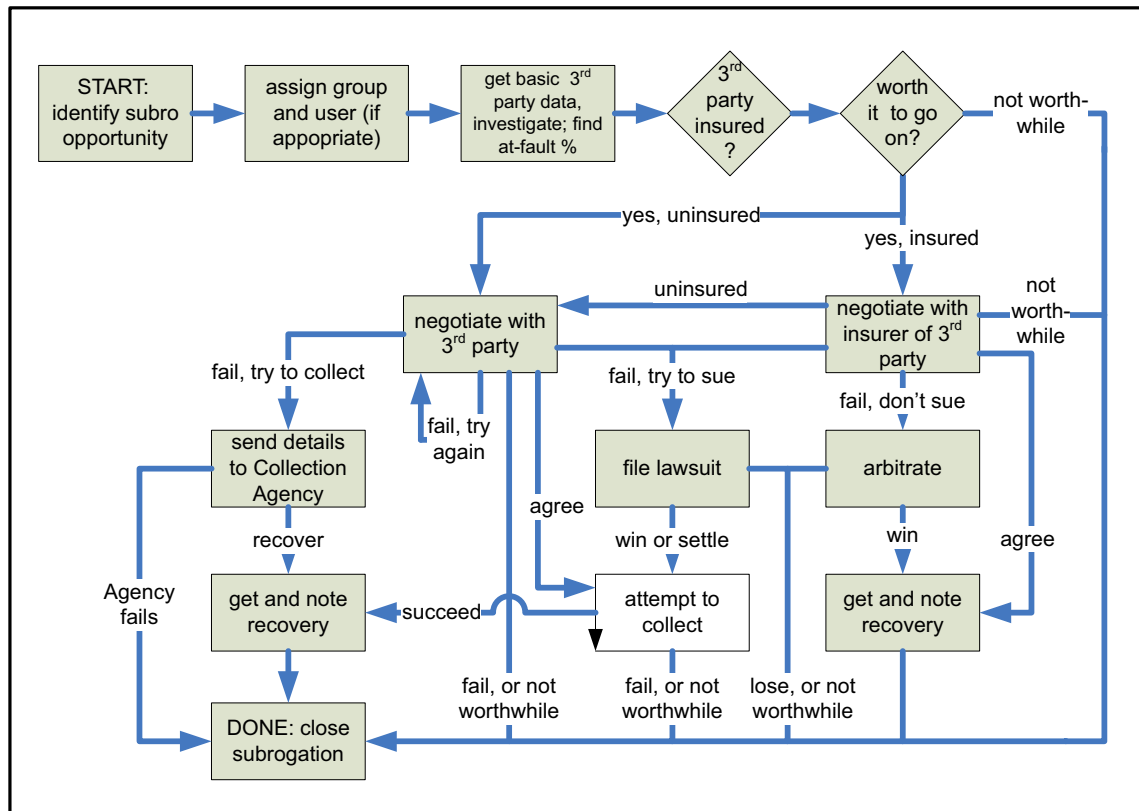
Starting a Subrogation

You access the **Subrogation** screen from a claim's **Subrogation** left sidebar menu item. This menu item is not visible until you start a subrogation by editing the **Loss Details** screen or by setting **Subrogation Status** to **Open** or **Review.**

Editing the Loss Details Screen

Typically, to start a subrogation, you edit the **Loss Details** screen in one of these ways:

- Set the **Fault Rating** field to **Other party at fault.**
- Set the **Fault Rating** to **Insured at fault** and the **Insured's Liability %** (which then appears 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 extendable FaultRating typelist. Possible values are: **Other party at fault**, **Fault unknown**, **Insured at fault**, and **No fault.**
  - **Insured's Liability %** is the amount of responsibility the *insured* bears for the loss. The field appears directly under **Fault Rating** after you set it 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 that look at values in the **Loss Details** screen to determine if subrogation is to be pursued.

Setting Subrogation Status

You can make the **Subrogation** menu item visible by setting the **Subrogation Status**. After setting this value, you can click **Subrogation** in the sidebar menu and edit the **Subrogation** screens. You can initially set the **Subrogation Status** as follows:

1. Open a claim and click **Summary** in the left sidebar menu under **Actions**.

2. Click the **Claim Status** tab on the **Summary** screen.

3. Click **Edit**, set the **Subrogation Status** to **Open** or **Review**, and click **Update** to save your changes.

   Note: After you have started a subrogation, **Subrogation Status** is also available on the **Subrogation** screen.

Assigning the Subrogation

You create and assign a subrogation activity just like any other activity on a claim, and you can write rules to perform the assignment. You can use manual or rule-based assignment. To assign to experts in subrogation, first identify them in one of the following ways:

- Placing them in a special group, such as a *subrogation specialists* group
- Granting users a special user role in the `UserRole` typelist
- Defining and using a new user attribute of `UserAttributeType`

You can instead create a manual assignment activity by using one of the special Activity Patterns, like pattern 66.

Recording the Subrogation Investigation

ClaimCenter provides a detailed **Subrogation** screen that can help you organize each subrogation investigation. It contains the following tabs.

General Tab

Use **General** to record:

- **Fault**: The same as **Fault Rating** in the **Loss Details** screen.
- **Insured's Liability %**: Same as **Insured's Liability %** in the **Loss Details** screen.
- **Subrogation Status**: This field has the following possible values:
  - **none selected**: No subrogation has been attempted for this claim.
  - **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.
  - **Closed**: The subrogation attempt has been completed or abandoned.
- **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 - Escalate to Subro?**: If you answer **Yes**, you must enter a **Referral Comment**, and **Referral Date** and time of the referral also appear on this screen. You cannot say **No** after you have entered **Yes**.

Besides these fields, the **General** tab gives summaries of:

- **Responsible Parties**: This editable table lists all responsible parties with a few of their characteristics, such as their responsibility percentages. You must use the **Responsible Party Detail Tab** to add or remove them, along with providing more information about them.

- **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 table on the subrogation screen, you can view and enter the following information:

  - **Type**: The subrogation type can be **Medical** costs, **Property Damage**, or **Other**.

  - **Jurisdiction State**: The state or province of the statute.

  - **Description**: Text you enter describing this statute of limitations item.

  - **Statute Deadline**: The deadline imposed by the statute.

- **Subrogation Notes**: You can view, but not enter, the latest notes affecting subrogation. You add these notes by using the **Actions** → **New Note** screen and choosing **Subrogation** as the **Topic**.

Responsible Party Detail Tab

This screen reprises the **Responsible Parties** table in the **General** tab. Select any party from this table and edit all contact or other information, which is key to deciding whether to collect and how to attempt to collect from this party. 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 100% or less.

- **Expected Recovery %**: This field is your estimate of the actual amount that you expect to recover. If the Script Parameter `GlobalUtilizeRecoveryReserves` 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` typelist, are limited in the base configuration to the values `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 pursing a subrogation recovery against this responsible party. The choices come from the `SubroStrategy` 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.

- **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.

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 through Subrogation**: The portion of the **Total Amount Recovered** for the cost type Claim Costs and the recovery category Subrogation.

- **Scheduled Payment**: Choosing **Yes** opens additional fields that can help in tracking the expected recovery receipts. See "Promissory Notes and Arbitration Settlements" on page 278 for details.

Financials Tab

The **Financials** tab shows the key 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 278 for more information.

The **Financials** tab shows the following tables:

- **Responsible Parties Table**: Contains for each party the **Liability %, Expected Recovery %, Actual Recovery,** and the **Actual % recovered through Subro,** based on the total payments made.
- **Reserve Lines for Claim Costs Table**: Contains for each reserve line the amount **Paid, Net Paid (excluding Subro Recovery), Subro Recoveries** amount, and **Actual % Recovered** of the amount **Paid.** It is represented by the subrogation recoveries.

Following are some industry best practices that the base configuration of ClaimCenter uses to display financial information related to recoveries. This feature might 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 273 for a visual representation of these strategies.

You enter the **Strategy** in the **Responsible Parties** subtab. The **Strategy** field lists as options the common ways to proceed. You can choose to add rules using 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` typelist.

Liable Party is Uninsured

- **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** section.
- **Drop Pursuit**: Often, the time and cost of recovery is not worth it.

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 278.

Liable Party is Insured

- **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**: Often, the time and cost of recovery is not worth it.

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 149.

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 **Update Open Recovery Reserve to Expected Recovery?** button to update recovery reserves. This 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%.

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

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, edit the responsible party in the Responsible Party Detail tab

1. Click **Subrogation** in the sidebar menu to open the **Subrogation** screen.

2. Click the **Responsible Party Detail** tab and edit the **Responsible Party**.

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. In the **Scheduled Payments** table, add **Date of Planned Payment** and **Installment Amount** for each recovery you expect.

Closing the Subrogated Claim

Typically, you do not close a claim while a subrogation is pending. ClaimCenter prevents you from closing a claim if any of the following conditions are 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 selected **Other Party at Fault** and the total **Liability %** is less than 100%.
- If you selected **Insured at Fault** and the **Insured's Liability %** is less than 100%.

Although 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
GlobalUtilizeRecoveryReserves	**Administration** tab → **Script Parameters** in the user interface.	You must set it to True for the following buttons and fields to appear in the **Financials** tab of the **Subrogation** screen: • The **Update Open Recovery Reserve to Expected Recovery?** button next to the **Edit** button at the top of the tab • On the **By Reserve Lines** list view, the **Open Recovery Reserves** field, and the **Anticipated Recovery %** field.
UseRecoveryReserves	The `Financial Parameters` section in the `config.xml` file in Studio.	This parameter set to `true` enables recovery reserves to show in the **Financials** tab of the **Subrogation** screen.
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 Claims Supervisor roles:
- `viewsubrodetails`
- `editsubrodetails`

Roles Used in Subrogation

The subrogation feature uses these roles:
- Subrogation Owner (exclusive to exposure)
- External subrogator
- 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 Studio. Navigate to **Rule Sets** → **Preupdate** → **ClaimPreupdate**.

The following descriptions are scenarios for subrogation rules you could 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, an activity with an activity pattern of type *55,* 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 using its particular template.

Subrogation Data Model

Subrogation uses the following typelists:

Subrogation Typelist	Values
AdversePartyDenialReason	License Suspended or Policy Lapsed
MatterType	Arbitration or Lawsuit
StatuteLimitationsType	State Involved, City Involved, Medical, Damage, Other
SubroClassification	Insured or Uninsured
SubroClosedOutcome	Closing outcomes: Full Recovery, Compromised, Uncollectable, or Discontinued
SubroGovernmentInvolved	Yes or No; categories of StatuteLimitationsType
SubrogationStatus	Review, Open, Closed
SubroSchedRecoveryType	Prommissory Note, Arbitration Settlement
SubroStrategy	Pursue against insurer, Negotiate against insurer, or Arbitration (against insurer), Pursue or Utilize Collection Agency (against uninsured), Lawsuit, Drop Pursuit (both insured and not)

The following entities support subrogation:

Entity	Description
Claim	There are three fields on `Claim` that are related to subrogation: • `SubrogationStatus` – Type key to `SubrogationStatus` • `SubrogationSummary` – Foreign key to `SubrogationSummary` • `subrogator` – Derived property returning `Contact`, the external subrogation firm for the claim
Matter	There is a field on `Matter` that is related to subrogation: • `SubroRelated` – Boolean indicating if the matter has a related subrogation
StatuteLimitationsLine	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. The `SubrogationSummary` entity has an array key, `StatuteLine`, to support multiple statute limitations.
SubroAdverseParty	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 foreign keys to `Contact` and `SubrogationSummary`. 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.
SubrogationSummary	Represents a subrogation for a claim. An object of this type is instantiated for every new claim.
SubroPaymentSchedule	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.

Lines of Business

chapter 31

Homeowner's Line of Business

Guidewire designed the ClaimCenter Homeowner's line of business to collect the data needed to track, manage, and if necessary, pay on the claim. Claimants file Homeowner's claims usually when a loss occurred at the claimant's property that affected either the property itself or the contents therein. Claimants can also file a claim if someone was injured on the property as well.

ClaimCenter handles these claims and provides the following benefits:

- **Summary information located in one place**: you can quickly understand the current status of the claim and whether you need to take action.
- **View the policy** in a policy administration system (PAS)
- **Streamlined FNOL** means that the claims intake process for claims is streamlined and claims can be quickly captured.
- **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** in the claim intake process.
- **Scheduled items are automatically pulled into the claim**.
- **Manage contents.** You can manage damaged items on a claim including scheduled items.

This topic includes:
- "Homeowner's Screens" on page 285
- "Homeowner's Types" on page 288

Homeowner's Screens

The homeowner's line of business contains screens that specifically capture information that is needed to process that type of claim. ClaimCenter organizes that data in meaningful sections. This section provides sample screens and descriptions of fields that specifically pertain to this line of business.

The following sections contains these topics:
- "Summary Screens" on page 286

- "Loss Details Screens" on page 286
- "Policy Screens" on page 287

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. To learn specifically about Claim Performance Monitoring see "Claim Performance Monitoring" on page 315.

Loss Details Screens

The **Loss Details** screens contain information about the loss as it specifically relates to homeowner's, and are organized into: **Loss Details**, **Associations**, **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 were selected in the FNOL process and the questions were answered, then the damage types show the answers to the Fire and Water questions.
- **Loss Items**: The incidents are listed as follows.
  - **Dwelling**: There can only be one loss related to dwelling. This section contains sections which describe the damage, repairs (if any), services, and related exposures.
  - **Injury**: Captures information about people who may have injuries.
  - **Living Expenses**: The living expenses incident is associated with the *loss of use* coverage type. This section captures information if the claimant needs to live or eat elsewhere and any related exposures.
  - **Other Structure**: This section captures information about structures other than the main dwelling, such as a second building (a shed or artist's studio for example). This the also the section to enter data if a shared fence was damaged.
  - **Property Liability**: Use this section to capture any damage to third party property.
  - **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. See the *Line Items* section for details.

  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.
- The **Line Items** section is where you can work out the details of how the claimant is to be reimbursed. To learn more about how to do this, see the *Line Items* section.
- **Witnesses**: in edit mode, you can list witnesses that may 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 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.
- **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** tab is not enforced. If you want to use that feature for ISO or any other stationary reporting organization, then 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 workaround is to set configuration parameter `EnableClaimantCoverageUniquenessConstraint` to `false` in `config.xml`.

Line Items

A claimant's policy can contain specific items which are mentioned in the policy. Examples could include a heirloom grandfather clock, or a wedding ring. If these items are damaged or stolen, how does an adjuster determine those amounts? That 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, they are either reimbursed by the RCV or the ACV.

- **Replacement Cost Value (RCV)** is 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 your property with new, identical, or comparable property. For example, five years ago you 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 you for the item is $125, plus sales tax.

- **Actual Cash Value (ACV)** is 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 = 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 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 you used it for five years, the table might 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 pays you for the table is $62.50, plus sales tax (current replacement cost, $125, plus sales tax, less 50% depreciation).

Homeowner's 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 to it. For example, if there was a large accident at work and several claimants, you might associate all the claims together.

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 101.

Policy Screens

The **Policy** screens contain information related to the policy. ClaimCenter organizes them into: **General**, **Locations**, **Endorsements**, **Statistical Data**, and **Aggregate Limits** sections.

- In the **General** section, you can: 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 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.

Action	Description
View the policy in a policy system	If ClaimCenter is integrated with a policy administration system or with Guidewire PolicyCenter, then a new browser window opens into that application.
	See *ClaimCenter Integration Guide* for details.

This screen contains information related to the policy, such as policy number, type, dates, status, data on the insured, agent, underwriter and other related information. Again, to edit this information is to de-verify it as it derives from a PAS.

See "Working with Policies in Claims" on page 71 to learn more.

- The **Location** section contains address details of the locations besides 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. Again, adding or deleting locations deverifies the policy.

- The **Endorsement** section lists any endorsements that might be on the policy. For example, your homeowner's policy has a limit of $4000 USD for jewelry, but you decide to have a separate endorsement for your very expensive heirloom necklace.

- The **Statistical Data** section can contain additional information from the PAS that is specific to the carrier.

Homeowner's Types

To understand the relationships between coverages, subtypes, exposures, and incidents, it might be useful to see this in Studio. Navigate to **configuration → Lines of Business → LossType → Property → Homeowner's**. Expand the subfolders as seen in the example for the travel line of business under "Personal Travel Coverage Types" on page 294.

The following table lists the homeowner's coverage types, subtypes, exposures, and incidents.

Coverage type	Coverage subtype	Exposure type	Incident
Dwelling	Dwelling - PropertyDamage	Dwelling	DwellingIncident
Earthquake	Earthquake DWL - PropertyDamage	Dwelling	DwellingIncident
	Earthquake - Other Structure - PropertyDamage	Other Structure	OtherStructureIncident
	Earthquake - Personal Property Damage	Content	PropertyContentsIncident
Flood	Flood - Dwelling - PropertyDamage	Dwelling	DwellingIncident
	Flood - Other Structure - Property Damage	Other Structure	OtherStructureIncident
	Flood Personal Property - Personal Property Damage	Content	PropertyContentsIncident
Liability - Medical Payments to Others	LiabilityMedical Payment to Others - MedPay	Med Pay	InjuryIncident
Loss of Use	Loss of Use Damage	Living Expenses	LivingExpensesIncident
Mold	Mold - Property Damage	Dwelling	DwellingIncident
Other Structure	Other Structures - Property Damage	Other Structure	OtherStructureIncident
Personal Liability	Liability - Property Damage	Property	FixedPropertyIncident
Personal Property	Personal Property Damage	Content	PropertyContentsIncident
Schedule Property	Scheduled Property - Personal Property Damage	Content	PropertyContentsIncident

chapter 32

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 travel. The policy usually 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 a 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

This topic describes why someone might purchase a travel policy, which has a policy type of personal travel. The topic also describes items that are not covered under this policy.

Use Cases

The following are some of the reasons why you would purchase a personal travel policy.

Personal Property/Baggage/Contents

Covers scenarios such as:

- Losing a bag with personal possessions in a foreign country and needing to 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.
- Filing 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.
- Losing 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 or hotel or rental car due to a death in the family, with proof. The carrier pays cancellation fees for all bookings as well as agent fees, if applicable, up to the maximum covered.

Delay

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 and provide 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

A health related cost for a disabling injury, sickness, or disease. Costs can include medical bills, ambulance costs, accommodation costs, and so forth, which are paid. However, the insured cannot have any associated pre-existing conditions in the set time period.

Rental Car

The insured has an accident in a rental car. The auto policy covers a portion of all damages incurred. The rental car coverage pays excess for auto damages over the purchased auto rental insurance. The insured is liable for any 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

Some Items Are Not Covered

A 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 locking the car, hotel room, or leaving possessions unattended

Working with the Travel Line of Business

This section describes how to work with a personal travel claim by using the New Claim wizard.

To create a new travel claim

1. Navigate to the **Claim** tab and select **New Claim**.

    The New Claim wizard opens and, under Step 1, you must find a policy to associate it with.

2. After finding the policy, enter a loss date. At this point, you can use either the New Claim wizard or the Quick Claim Baggage or Quick Trip Cancel wizards. This example uses the New Claim wizard.

3. Step 2 gathers information. Optionally, edit the contact information.

4. Use step 3 to enter loss details. Select a loss cause where you can create the following type incidents: trip, baggage damage, injury, vehicle, and property damage.

5. In step 4, you assign the claim and exposures and save your claim.

Personal Travel Screens

The travel line of business contains screens that specifically captures 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 first entering the claim. The adjuster can 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:

- "Travel Summary Screens" on page 291
- "Loss Details Screens" on page 292

Travel Summary Screens

The **Summary**, **Claim Status**, and **Claim Health Metrics** screens contain information that is relevant for you to determine the status of a claim, as seen in the example that follows. You immediately know:

- How long the claim has been open.
- What occurred —claimant lost her passport.
- Have any monies been paid?
- Are there any high risks to this claim?
- What exposures are on the claim and their status.
- Where the incident occurred.
- Who was involved.
- Any planned activities.

From the **Summary** screen, you can click directly on an exposure under the **Exposures** section. Clicking an exposure opens the **Exposures Details** screen, in which you can edit, assign, create a reserve, or close the exposure.

To learn specifically about Claim Performance Monitoring see "Claim Performance Monitoring" on page 315.

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**.

The editable **Loss Details** screen contains the following sections:

- **Loss Details** – Contains information about the incident. Of note is the drop down menu **Loss Cause** which you can think of it as loss *because* (for example, loss because the passport document was lost.) This list is configurable.

- **Loss Location** – Contains geographical details 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 exactly were they located when they witnessed the incident.

- **Contributing Factors** – Additional information if applicable. For example, the default choices for **Category** are driver or environmental conditions. You can enter data such as that the driver was driving too fast or that the highway had no barrier.

- **Loss Items** – Incidents listed as follows:

- **Trip** – Captures details of a trip *incident*, which is a subtype of `Incident`. Editing this section displays 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 as seen in this example.

- **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 learn how do calculate the value of a line item the details of how the claimant is to be reimbursed, see the *Line Items* section later in this section.

- **Injuries** – Shows the **Injury Incident** screen. Enter any injury details.

- **Vehicles** – Captures information on any vehicles that were involved.

- **Properties** – Property incident associated with the *liability* coverage type, `PropertyDamage-Vehicle` coverage subtype, *vehicle damage* exposure type, and *vehicle incident*, incident type.

- **Officials** – Official involved, such as a police officer or coroner, who wrote a report. If there was one, you can enter it that information in this section.

Note: In the base configuration, the **ISO** tab is not enforced. If you want to use that feature for ISO, or any other stationary reporting organization, then 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, how 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) or actual cash value (ACV). The reimbursement type depends on the type of coverage the insured has.

- **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 insured paid $100, plus sales tax, for a camera. It 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 *with* 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 the insured paid $100, plus sales tax, for a camera. Since ACV is the current replacement cost less depreciation, the adjuster must consider *wear and tear*, if any. If the camera had a reasonable life expectancy of 10 years, and the insured 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 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, you enter that limit into the **Limit Amount** field. Because 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 it. For example, if there was a large accident at work and several claimants, you could associate all the claims together.

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 101.

Personal Travel Coverage Types

Personal travel has the following coverage types:

- **Baggage** – General coverage for items such as suitcases, the contents of suitcases, personal property, such as electronics, cell phones, cameras, and wallets, and documents, such as passports.
- **Health** – Medical payments.
- **Hired Auto** – Generally, excesses for hired or rented autos.
- **Liability** – Third party liability.
- **Trip** – If the journey was canceled or delayed.

To understand the relationships between coverages, subtypes, exposures, and incidents, it might be useful to see the Travel line of business in Guidewire Studio. Navigate to **configuration** → **Lines of Business** → **Travel**. Expand the subfolders as seen in the following example.

In this example you see the following:

- Coveragetype is Baggage
- CoverageSubtype is Baggage - Loss, Damage or Delay
- ExposureType is Baggage
- Incident is BaggageIncident

chapter 33

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 with permanency and awards may 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 benefits:

- **Summary information located in one place** – You can quickly understand the current status of the claim and whether you need to take action.
- **Medical details grouped in sections for convenience** – Includes views of summary information, details, and medical case management.
  - **Listing Medical diagnosis** – Tracks diagnosis to injury using international standards.
  - **Medical notes** – Automatically marked for security reasons, so that only those with certain permissions can view them.
- **Time Loss** – Contains benefit information such as type of disability, waiting period, and other jurisdictional factors that you can modify.
- **Search** – For workers' compensation claims by injured worker.
- **Automatic creation of injury incident and two exposures** – In the base configuration, exposures—Medical Details, Time Loss, and Employer Liability—are located on the left pane of the user interface for convenience.

This topic includes:

- "Workers' Compensation Administration" on page 306
- "Workers' Compensation Types" on page 306

Workers' Compensation Overview

The New Claim wizard for workers' compensation can automatically create an injury incident and the Medical Details and Time Loss exposures, depending on how much data is entered. After creating the claim, you then can then create an Employer Liability exposure. You can access all exposures from the left pane.

Medical Details Exposure

Create a Medical Details exposure in the **Loss Details** step of the wizard based on 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** for **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, then you can add that exposure by navigating to the **Loss Details** screen and selecting **Yes** for **Employer Liability.** This selection creates the exposure, and it becomes accessible from the left pane of the user interface.

Workers' Compensation Screens

The workers' compensation line of business provides screens that capture information specifically needed to process that type of claim. Many times, an adjuster needs to see the information in order to process the claim efficiently. ClaimCenter organizes that 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 first entering the claim. The adjuster would need to return to the claim either to add more information or to work on the claim. This section provides sample screens and descriptions of fields that specifically pertain to this line of business.

This topic includes:

- "Workers' Compensation Summary Screens" on page 298
- "Loss Details Screens" on page 300
- "Medical Details Screens" on page 301
- "Time Loss Screens" on page 302
- "Finding Injured Workers" on page 304

Workers' Compensation 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, as seen in the following example. To learn specifically about claim performance moni-

toring see "Claim Performance Monitoring" on page 315.

Loss Details Screens

The **Loss Details** screens contain information about the loss as it specifically relates to workers' compensation and are organized into: **Loss Details**, **Associations**, **Special Investigation Details**.

The editable **Loss Details** screen contains the following sections:

- **Loss Details** – Information about the injury and where it occurred.
- **Injured Worker** – Standard information about the claimant.
- **Employment Data** – 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 show on the **Info bar** and **Summary** screen.
- **Classification** – ClaimCenter groups in one location the different 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** link becomes available on the left pane.
- **Key Dates** – Contains the date of injury, notification to employer, time of injury, and so forth.
- **Notification and Content** – Captures the information regarding how the injury was reported, who reported it, and who is the main contact.
- **Compensability Factors** – Helps you determine if the claim is compensable by asking a set of questions.
- **Compensability Decision** – Captures compensability details related to jurisdiction, such as 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** – Specify the area of the body that was injured and if a decision was made whether to accept or deny compensability.

- **Job Details** – List a claimant's employment history and possible current other jobs to help 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.

    Note: In the base configuration, even though you see the ISO tab, you must first enable it.

Associations Screen

Use this screen to associate any other claims to 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

This section contains a question set that, depending on the answers, could trigger an investigation to rule out fraud. To learn about this feature see "Claim Fraud" on page 101.

Medical Details Screens

The Medical Details screens are organized into Summary, Details and Medical Case Mgmt tabs, and there are several actions that you can perform.

- **Edit** – You can edit certain fields, such as the Alternate Contact field or Nurse Case Manager.
- **Assign the exposure** – You can assign the exposure to someone else, either by using automated assignment or by directly finding another adjuster.
- **Close the claim** – If you close the claim, then select an outcome from the drop-down menu. Default choices include completed, duplicated, fraud, mistake, payments complete, and unnecessary.
- **Create a reserve** – 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 tab provides the following sections:

- **Exposure** – Basic information related to the exposure, Workers' comp-medical, including 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.
- **Body Parts** – Lists the areas of the body 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.

The Details tab provides the following sections:

- **Medical Provider Network** – Confirms if the physician and the injured worker are in the medical provider network.
- **Maximum Medical Improvement** – Note the date if the claimant has reached the maximum medical improvement (MMI) limit. The MMI limit is the point at which the claimant's condition cannot be improved any further or when a treatment plateau is reached. It can also mean that the claimant has fully recovered from the injury. It can also indicate that the medical condition has stabilized sufficiently that 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** – Initial provider records what the claimant is complaining about and assesses the condition based on their medical background.
- **First Report of Injury** – Critical information including who was the attending doctor and what the diagnosis was.
- **Settlement**: was there a settlement date and method?

The **Medical Case Mgmt** tab provides the following sections:

- **Medical Personnel** information.
- **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. To learn more about these codes, see "ICD Codes" on page 417.

  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 at **Medical Details** screen → **Medical Case Mgmt** tab → **Medical Diagnosis** section. In a personal auto claim, it is located at: **Loss Details** screen → select a person under the **Injuries** section → **Injury Incident** screen, click **Edit**.

  Typically, an adjuster receives a form with one or more ICD codes. These codes are entered on the **Medical Case Management** screen and can additionally be viewed on the **Summary** tab of the **Medical Details** screen. If there is more than one code, you must make one primary. Making a code primary is necessary for sovereign organizations, such as ISO in the United States.

  You can also enter dates and comments, and you can mark 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.

- **Medical Treatment Approvals** – List the medical treatments that have been approved for the claimant.
- **Medical Actions and Information** – List the actions, date, and other information.

Time Loss Screens

The **Time Loss** screens are organized into: **Summary** and **Benefits** tabs, and there are several actions that you can perform that are the same as in the previous topic.

The **Summary** tab contains the following sections:

- **Exposure** – Identifies the type of exposure and if there is a statistical line.
- **Return to Work** – Indicate if the injured employee can return to work with full or modified duties.
- **Compensation** – 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** – Record basic information about when the claim was first entered into the system.
- **Financials** – Some of the financial information is repeated in this section for convenience and hence it is not editable.

Use the **Benefits** tab to add or remove your defined benefit periods. The **Benefits** tab contains 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.
- **Waiting Period** – While this section gets its data from the *Jurisdictional Benefit Calculation Management* section, it is editable.

  The following four sections derive their data from jurisdictional parameters that are entered through the **Administration** tab → **WC Parameters**. What you can do in this section is *manually override* those amounts. Definitions of the following are located in the "Jurisdictional Benefit Calculation Management" on page 305 section.

- **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** tab → **WC Parameters** so that they display in the **Benefits** tab.

- **Other Jurisdictional Factors** – This section is not editable and gets its data from the **WC Parameters** section. This is additional information that a carrier can capture.
- **Settlements** – Lists if there were any settlements on the claim.

Employer Liability Screen

Employer Liability is another exposure and as such the **Employer Liability** screen contains the following sections:

- **Exposure** – Identifies the type of exposure.
- **Damage** – List any damage and the loss estimates that came from it.
- **Settlement** – Enter a date and the type of settlement that was conducted.
- **Coding** – You can enter the jurisdictional state.
- **Financials** – Summarizes the exposure's key financials in one location.

Compensability Decision

Compensability decision refers to determining if a workers' compensation claim is valid, and hence payable. There are several factors to consider when deciding this. For example, an adjuster may ask a series of questions, such as: Was safety equipment used? Was the person using illegal substances? The adjuster also needs to deter-

mine 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.

Compensability Decision Based on Jurisdiction

Carriers must adhere to the *jurisdictional* deadline to accept or deny the claim. This deadline changes by jurisdiction but is based one of the following criteria:

- 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. 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 specified 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 the **Administration** tab → **WC Parameters**. See "WC Parameters" on page 414 for details.

Working with Jurisdictional Compensability

ClaimCenter generates an activity whether to accept or deny compensability (Determine Compensation). This activity is based on the **ActivityPattern** *claim_acceptance*. You can see this in one of the following locations:

- Your **Desktop** → **Activities** list.
- The **Loss Details** screen → **Compensability Decision** section. The due date displays, and if you click the **Update: Determine Compensability** button, ClaimCenter displays 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**, then 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 reference table, the reference data is utilized to indicate which formula to use.

- **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 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 default escalation date is three days prior to the due date. The claim's **Compensability Due Date**— `Claim.DateCompDcsnDue`—is also set to the activity's due date.

Finding Injured Workers

Because a company can have more than one injured worker, ClaimCenter can be configured so that you can sort by injured worker. View from:

- The adjuster's **Desktop** → **Claims** link
- On the **Claim Search** screen

For all users, there is a column whose header is **Claimant** on those two areas. This column is not sortable. For many claim types, such as in 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 becomes sortable.

See Also

- "To Change a Role's Sort Criteria" on page 406

Jurisdictional Benefit Calculation Management

One of the key activities that a workers' compensation adjuster performs is calculating the payments for lost time—Time Loss exposure—due to disabilities. You can see this on the **Time Loss → Benefits** tab. Benefits calculations for the following categories vary by jurisdiction in accordance with regulatory formulas.

The areas include:

- **Temporary Disability (TD)** – An employee is injured, but the expectation is that the employee will make a recovery or return to work. There are two types of TD:

  - **TPD - Temporary Partial Disability** – An employee is injured on the job, but can work in a reduced capacity. For example, the worker fell and sprained a wrist.

  - **TTD - Temporary Total Disability** – An employee is injured on the job, cannot return to work, and is entitled to receive TTD benefits during the convalescence. For example, a worker is injured at work and requires surgery. The worker cannot perform work duties for some period of time.

- **Permanent Disability (PD)** – If the injured worker is still totally or partially disabled once the maximum medical improvement (MMI) has been reached, then permanent disability benefits are determined.

  - **PPD - Permanent Partial Disability** – An example of this is an employee whose finger is cut off or loses an eye. The loss is permanent but at some point they can still work. PPD may 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/administrator can calculate and enter those amounts in the **Administration** tab → **WC Parameters** screens. The calculations, which are contained in Gosu code, use those numbers. For example, you can calculate the *comp rate*, the weekly benefit for the injured worker based upon their `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** tab from within a claim.

Jurisdictional Waiting Period

Another key component to managing Benefit Payments is understanding the jurisdictional waiting period. Each state can mandate a set amount of days before paying benefits. The **Waiting Period** section, on the **Benefits** tab displays:

- **Waiting Period Applied**
- **Waiting Period Days**
- **Retroactive Period**

See Also

- "WC Parameters" on page 414 to learn about the calculations and how to administer the benefits. In this topic, you can also find out about the workers' compensation reference tables that are available in the user interface.

Workers' Compensation Administration

There are several areas in the user interface where you can change workers' compensation settings if you have administration permissions. You can make the following settings:

- **WC Parameters** – Enter the benefit parameters, PPD minimum and maximum values, PPD weeks, and denial period information. See "WC Parameters" on page 414.
- **IC Codes** – Administer the codes that are used in for medical diagnosis. See "ICD Codes" on page 417.
- **Role Sort Criteria** – Change a user's role so that they can sort by injured worker instead of by claimant. See "To Change a Role's Sort Criteria" on page 406.

For a list of related permissions, see "Workers' Compensation Permissions" on page 416.

Workers' Compensation Types

To understand the relationships between coverages, subtypes, exposures, and incidents, it might be useful to see this line of business in Studio. Navigate to **configuration** → **Lines of Business** → **LossType** → **Workers' Comp** → **Workers' Compensation**. Expand the subfolders in a similar manner to the travel line of business under "Personal Travel Coverage Types" on page 294.

The following table lists the workers' compensation coverage types, subtypes, exposures, and incidents.

Coverage type	Coverage subtype	Exposure type	Incident
Workers' comp-employer's liability	Workers' comp - Employer Liability	Employer Liability	Incident
Workers' comp-indemnity	Workers' comp Indemnity - Time loss	Time Loss	InjuryIncident
Workers' comp-medical	Workers' comp - Medical Details	Medical Details	InjuryIncident

chapter 34

Configuring Your Lines of Business

A line of business (LOB) is a business unit that is independent of other business units in a company. A key feature of ClaimCenter is its ability to model the responsibilities of each business unit of an insurance carrier. In this way, you model the business structure of your carrier, and tell ClaimCenter how to customize its displays and methods of handling claims for each part of your business. This modeling is accomplished by a series of type-lists, which

- Define what each LOB does, including the policies it writes and the coverages they contain (the relationship between the `policyType` and `coverageType` typelists)
- Relate the LOBs to each other by the types of losses they cover (the relationship between the `LOBCode` and `lossType` typelists)
- Associate ClaimCenter exposures with coverages (the `coverageSubtype` typelist, which relates the `coverageType` and `exposureType` typelists

See "Coverage Subtype Relates Coverages to Exposures" on page 309.

ClaimCenter has a set of typelists containing typical LOB elements to model these business types (besides defining new ones):

- Personal and commercial auto
- Personal and commercial property loss, including inland marine (trucking) and cargo
- General liability (for both professionals and business owners)
- Workers' compensation

This topic includes:

LOB Typelists

ClaimCenter uses these typelists to configure the displays you see when entering a new claim and working with existing ones.

Loss Type: A category of activity which is an industry standard for insurance activity. Defining the loss type is one of the first steps in starting a new claim. It is a way of grouping your lines of business together.

LOB Code: a type of work handled by one business unit of an insurance company. This is typically defined in the Loss Details page of the FW and the claim. Many LOBs handle the same type of loss. For example, personal and commercial auto LOBs both sell policies covering losses from vehicles.

Policy Type: A product, or policy, sold by an LOB unit. It pays damages for certain defined loss events. One business unit can sell many types of policies. A given policy can be sold by many LOBs, so `PolicyType` and `LOBCode` have a many-to-many relationship in the data model.

Coverage Type: A subdivision of a policy which deals with one type of loss covered by the policy. For example, a PIP policy could have medical, lost wages, and death coverages, so you can associate many coverages with a specific policy. This defines the product sold. Also, a particular coverage can be part of many policies. Thus, `PolicyType` and `CoverageType` are related in a many-to-many relationship.

Coverage Subtype: A typelist devised for defining a unique mapping between one coverage type and one exposure type. This special typelist enables defining exact coverage-to-exposure pairs. These facilitate precise claim filing and data validations without compromising the flexibility and additional querying power afforded by the many-to-many relationship of exposure type to coverage type.

Exposure Type: An exposure is a single type of loss paired with a single coverage type. A claim's exposures relate coverages to claimants. For example, an auto accident claim would typically have an exposure for the owner of each vehicle damaged, as well as one for each person injured.

Typecodes Defining Lines of Business (LOB's)
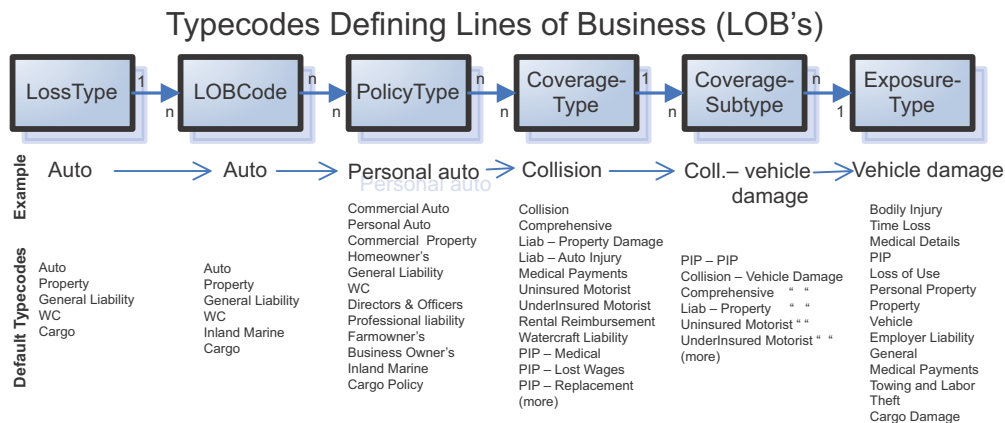
Relationships Among LOB Typelists

LOB typelists are related tightly to each other. Any pair of adjacent typelists refer to each other, using typecodes for the two-way references. Because of these two-way relationships, it is complicated to add and remove entries while keeping the pairings correct. Guidewire Studio simplifies this process by helping you change any typelist, then changing both adjacent typelists.

Coverage Subtype Relates Coverages to Exposures

The CoverageType and ExposureType typelists have a many-to-many relationship, yet still have a one-to-one relationship between any single typecodes in the two typelists. The CoverageSubtype typelist creates this set of relationships, as shown by this diagram:
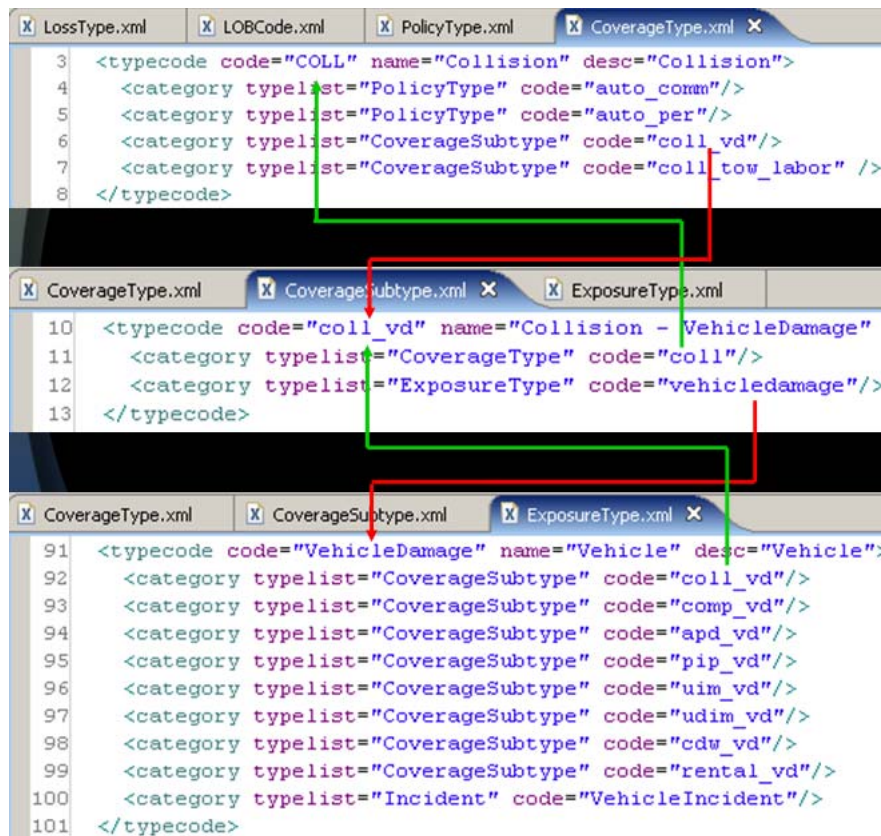
Coverages and Policies

After you obtain a policy snapshot or refresh, ClaimCenter transfers coverages from the policy. However, coverages in a policy are typically more detailed than what is needed for the application's use. For example, a policy holder can have several coverages that apply to property damage. In the base configuration, the snapshot contains only one of these coverages, however, you can configure it to your business requirements. The following table contains a list, by LOB, of the coverages used in PolicyCenter. It shows which ones are used by ClaimCenter, and which ones are not transferred. The actual aggregate limit for a coverage can be lower than the policy's total aggregate limit; only the coverage limit of the coverage used applies to the aggregate limit.

The coverages used are typecodes in new LOB typelists. Workers' compensation and homeowner LOBs use unchanged typelists.

Personal Auto Coverages use this Changed LOB Typelist

After the LOBCode typecode is Auto(auto), and the PolicyType typecode is Personal auto (auto_per), the associated CoverageType, CoverageSubtype and Exposure typecodes for ClaimCenter.

Coverage type	Coverage subtype	Exposure type
Collision (coll)	Collision - VehicleDamage	VehicleDamage
	Collision - Towing and Labor (coll_tow_labor)	VehicleDamage
Comprehensive (comp)	(removed) Comprehensive - Theft	
	Comprehensive - VehicleDamage	VehicleDamage
	Comprehensive - Towing, Labor (comp_tow_labor)	VehicleDamage
Liability -Physical damage (apd) name changed to Property Damage	(new) Liability - PropertyDamage-Property (WAS: Auto physical damage - VehicleDamage) (apd_pd)	PropertyDamage
	Liability - PropertyDamage-Vehicle (WAS: Auto physical damage - VehicleDamage) apd_vd	VehicleDamage
Liability - (abi) Bodily Injury	Auto bodily injury - BodilyInjury Damage	BodilyInjuryDamage
	(removed) Auto bodily injury - MedPay	(removed) MedPay
	(removed) Auto bodily injury - GeneralDamage	(removed) GeneralDamage
Medical Payments(mpay)	(removed) Medical payments - GeneralDamage	
	Medical payments - MedPay	MedPay
	(removed) Medical payments - BodilyInjuryDamage	
Uninsured Motoris(uim)	Uninsured Motorist - BodilyInjuryDamage (uim_bid)	BodilyInjuryDamage
	Uninsured Motorist - VehicleDamage (uim_vd)	VehicleDamage
	(removed) Collision Deductible Waiver - VehicleDamage (cdw_vd)	
Underinsured Motorist(udim)	Underinsured Motorist - BodilyInjuryDamage (udim_bid)	BodilyInjuryDamage
	Underinsured Motorist - VehicleDamage (udim_vd)	VehicleDamage
Towing and Labor (TOWLABOR)	Towing and Labor (towlabor_Towlabor)	VehicleDamage
Rental Reimbursement(rental)	Rental - VehicleDamage (rental_vd)	VehicleDamage
Watercraft Liability(watercraft)	Watercraft - GeneralDamage (watercraft_gd)	GeneraliDamage
PIP	PIP - PIP	PIPDamages
PIP Medical (PIP_MED)	PIP Medical (pip_med)	PIPDamages
PIP Rehabilitation (PIP_RHB)	PIP Rehabilitation (PIP_RHB)	PIPDamages
PIP Lost Wages (PIP_IL)	PIP Lost Wages (PIP_IL)	PIPDamages
PIP Funeral (PIP_FUN)	PIP Funeral (PIP_FUN)	PIPDamages
PIP Death (PIP_DTH)	PIP Death (PIP_DTH)	PIPDamages
(removed) PIP Replacement (Essential) Services (PIP_ESS)	(removed) PIP Replacement (Essential) Services (PIP_ESS)	PIPDamages
(removed) PIP Optional Basic Economic Loss (PIP_OBEL)	(removed) PIP Optional Basic Economic Loss (PIP_OBEL)	PIPDamages
PIP Extraordinary Medical (PIP_EXMED)	PIP Extraordinary Medical (PIP_EXMED)	PIPDamages
(removed) Additional PIP Medical (ADD_PIP_MED)	(removed) Additional PIP Medical (ADD_PIP_MED)	PIPDamages
(removed) Additional PIP Lost Wages (ADD_PIP_IL)	(removed) Additional PIP Lost Wages (ADD_PIP_IL)	PIPDamages
(removed) Additional PIP Replacement (Essential) Services (ADD_PIP_ESS)	(removed) Additional PIP Replacement (Essential) Services (ADD_PIP_ESS)	PIPDamages
(new) Additional PIP (PIPADD)	(new) Additional PIP (pipadd_pipd)	PIPDamages

Note: Pay special attention to the typecodes marked as (*removed*) and (*new*).

These tables present the same information as the previous table, but just highlight changes from previous versions of ClaimCenter:

Deleted coverages	Changed coverages	New coverages
		TOWLABOR
PIP_ESS	ADD_PIP_ESS => PIPADD	
	PIP	
	PIP_MED change to PIPMED	
PIP_OBEL	PIP_RHB change to PIPRHB	
ADD_PIP_MED	PIP_IL change to PIPIL	
	PIP_FUN change to PIPFUN	
	PIP_DTH change to PIPDTH	
ADD_PIP_IL	PIP_EXMED change to PIPEXMED	
		PIPADD

Deleted coverage subtypes	Changed coverage subtypes	New coverage subtypes
coll_tow_labor	comp_tow_labor => towlabor_towlabor	apd_pd
abi_gd	ADD_PIP_ESS => pipadd_pipd	pipadd_pipd
abi_mp	PIP to pip_pipd	
mpay_gd	pip_med to pipmed_pipd	
mpay_bid	PIP_RHB to piprhb_pipd	
cdw_vd	PIP_IL to pipil_pipd	
comp_theft	PIP_FUN to pipfun_pipd	
PIP_ESS	PIP_DTH to pipdth_pipd	
PIP_OBEL	PIP_EXMED to pipexmed_pipd	
ADD_PIP_MED		
ADD_PIP_IL		

The LOB Editor does not Update all Associated LOB Typelists

The LOB editor manages the LossType, PolicyType, LOBCode, CoverageType, CoverageSubtype and ExposureType typelists, together with the filtering relationships between these types. However, after the LOB editor is finished, there are other places that reference these typelists and they can need further cleanup. In particular:

- LossParty type is filtered by CoverageSubtype
- CostCategory and LineCategory are filtered by CoverageType
- InsuranceLine is filtered by PolicyType
- ClaimantType, LossCause, MetroReportType, OfficialType, PriContributingFactors, QuickClaimDefault, ResolutionType and SeverityType are filtered by LossType.

Also, there are many PCF files which are modal and based on LossType and ExposureType. These include:

For LossType: LossDetailsDV, NewClaimLossDetailsDV, ClaimPolicyGeneral, ClaimEvaluationDetailsDV, NewClaimLocationsLV, NewClaimPolicyGeneralPanelSet, PolicyGeneralPanelSet, LocationDetailPanelSet, LocationsLV, LocationDetailPanelSet, SubrogationMainDV, SubrogationFinancialsDV, FNOLWizard_BasicInfoScreen, FNOLWizard_NewLossDetailsScreen, and FNOLWizard_AssignSaveScreen.

For ExposureType: NewClaimExposureDV, ExposureDetailDV, and NewExposureDV.

The section on "The Studio Lines of Business Editor" on page 584 in the *Studio Guide* contains a detailed description of what other typelists are related to these typelists. It also explains how to edit them to match your new lines of business.

Other Coverages Use Changed LOB Typelist. These include:

- Business Auto Coverages
- General Liability Coverages
- Business Owners Policy Coverages

ClaimCenter Management

Claim Performance Monitoring

Adjusters can have several hundred open claims at any given time, and their supervisors might manage an average of 12 adjusters. Therefore claim supervisors can be responsible for a book of claims that number in the thousands. ClaimCenter helps these supervisors and adjusters focus on claims that might be problematic and provides tools that can quickly diagnose a claim's status.

Adjusters and supervisors use the *Claim Performance Monitoring* tools in ClaimCenter to proactively manage their claims files. These tools monitor the health of a claim and automatically track the status and health metrics within each claim. Using this information, you can diagnose the health of the claim file and 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, they provide data—metrics. You can see the overall health of a claim and to compare it to your company's specific benchmarks.
- **Claim Reports** – Aggregate key 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** – Located at the top section of the claim **Summary** screen, it presents a view of the most important aspects of a claim.
- **High Risk Indicators** – Visible in an enhanced claim **Summary** screen and persistent on the claim **Info bar**, these indicators provide a risk assessment of the claim. They are also available on the claim startup page.

Use the metrics, coupled with high-risk indicators, icons, and flags to understand certain aspects about a claim quickly and possibly take immediate action. Think of this feature as a multi-prong approach in accessing claims.

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 316
- "Aggregate Reports" on page 319
- "Claim Headline" on page 319
- "The Claim Status Screen" on page 321
- "Administering Metrics and Thresholds" on page 322

See Also

- "Metrics and Thresholds" on page 418 to learn how to administer metrics and thresholds.
- "Configuring Claim Health Metrics" on page 645 in the *Configuration Guide* to see examples of how to configure metrics.
- "Viewing the Guidewire Reports" on page 84 in the *Reporting Guide* to learn about the different types of claim metric reports.

Claim Health Metrics

The **Claim Health Metrics** screen shows how a claim and its exposures perform against target values for the carrier defined metrics. Initially, it provides a fast way for you to understand the claim's health. Then you can compare the claim's health to a defined target. This screen can trigger questions like:

- Why has it been so long since an adjuster reviewed this claim?
- Why is the current reserve so much higher than the initial reserve?
- Why is the expense to loss cost ratio so high?

In the base configuration, ClaimCenter contains pre-configured *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, the exposure level, or both. By comparing a claim's Health Metrics against company-specific targets and service levels, adjusters and managers have information they need to understand the status of a claim. If necessary, they can take the appropriate action. These metrics can be further defined by *tiers*, which provide a finer level of granularity.

The metrics can differ depending on the line of business. For example, **Compensability Decision** applies only to workers' compensation claims.

Benefits of Using Claim Health Metrics

- Real-time information delivered within 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.
- Since ClaimCenter tracks open *and* closed claims for **Claim Health Metrics**, the information is forward-looking and actionable. This means that over time, adjusters can actively work to reduce their cycle times, lower claim related expenses, and improve customer experience. Carriers can change metrics and set new targets for these metrics.

This section contains the following:

- "Claim Health Metric Fields" on page 316
- "Claim Health Metrics Calculations" on page 317
- "Claim Tiers" on page 318

Claim Health Metric Fields

If you view the Claim Health Metrics tab on the Claim Health Metrics screen, you see **Value**, **Target/Service Level**, and **Status** columns.

- **Value –** The calculated value of this metric for the claim.
- **Target/Service Level** – The carrier defined target business value set for this particular metric
- **Status** – The visual representation of how the claim performs against the target values set by the administrator. Statuses include:
  - Green check mark: on target
  - Yellow exclamation point: at risk
  - Red X: requires attention
  - Gray circle: not applicable or is not set by the administrator

ClaimCenter re-evaluates the Claim Health Metric statuses at the end of the pre-update rules. As you view the **Claim Health Metrics** screen, ClaimCenter also evaluates the time-based metrics. At the time the application creates the claim/exposure, it stores the metric target values as a temporal snapshot on the claim/exposure itself. Storing this snapshot means that later changes to the administrative data do not affect the metric targets for that claim/exposure. ClaimCenter also stores the claim/exposure's current metric statuses, not the calculated value of the metric, on the claim/exposure, whenever metrics are re-evaluated. This is for efficiency of reporting. See the "Viewing the Guidewire Reports" on page 84 in the *Reporting Guide* for information the various aggregate claim reports.

If a claim or exposure changes tiers, ClaimCenter uses the current metric limit values defined in the **Thresholds and Metrics** section of the **Administration** tab. If the claim or exposure changes tiers due to some change in information, its metric targets and status are updated. Updating might happen, for instance, when an injury incident is added, and is based on the current administrative settings for the respective tier. See "Claim Tiers" on page 318.

Claim Health Metrics Calculations

The following tables describe how ClaimCenter calculates metrics that vary based on calculations.

Metric	Closing Event	Skipped Event	Open Calculation	Closed Calculation
Days Open	`Claim.Status ==` "Closed"	Not applicable	Days between `Claim.ReportDate` and today	Days between `Claim.ReportDate` and closing event
Initial contact with Insured (Days)	Activity with `ActivityPattern ==` Initial Contact with the Insured activity has `Activity.Status ==` Closed	Activity with `ActivityPattern ==` XX has `Activity.Status ==` Skipped	Days between `Claim.ReportDate` and today	Days between `Claim.ReportDate` and closing event
Time to First Loss Payment (days)	1st escalated payment with `CostType` = Claim Cost	Not applicable	No payment made.	Days between `Claim.ReportDate` and the scheduled send date of the claim cost payment that is escalated *or* the time of the claim's closing if no such payment was made
Days Since Last View - Adjuster	`Claim.Status ==` "Closed"	Not applicable	Days between date last viewed by `Claim.Owner` and today	Not applicable
Days Since Last View - Supervisor	`Claim.Status ==` "Closed"	Not applicable	Days between date last viewed by supervisor of the `Claim.Owner's` and today	Not applicable

Metrics with other calculations

Note: In the default configuration, some metrics are valid for claims and others for exposures. For example, number of reserve changes apply only for claims.

Metric	Calculation
Activities Past Due Date	Count where `activity.status` == Open and `activity.TargetDate` < today
Open Escalated Activities	Count where `activity.status` == Open and `activity.escalated`
Number of Escalated Activities	Count where `activity.escalated == true`
% of Escalated Activities	Count where `activity.escalated` / Count of all activities
# of Reserve Changes	Count starts at 0 after claim's created. List of Reserves to Count: • Regular Positive Reserves Created (one or multiple `ReserveSets` are counted as one change) • Negative Reserves Created List of Reserves not counted: • Zeroing offset Reserves from closed exposure/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 Paid	Paid
Paid Loss Costs as% of Total Paid	(Payments for `CostType` == claimcost) / Total Payments
Incurred Loss Costs as% of Net Total Incurred	(Net Total Incurred for `CostType` == claimcost) / (Net Total Incurred)
% of Reserve Change from initial reserve	Same criteria as # of Reserve Changes, percentage is calculated based on Reserve Amount changes. This is the amount of the reserves that counts in # of Reserve Changes divided by initial reserves. Initial Reserves are defined as: • Any reserves created during exposure creation, or • After creating first approved reserve set on the claim, any reserves created within the `InitialReserveAllowedPeriod` are considered initial reserved. Also, the configuration parameter `InitialReserveAllowedPeriod`, which defines the number of days after first initial reserve, is created. This means that all reserve changes within that period count as initial reserves.
Deferred: % of Reserve Change from initial user set reserve	(Current Incurred net- Initial user-set reserve) / Initial user-set reserve

See "Administering Metrics and Thresholds" on page 322 for detailed information on the organization of metrics and how to administer them from the **Administration** tab.

Claim 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 in 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.

- **Claim Tier Type List** – 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, and it is contained in pre-update rules. You enter metric data through the **Metrics & Thresholds** link 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.

- **Exposure Type List** – A typelist that groups similar exposures.

  Note: While claim and exposure tiers can span policy types, the system manages the targets per policy type per claim or exposure tier.

The system evaluates initial and subsequent tiering claims for which tier it belongs to after first created. Then, as claim information is added or changed, it can change the claim tier. After the claim tier changes, the metrics are recalculated.

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.* As shown in this example, new information can be added to change the tier, so the evaluation for tiering happens at every update on the claim. The pre-update rules evaluate the properties that make up the tiers and re-evaluate those values after the claim changes to see if the claim needs to be re-tiered.

See Also

- Use the **Metric and Thresholds** screen in the **Administration** tab to enter tier values. See "Defining Claim Tiers" on page 323.
- Use Studio to configure tiers. See the *ClaimCenter Configuration Guide* for details.

Aggregate Reports

Aggregated claim reports enable supervisors and managers to see a group of claims based on predefined criteria. To see aggregated claim reports, you must install the InetSoft Style Report Enterprise Edition and have the correct permissions. See the *ClaimCenter Reporting Guide* for details and the list of the base configuration reports.

> **IMPORTANT** ClaimCenter contains similar aggregated metrics functionality as seen through the Team and Dashboard functions. Those functions aggregate values specifically by the group hierarchy based on well defined time frames. Because the system calculates these metrics and runs them separately from the metric level calculations, those numbers might not be consistent with the Claim Metric numbers.

See the "Viewing the Guidewire Reports" on page 84 in the *Reporting Guide* for information the various aggregate claim reports.

Claim Headline

View the claim **Summary** screen to see summarized information relating to the most important aspects of a claim's overall condition. There are visual cues—icons—that ClaimCenter updates on a regular basis. These visual cues

draw your attention to essential information, such as the age of the claim, the level of funding available, and other high risk indicators.
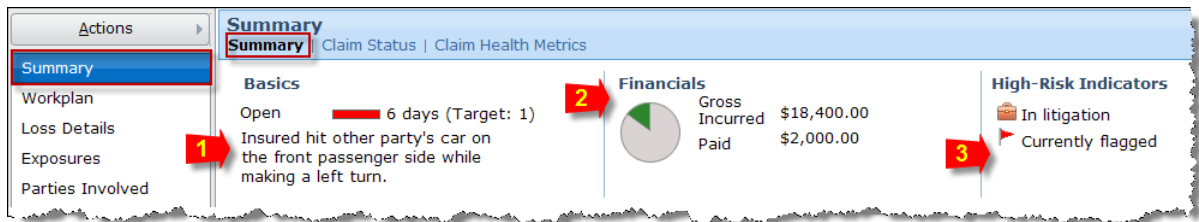
1. The **Basics** section indicates the age of the claim. The number of days and the graphic help you to see if the claim is in critical condition, and if so, for how long. If you have defined company targets, **Basics** also shows the **Target** number of days for the lifecycle of this claim. The description below the graphic is from the **Loss Details** screen.

2. The **Financials** section indicates the a claim's current cost—in other words, the total gross incurred and what monies have been paid to date, if any. These numbers originate from the **Financials** screens. The **Incurred** amount uses the formula of *Gross Total Incurred = Open Reserves plus all payments made today or earlier.* To see additional details relating to this value, click the **Claim Health Metrics** link on the **Summary** screen and scroll to the **Claim Financials** section. Also, you can select the **Financials** link in the left pane to see detailed information.

3. The **High-Risk Indicators** section displays any attributes that make the claim a high risk. View details of these indicators from the **Claim Status** link. For information regarding flags, see "Flags" on page 321.

   Note: These icons are also on the **Info bar**, which is always visible in the claim file.

Other claim details are also visible with a quick scan of the **Summary** screen including **Loss Details**, **Exposures**, **Recent Notes**, **Parties Involved**, **Planned Activities**, **Litigation**, and **Associated Claims**.

Under the **Exposures** section, the **Open/Closed** icon shows whether the exposure is open or closed as seen in the following example. This icon also indicates if the claim is open or closed on the **Info bar** and on the **Claim Status** screen.
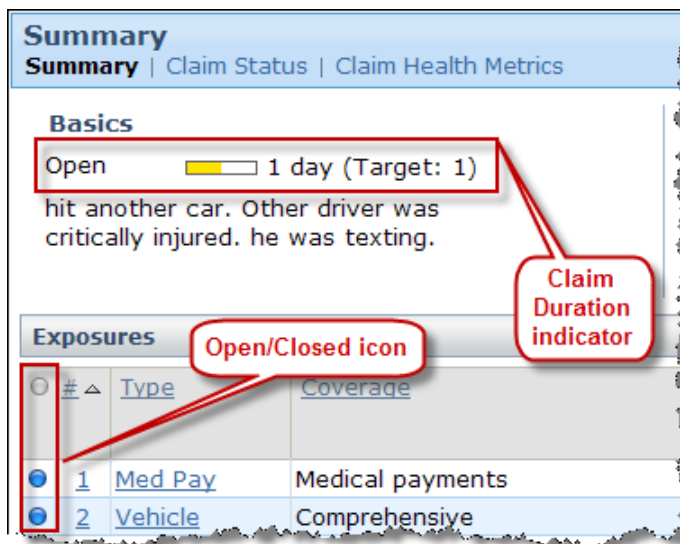
The Claim Status Screen

The **Claim Status** tab on the same named screen provides a deeper level of detail and is organized into a **General Status** and **High Risk Indicators** sections.

> **Note:** Indicators and flags are present on the **Info bar**, which is always visible at the top of a claim, besides the **Summary** screen.

General Status Section

This section displays the status of a claim in several areas. These areas include line of business, status, claim creation date, claim owner, claim validation level, and so on—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 at the top of the **Claim Summary** screen, these icons are immediate indicators of key events in a claim's lifecycle.

The default configuration provides the following pre-configured **High Risk Indicators**:

- **Litigation** – Claims that are in litigation. In edit mode, you can change the **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 from **Administration** tab → **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** – The Special Investigation Unit section contains information about possible fraudulent claims, such as the status, score, or if the claim was referred to the SIU team. This indicator is controlled by the SIU question set accessed from the **Loss Details** screen.

While the default configuration has pre-configured indicators, some of them can be configured in Studio. See "Configuring Claim Health Metrics" on page 645 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 has occurred:

- A critical or high priority activity, which 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.

You cannot manually flag a claim, but a supervisor can remove a flag. 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 are *Flagged*, *Was Flagged*, and *Never Flagged*. There is also a `FlaggedDate` and a `FlaggedReason` field. If a claim is flagged and the `claim.removeFlagReason` method removes the last reason from the `FlaggedReason` field, the *Flagged* field becomes *Was Flagged*.

You can search for claims that have flags though the advanced search.

Removing a Claim Flag

The only person who can remove a flag from a claim is the supervisor or manager of the group to which the claim is assigned. Or this person can be the supervisor of any parent group. A supervisor needs first to attend to the issue as appropriate, and then to remove the flag.

To remove a claim flag

1. Navigate to the claim's **Claim Status** screen from the **Summary** link in the left pane.

2. Click **Remove Flag**.

3. You must give a reason and click **Remove Flag** again.

   You can see the reason under the **Latest Notes** section on the **Summary** screen of the claim.

   Note: You can also remove flags from the **Team** tab.

Administering Metrics and Thresholds

If you have administration permissions (`metriclimitmanage`), you can edit the health claim metrics target values through the **Administration** tab. You do this by navigating to the **Threshold and Metrics** link on the left pane. You *assign* values to metrics through the user interface, but *create* new metrics in Studio. This section describes how to do this.

> **Note:** To create new metrics, define them by using Gosu in Studio. See "Configuring Claim Health Metrics" on page 645 in the *Configuration Guide*.

Metrics and thresholds are administered by claim, by exposure, and by policy type within the claim and exposure. You must select the policy type (line of business) first, and then enter the values for either claim or exposure. All policy types have the same metrics, but might have different target values associated with them.

The Metric and Threshold screen contains the following tabs:

- **Claim Metric Limits** – Enter values for overall metrics, claim activity, and claim financials. You can also enter the target/service level values for overall, at risk, or overdue elements.
- **Exposure Metrics** – Enter values for exposures, which can be different based on the policy type.
- **Large Loss Threshold** – Enter an amount for the large loss indicator. If you have integrated PolicyCenter with ClaimCenter, you can also enter a different threshold amount for it.

The Claim Duration Section

The **Claim Duration** indicator is a visual cue of the **Days Open** metric. It displays 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 the limits are null.

Refer to the following table to see the range of colors if targets have been set. Optionally, set Target/Service Level, the yellow warning level, and the red over target level.

Did you set the target?	Set Yellow?	Set Red?	Then, the Claim Duration indicator color is...
Not applicable	Yes	Yes	Green
Yes	No	No	Blue only
Not applicable	Yes	No	Green until 100%. Then it turns blue at 100%.
Not applicable	Yes	Yes	Green or blue until yellow or red, then red at 100%.

Did you set the target?	Set Yellow?	Set Red?	Then, the Claim Duration indicator color is...
Not applicable	No	Yes	Green until 100% then it turns red at 100%.

To see how to add or change target values, see "Administering Metrics and Thresholds" on page 322. Guidewire recommends being consistent in how you set the targets.

Defining Claim Tiers

You have the option in ClaimCenter to have different target values for a particular metric within a specific policy type. This is called *tiers*. Tiers are a way to have further granularity within the policy type.

Example

In the following example, for the personal auto policy type, values for the high severity tier have been entered. 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 have the default 5/4/6 values for **Days Open** because they have not been overridden.

Health Metric Permissions

The following permission is used to control user access to setting health metrics: `metriclimitmanage`.

chapter 36

Team Management

ClaimCenter provides a visual management tool that helps supervisors and managers manage their groups. This tool displays the number of Claims, Exposures, Matters, and Activities grouped by whether items are open, closed, flagged, new, or completed. Access this tool (with the correct permissions) from the **Team** tab, and use it to control and distribute your team's activity and workload.

> **Note:** There is no actual *Team* entity in ClaimCenter. The mechanisms for assigning work, supervising users, and managing users is all done through groups.

Use the **Team** tab to:

• Examine the structure of your **Groups and Members**.
• See summaries of your **Group Workloads** for the last month.
• See summary **Statistics** of all the work of your entire team.
• Change the **Preferences** - password, startup view, and the recently viewed claim list - of those reporting to you.
• Change the **Vacation Status** of those reporting to you.

This topic includes:

• "Team Management Overview" on page 325
• "Using Flags" on page 328

Team Management Overview

Supervisors and managers can manage their teams, obtain status information, monitor case loads, identify backlogs, and reassign activities using the team management functionality in ClaimCenter. In some respects, team management is a reporting tool, where you can see summaries of a group's workload. You can then navigate to view and manage the workload of a team member. The reporting categories for workloads are: **Summary**, **Aging**, **Claims**, **Exposures**, **Activities**, and **Matters**.

When you first select **Team**, ClaimCenter defaults to **My Groups** as shown in the following example.

- 1 represents groups
- 2 represents the reporting categories
- 3 represents the date and time when last calculated

Groups

Supervisors can quickly glance at the team's current case load and the statistics for each adjuster's claims, exposures, and activities. You can also see any flagged claim that need immediate attention within the group. ClaimCenter organizes users into groups and subgroups.

- **My Groups** displays a summary of objects owned by all groups listed. The **Western Auto Group** displays a summary of objects owned by this group. Expand the tree in the left pane to see summaries of objects owned by listed individuals.
- The **Other** user category contains claims, exposures, activities, and matters assigned to the group under which the node appears, but it was assigned to an invalid user. An invalid user is someone who is no longer a member of the group. Perhaps the user switched groups or retired.
- **In Queue** contains activities that have not been assigned to anyone. These activities sorted using the filter. For example, selecting **Overdue only** from the drop-down menu displays overdue activities that need to be attended to or assigned to someone who can address them.

Selecting a node in the tree hierarchy on the left pane of the screen updates the main work area with that group or user's information. Select a reporting category to see that group or user's information.

The reporting categories for the **My Groups** screens are:

- **Summary**: This screen lists information about the claims, exposures, matters, and activities assigned to each group. It is the status of all assignable entities.
- **Aging**: This screen 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 those claims under litigation. It displays the time of which claims and exposures have been open.
- **Claims**: The *group* **Claims** screen displays all claims belonging to your group. (The *user* **Claims** screen display the same information except only for that user.) Use these screens to assign a claim to another user or to remove a flag.
- **Exposures**: The *group* **Exposures** screen displays all exposures belonging to your group. (The *user* **Exposures** screen display the same information except only for that user.) Use these screens to assign an exposure to another user.

- **Activities**: The *group* **Activities** screen displays all activities belonging to your group. (The *user* **Activities** screen display the same information except only for that user.)
- **Matters**: The *group* **Matters** screen displays all legal matters belonging to your group. (The *user* **Matters** screen display the same information except only for that user.)

Statistics

The **Team** tab defaults to the Statistics display in the base configuration. Its columns show, for your team, these summaries:

- The number of open, overdue, and recently completed **Activities**.
- The number of open, new (and still open), and recently closed **Claims**.
- The number of the Team's overdue activities, open claims, new (and not yet closed) claims, and claims closed this week.

In addition, you can view other statistic on your team's workloads by clicking **Summary** and **Aging**. Both provide information about your team's workload, including the number of newly opened claims and claims that are still open after a long period.

Summary Link

This link shows these totals of work items:

- The number of each group's open, flagged, new, and closed claims.
- The number of each group's open and closed exposures.
- The number of each group's open and closed matters.
- The number of each group's open, overdue, and completed activities, as well as those completed today.

    Note: The number of new items is defined as the number of items that have been created for the current week with a status of open. For example, if a new claim is opened and then closed in the same week, the number of new claims does not change.

Aging Link

The **Aging** link shows a summary of claims and exposures still open after 30, 60, 90, 120, and more than 120 days. It notes the number of open claims that are under litigation (that have at least one open matter), because such claims are not likely to be completed as unlitigated ones.

Groups and Members

The left pane of the **Team** page shows a tree of your groups. If you expand the tree, then you can see subgroups and group members. After you select a team member, you can then change the team member's associated **Preferences** and **Vacation Status**.

Group Workloads

The **Team** tab defaults to a current work **Summary** table for your team. You can also select a work summary of incomplete, or **Aging** work. Click **Print/Export** to print a report as a `.pdf` file or export the information as a `.csv` file.

Preferences

You can change the password or **Startup View** of your team members. See "User Login and Passwords" on page 395 for details. You can change the default display (normally current activities) to the New Claim wizard, or show a list of their current claims or exposures, or a claim search screen. You can also set the *entries in recent claims list*.

Vacation Status

You can change the vacation status of your team members to **At Work**, **On Vacation**, or **On Vacation (Inactive)**. You can also specify a backup to accept new work assigned to them. See "Vacation Status" on page 261 for more details.

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 attends to the issue, and after completing the task, removes the flag.

To Remove a Flag

1. Navigate to the **Team** tab and drill down to a specific user.

2. Select the claim's checkbox for the flag you want to remove. This enables the **Remove Flag** button.

3. Click **Remove Flag**.

4. You must provide a reason in the **Note** field and click **Remove Flag** again.

The reason shows under the **Latest Notes** section on the **Summary** screen of the claim.

Dashboard

The **Dashboard** tab provides an executive summary of ClaimCenter data. Managers use it to gain a high-level over-view 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.

You can view Dashboard data for your team as a whole, or your can drill down to view individual groups. At the organization level, Dashboard data is subtotaled by business group, line of business, loss type, and coverage. In particular, the Dashboard shows you these reports:

• **Open Claim Count Report**: information on open claims, organized by Group, LOB, and Loss Type,

• **Open Claim Financials Report**: a financial summary of all currently open claims, organized by Group, LOB, Loss Cause, and Coverage. Drill down through each category to Transaction Detail reports.

• **Period (Past 30 Day Claims) Report**: how many claims and exposures are new, closed, or new-report only, as well as new matters.

• **Period (Past 30 Day Financials) Report**: payments and recoveries in the period, as well as payments made on closed claims.

These tables are generated by reporting batch processes.

See Also

• *ClaimCenter System Administration Guide* for scheduling these reports or running them manually to update them. Your installation can provide additional dashboard reports.

• For more information, see "Dashboard Reports" on page 97 in the *Reporting Guide*. This *Guide* also describes how to write and edit these reports.

Key Integrations

chapter 38

ClaimCenter Integration Points

By design, ClaimCenter is flexible and integrates 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.

This topic includes:

• "Systems That Can Require Integration" on page 333

Systems That Can Require Integration

ClaimCenter can integrate with many external systems using a diverse toolbox 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*. Theoretically, ClaimCenter can be integrated with any system that can make information available externally through a commonly established technology. The following list is a starting point of the most common types of systems that may need to be integrated.

• **Authentication system**: This allows a person access to ClaimCenter.

• **Policy Administration System**: ClaimCenter pulls related policy information during the claim process. To learn more how ClaimCenter integrates with a policy administration system, see "Policy System Integration" on page 335.

• **Contact Management or Address Book application using a Geocoding Service**: This is a separate application for contact information. It is often necessary to store and maintain contact information separately from ClaimCenter because users outside of ClaimCenter might need access to it. The Geocoding service works with Bing Maps to help users find services within a given location. See *Guidewire Contact Management Guide* for details.

• **Document Production System and Document Storage System**: ClaimCenter creates and manages claim-associated documents. These documents can be online documents (existing or created within ClaimCenter) as well as hard copies in a file cabinet. See "Document Management" on page 345 for details.

• **Metropolitan Reporting Bureau**: This is 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 decreases deployment time for Metropolitan Reporting Bureau integration projects. See "Metropolitan Reports Overview" on page 353 for details.

- **Reporting system**: ClaimCenter Standard Reporting is an optional integration with InetSoft requiring the installation of the InetSoft StyleReport Enterprise Edition as the report server. Once integrated you can access a number of predefined reports available in the base configuration.

- **General Ledger, Check Processing System, and Financial Institution**: ClaimCenter passes financial information to a downstream system. See "Claim Financials" on page 131 for details.

- **ISO**: In the United States, ClaimCenter integrates with ISO, formerly known as the Insurance Services Office. ISO provides a service called *ClaimSearch* which 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 361 for details.

For more information on how to integrate with other systems, see the *ClaimCenter Integration Guide*.

chapter 39

Policy System Integration

The default configuration of ClaimCenter includes a functional integration with Guidewire PolicyCenter. You must integrate PolicyCenter with ClaimCenter yourself. 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 PolicyCenter in particular.

This topic includes:
- "Policy System Integration Overview" on page 335
- "Getting a Policy into ClaimCenter" on page 336
- "Viewing Policies in a Policy Administration System (PAS)" on page 336
- "Large Loss Notifications" on page 337
- "Permissions for Working with Policies" on page 341

See Also
- "Enabling Integration between ClaimCenter and PolicyCenter" on page 64 in the *Installation Guide*
- "Claim and Policy Integration" on page 443 in the *Integration Guide*

Policy System Integration Overview

Guidewire has set up ClaimCenter in the default configuration to:
- **Get a policy snapshot in the process of gathering claim information**. As you recall, ClaimCenter needs a verified policy in order to ultimately pay on the claim. An example of this is in the New Claim wizard. You must either find a policy or enter policy information and the policy is unverified.
- **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.

ClaimCenter and a Policy System High Level Integration
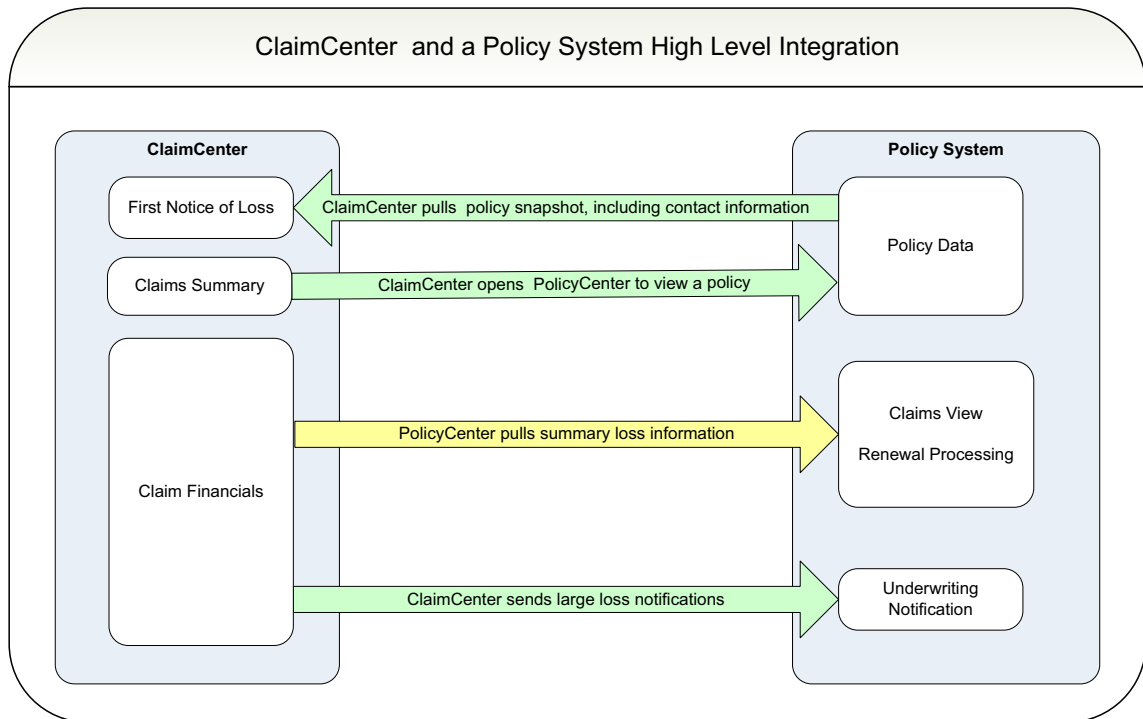
See Also

- For information about the parts of the integration that originate in PolicyCenter, see the *PolicyCenter Application Guide* topic *ClaimCenter Integration*.

Getting a Policy into ClaimCenter

The `IPolicySearchAdapter` plugin registry can be configured with a plugin implementation that pulls policies from a policy administration system into ClaimCenter.

Viewing Policies in a Policy Administration System (PAS)

ClaimCenter also integrates with a policy administration system (PAS) when viewing a policy in the PAS.

If enabled, from the **Policy** screen, you can open a web browser window of the policy system. This system can be Guidewire PolicyCenter, or another system if it has a web interface.

The following directions are used with the integrated version of PolicyCenter.

To View a Policy in PolicyCenter

The **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. This button opens a window to PolicyCenter. You must have a user account in PolicyCenter. If you are not logged in, the login screen appears. When you are logged in, PolicyCenter displays the policy. If you have single sign-on, PolicyCenter opens directly to the policy summary screen.

Perform the following steps to view a policy in PolicyCenter.

1. Find a claim and select the **Policy** link on the left pane.

   The **Policy: General** screen opens.

2. Click **View Policy in Policy System**.

   A new instance of PolicyCenter opens. You must log in to it. If the policy system finds the policy, it displays the information. If it does not find the policy, you can search for it in PolicyCenter.

3. Select the policy link.

4. The PolicyCenter **Policy Summary** screen opens, in which you can see policy information.

   Note: Based on your business requirements, you might have ClaimCenter integrated with several policy administration systems. This integration appears to be seamless from the user interface.

Large Loss Notifications

Sometimes a claim has a large loss associated with it. Carriers determine what large loss amount is based on their business practices. The amount can vary depending on the line of business or policy type. In other words, a personal auto large loss notification might have a lesser amount than one for a homeowner's policy. The large loss information is critical to an underwriter who uses that information in determining risk and ultimately granting a renewal policy. ClaimCenter can send that information to a policy administration system if the two systems are integrated.

Policy System Notification Framework

Guidewire created a *policy system notification framework* so that ClaimCenter can 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 message transport then delivers the messages to the policy system through the plugin `IPolicySystemNotificationPlugin`, which you can implement to talk to a policy administration system. The plugin has the following method:

```
function claimExceedsLargeLossThreshold(
        lossDate : Calendar,
        policyNumber : String,
        grossTotalIncurred : String,
        transactionId : String)
   throws PolicySystemRetryableException, PolicySystemAlreadyExecutedException
```

In the default configuration, this plugin is not enabled.

Built-in PolicyCenter Implementation

ClaimCenter also contains a PolicyCenter specific implementation, `PCPolicySystemNotificationPlugin`, which calls a web service that PolicyCenter publishes. The PolicyCenter web service interface is called `ClaimToPolicySystemNotificationAPI`.

Handlers

The notification system works by registering *handlers* for each event name associated with a policy system notification. The handler is called:

- In event fired rules to create a message
- Sending the message
- If the messaging destination is resynced

You can modify the handler to behave differently at each of these points. In the default configuration, ClaimCenter has one handler: `LargeLossPolicySystemNotification`, for delivering large loss notifications to the policy system.

ClaimCenter Sends the Notification to the Policy Administration System

If a claim's loss reaches that predefined threshold, ClaimCenter creates a message. The message transport calls a web service in PolicyCenter with the claim's policy number, loss date, and the total gross incurred. The PolicyCenter web service then creates an activity on the policy's account and adds a referral reason to the policy where an underwriter can see this information.

In the base configuration, the PolicyCenter referral reason type is `UWReferralReason`. The issue description states the gross total incurred of $X reported on (date). The severity is high at 30 points, and the status is Open. PolicyCenter assigns it to the policy underwriter. PolicyCenter creates an activity to the underwriter assigned to the policy after a claim's gross total incurred crosses the threshold in ClaimCenter. The underwriter needs this type of information in deciding whether to grant a policy renewal.

> **Note:** To integrate ClaimCenter with other policy administration systems, you can write your own implementation of the plugin. Your implementation of the `IPolicySystemNotificationPlugin` can work differently with your policy administration systems, and does not have to use web services.

How Does it Reach That Certain Threshold?

Whether a loss is *large* is decided by comparing the gross total incurred amount for the claim with a threshold that has been entered into a reference table. The reference table is accessed through the **Administration** tab in the user interface. (See "Administering Large Loss Notifications" on page 339.)

You can reach a certain threshold in the user interface in either of the following ways:

- Create a claim in ClaimCenter with reserves so that gross total incurred on the claim exceeds the large loss gross total incurred threshold for the claim's policy type, or
- Add a new reserve, or new eroding future scheduled payment, or new payment to an existing claim. This is so that the gross total incurred for that claim exceeds the large loss gross total incurred threshold.

After that threshold has been reached, ClaimCenter stores data indicating whether a notification has been sent to a policy system. The `Claim` entity has the `LargeLossNotificationStatus` property. It contains one of the following typecodes from the `LargeLossNotificationStatus` typelist:

Code	Description
InQueue	ClaimCenter created the notification message and it is waiting to be sent.
None	ClaimCenter did not send the notification.
Null	This is the same as None.
Sent	The notification was successfully sent.

Rules Related to Large Loss Notifications

ClaimCenter uses the following rule sets in large loss notifications.

The following table summarizes the rules sets that ClaimCenter uses for large loss notifications.

Purpose	Rule Set	Description
Preupdate rules to detect large losses	Large Loss Notification	This **Preupdate → TransactionSetPreupdate → Large Loss Notification** rule fires whenever transaction sets are created or changed. The rule checks if the claim exceeds the large loss threshold for the claim's policy type. It also checks whether a message is in the queue or if PolicyCenter has been notified. If the condition passes, it adds a `ClaimExceedsLargeLoss` event to the claim. Define the thresholds within the administration user interface of ClaimCenter.
Event rules to support policy system notifications in general	Policy System Notification	This **EventMessage → EventFired → Policy System Notification** rule is a general rule for all policy system notification events: **1.** The rules determine the event name. For a large loss, the event name is `ClaimExceedsLargeLoss`. If you register additional notification handlers, the event name is different. **2.** The rules find the policy system notification handler that supports the current event name. For large loss, the handler class is `LargeLossPolicySystemNotification`. **3.** The rules call the handler's `createMessage` method to create an outgoing message to persist to the database in the same transaction as the change that triggers the large loss notification. This does not actually send the message yet, which happens asynchronously in another thread. The handler's `createMessage` method delegates the actual sending behavior to the `IPolicySystemNotificationPlugin` interface. The `message.EventName` property encodes which notification occurred. The body of the message contains information that the notification handler might need. For large loss, for example, it would contain the size of the loss. At message send time, the messaging transport calls the notification handler's `send` method and does not use this rule set. If a claim resync happens (a `ClaimResync` event), then ClaimCenter drops all queued (pending/errant) messages for the destination. However, first ClaimCenter calls the **EventFired** rule set to preserve and queue messages. These event rules trigger code that checks the notification handler's `MessageResyncBehavior` property for how to handle it. If the value is `COPY_LAST`, then only one pending message corresponding to that notification will be copied (the last one, by send order).

These rule sets are not enabled in the default configuration.

Administering Large Loss Notifications

You can define and map threshold amounts by using a reference table that you access from the user interface. Navigate to the **Administration** tab → **Metrics & Thresholds** → **Large Loss Thresholds** as seen in the following example.

To edit the threshold levels for large losses

1. Log in to ClaimCenter with an administrator user name.

2. Click the **Administration** tab

3. In the navigation bar, click **Metrics & Thresholds**.

4. Click the **Large Loss Threshold** tab.

5. From the **Policy Type** picker, select a policy type to set its threshold amount.

6. Click the **Edit** button.

7. Edit the value in the **Large Loss Indicator** text field.

8. Click the **Update** button.

9. If you want to change additional thresholds, select another policy type and repeat these steps.

You must configure a threshold per line of business (policy type). The following table lists the ClaimCenter policy type defaults that correspond to PolicyCenter.

ClaimCenter Policy Type	PolicyCenter Line of Business	Default Large Loss Total Reserve Threshold in US Dollars
BOP	BOP	25,000
Commercial auto	BA	50,000
Commercial property	CP	100,000
Farmowner's	not applicable	10,000
General liability	GL	50,000
Homeowner's	not applicable	10,000
Inland marine	IM	25,000
Personal auto	PA	20,000
Personal travel	not applicable	no default
Professional liability	not applicable	100,000
Workers' compensation	WC	25,000

In the default configuration, the workers' compensation and personal auto lines of business are mapped to their equivalent PolicyCenter lines of business for policy search and large losses.

See Also
- "Policy System Notifications" on page 443 in the *Integration Guide*

Enabling Large Loss Notification

By default, ClaimCenter does not enable any policy system notification integrations. Performing the following steps in Studio enables this behavior. PolicyCenter must be running. However, ClaimCenter does *not* need to be running because you must restart it for the changes to take effect after performing this procedure.

To enable the built-in integrations

1. Navigate to **Rule Sets → Preupdate → TransactionSetPreupdate** and select the box next to the **Large Loss Notification** to enable it.

2. Navigate to **Rule Sets → EventMessage → EventFired** and select the box next to the **Policy System Notification** rule to enable it.

3. Navigate to **Messaging** and in the row for **Policy System Notification** messaging destination, select the **Enabled** checkbox.

4. Navigate to **Plugins → gw → plugin → messaging → MessageTransport → policySystemNotificationTransport** and select the **Enabled** checkbox.

5. Find the demo plugin and change the Gosu class.

Navigate to **Plugins → gw → plugin → policy → IPolicySystemNotitificationPlugin**. In the base implementation, ClaimCenter uses a standalone (demo) implementation of the plugin, `StandAlonePolicySystemNotificationPlugin`, that does not connect to an actual policy system. To use the built-in PolicyCenter integration plugin implementation, change the class to `gw.plugin.policy.impl.PCPolicySystemNotificationPlugin` and select the box to enable it.

6. For the built-in PolicyCenter integration, verify the web service setup. Navigate to **Web Services → pcnotification**. The web service configuration looks for PolicyCenter on the local machine on port 8180. Set the URL field to the actual server URL for PolicyCenter.

7. Set the authentication in the **Default** tab to **HTTP**. Choosing **HTTP** expands the tab, so that you can enter a user name and password. The default user name is `su` and the password is `gw`.

   Alternatively, you can choose to set the authentication setting to **None** and modify the code to add authentication credentials programmatically. To do this, first edit the class `PCPolicySystemNotificationPlugin`. Next, find the line:

   ```
   _policySystemAPI = new ClaimToPolicySystemNotificationAPI()
   ```
   Immediately afterward, add a line similar to the following and then pass your user name and password:

   ```
   _policySystemAPI.addHandler(new GWAuthenticationHandler( "su", "gw" ))
   ```

8. Refresh the WSDL by clicking the **Refresh** button located to the right of the **URL** field.

9. If Studio has not already saved your work, then save it.

10. Restart ClaimCenter for the changes to take effect.

Test your integration

In a development system, test PolicyCenter by adding a claim with a loss that exceeds the threshold for that type of claim. If it works correctly, PolicyCenter adds a referral reason and an activity for that policy.

Permissions for Working with Policies

There are two permissions that allow the user to view policies in PolicyCenter.

- **View policies** – This permission controls the policy pages in ClaimCenter.
- **View policy system** – You can select the **View Policy** button in the user interface to open PolicyCenter, in which you can view a policy. The code for this permission is `viewpolicysystem`.

chapter 40

Contacts

This topic briefly explains how contacts are used in ClaimCenter.

This topic includes:

- "The Address Book in ClaimCenter" on page 343
- "Using ContactCenter" on page 343

See Also

- *Guidewire Contact Management Guide*

The Address Book in ClaimCenter

ContactCenter is a separate Guidewire application, designed to be the address book for ClaimCenter. There are several reasons for having a separate address book application:

- It facilitates sharing of contact information among other applications, like PolicyCenter and BillingCenter.
- It allows a common administrative interface to create, edit and delete address book contacts.
- It allows common management of contacts' groups and security permissions.

Using ContactCenter

The ContactCenter user interface has the same structure as the ClaimCenter user interface, with an **Action** button and **Menu** on the left for navigation. Use the **Contacts** tab to:

- Create a new person (contact), company (vendor), or place (legal venue).
- Edit and delete any of these entities.
- Search for any of these entities, using many additional criteria, such as contact subtype, role, and location.

Use the ContactCenter **Search** tab to search for contacts by attributes in the same way you manage them in ClaimCenter. However, entering multiple attributes can result in duplicate match results. You must delete or ignore the duplicates.

The ContactCenter **Administration** tab manages roles, login name and password, and group membership for every contact. This tab also manages the following items, in the same way you manage them in ClaimCenter:

- **Group Hierarchies**:
- **Roles**: This screen assists you in adding and deleting permissions to roles, as well as assign roles to ContactCenter users.
- **Regions**: This screen displays the current regions for ContactCenter contacts, and allows you to add or edit them.
- **Integrations**: This screen displays all ContactCenter integration plugins, and allows you to activate or deactivate them.
- **Script parameters**: This screen displays all script parameters. You can set them to `true` or `false` or set their value; but you cannot create new script parameters at this location.
- **Event messages**: This screen displays messages sent by ContactCenter and allows you to manage them in the same way you do in ClaimCenter.

Other features of ContactCenter:

- Sync contact information in both directions between ContactCenter and ClaimCenter.
- Implement security restrictions on contacts by contact types and subtypes.

Document Management

ClaimCenter creates and manages claim-associated documents. These documents can either be online (existing or created within 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 be a copy of a written police report. Use ClaimCenter to manage all of 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 categorizing them to simplify the searches.
* Link to external documents.
* Indicate the existence of documents that exist only in hardcopy.
* Remove documents.
* Associate a document to 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 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 files commands. You can also integrate documents with an external document management system. For more information, see "Configuring Document Management" on page 350.

Note: All documents must either be ASCII or use the UTF-8 character set. This makes all document management system see documents in all languages and character sets.

This topic includes:
* "Document Security" on page 346
* "Working With Documents" on page 346

- "Configuring Document Management" on page 350
- "Document Management Integration" on page 350

See also
- "Localizing Templates" on page 517 in the *Configuration Guide*
- "Document Creation" on page 151 in the *Rules Guide*
- "Document Management" on page 249 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:** "Access Control for Documents and Notes" on page 388 describes how to do this.

Permissions Related to Documents

These are the system permissions which provide security to 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	–
doccreateclsd	add documents to a closed claim	doccreate
docdeleteclsd	remove documents from a closed claim	docdelete
docviewall	view any document, regardless of its security type (ACL)	–
docmodifyall	modify any document, regardless of security type (ACL)	–
docview	view the documents on a claim	viewdocs

Hidden Documents

Most users only have permission to hide documents. This only sets a flag; it does not retire the document in the database.

> **WARNING** If you do not have this permission and hide a document, you cannot see the document again.

The `hiddendoc` permission is required to see hidden documents.

Hiding a document is **not** the same as deleting it. The `docdelete` permission is necessary to fully delete documents. Only users who do have that permission can delete. Since document deletion is (at least semi-) permanent, only one document at a time can be deleted 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 347
- "Searching for Documents" on page 347

- "Adding a New Document" on page 348
- "Linking to an Existing Document" on page 348
- "Creating a New Document" on page 348
- "Indicating the Existence of a Hard Copy Document" on page 349
- "Editing a Document" on page 349
- "Removing a Document" on page 349
- "Using an Activity to Create a Document" on page 349
- "Creating a Document with a Rule or in a Workflow" on page 349
- "Relating a Document to a ClaimCenter Entity" on page 349
- "Linking a Document to Another Entity" on page 349
- "Creating a Document Template" on page 350

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 **New Document** from the **Actions** menu while in any screen.

Viewing Claim Documents

The main screen that displays documents is the **Documents** page. The top of this page contains a search panel where you can find either all documents on the claim or a specific subset. The bottom of this screen is the unfiltered list of all documents related to the claim.

Select the **Documents** link, located on the left sidebar of all claim and New Claim wizard pages, to display this page.

You can view all documents for which you have permission. Click on any document name to view its details.

The `RestrictSearchesToPermittedItems` search parameter in `config.xml` determines whether you can see a document in the list for which you do not have permission to view.

Searching for Documents

Use the **Search** panel of the **Documents** screen to search for documents. It includes the following search attributes. You set these search parameter values for each document after you create 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**: this is especially useful for locating hard copy documents.
- **Status**: from the `Documentstatus` typelist; can be set in the user interface, but its main use is to track the approval process of a document in rules.
- **Author**: this can be the name of the creator, sender, or have any other value.
- **Include Hidden Documents**: whether to include Hidden Documents in the search.

You can add or delete most search filters in the `search-config.xml` file by modifying the following section and the document search PCF file. For example, search by type, whether incoming, or containing a particular section, and so on.

```
<!-- Map a search on Document to search criteria -->
<CriteriaDef entity="DocumentSearchCriteria" targetEntity="Document">
  <Criterion property="Section" targetProperty="Section" matchType="eq"/>
  <Criterion property="Status" targetProperty="Status" matchType="eq"/>
  <Criterion property="Author" targetProperty="Author" matchType="startsWith"/>
</CriteriaDef>
```

See also

- "Configuring Search Functionality" on page 387 in the *Configuration Guide*

Adding a New Document

Click **New Document** from the **Actions** menu while in any claim screen to see these choices for adding documents to the current claim:

- "Creating a New Document" on page 348
- "Linking to an Existing Document" on page 348
- "Indicating the Existence of a Hard Copy Document" on page 349

Linking to an Existing Document

1. Select **Actions** → **New Document** → **Attach to an existing document**.

2. Browse to the location of your document.

3. Click **Update** to create the link.

Creating a New Document

> **Note:** ClaimCenter supports the 32-bit version of Internet Explorer. This version of Internet Explorer supports documents.

1. Select **Actions** → **New Document** → **Create from a template**.

2. In the **New Document** tab, select the template to use, either by specifying its name and MIME type, or by clicking the **Select Template** search icon. You cannot create a document without specifying an existing template.

If you click the search icon, a second screen appears so you can search for document templates:

  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 **Document Type** picker, and click **Search**. ClaimCenter shows the list of document templates with the list narrowed to that document type only. After you find your choice, click **Select**.

After you select a template, ClaimCenter displays additional numbered steps along the right side of the screen.

IMPORTANT The base configuration *Sample Acrobat* document (`SampleAcrobat.pdf`) uses Helvetica font. If you intend to create a document that uses Unicode characters (for example, one that uses an East Asian language), then 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, be sure 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 print it and send it through the mail. You can also use 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 to ClaimCenter. Its description is now searchable. However, you have to go to your file cabinet to retrieve it. This option gives you all of the document attribute fields that you have for electronic documents. It 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 that which links an existing document to a claim, except that there is no **Attachment** (path name) text box. Enter any or all of the 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 documents if you have sufficient permissions or if the document does not have a status of **Final**. To edit a document, click **Edit**. This causes **Edit Local Copy** and **Upload** buttons to be enabled. Clicking **Edit Local Copy** downloads a copy of the file to your local drive and opens it in its appropriate editor. Clicking **Upload** returns it to your document management system. Clicking **Cancel** discards your local edits.

Removing a Document

After locating the document in the **Documents** list or a search, click **Delete**. If no button is visible, you do not have the authority to delete that file. See "Document Security" on page 346.

Using an Activity to Create a Document

If a document template has been 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 348.

Creating a Document with a Rule or in a Workflow

To learn how to automatically create documents using rules, see "Generating Documents from Gosu" on page 268 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 creating a document, specify the entity in the **Related To** text box. If the document already exists, you create this relationship 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 notes, activities, or certain financial objects. This is different than a document 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** displays a document search page almost identical to the **Documents** list page. Only one document can be linked at a time, and only existing documents can be linked.

> **Note:** You can *only* see **View** in a list of linked documents. You can edit a document *only* by clicking **Edit** that appears in the **Document** list pages.

Documents can be linked to a note in a similar fashion. For each linked document, a specially formatted link appears in the body of the note. The documents linked to the note do not display in a list.

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 **Other Resources → doctemplates** in Studio.

The location of the Document template files is 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 import details about document management, document templates, and related integration points, see "Document Management" on page 249 in the *Integration Guide*.

Configuring Document Management

For information on configuring document management, see "Configuring Guidewire Document Assistant" on page 25 in the *System Administration Guide*.

See also
- To configure search parameters for documents, see "Searching for Documents" on page 347.
- For details about document management and related integration points, see "Document Management" on page 249 in the *Integration Guide*.

Document Management Integration

The following are the main interfaces used to integrate to a document management system.

Interface	Description
IDocumentMetadataSource	ClaimCenter passes search parameters (metadata) to this interface, which searches its metadata and returns a list of documents found. • Interface to 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. • Separate from IDocumentContentSource because of different architectural requirements.

Interface	Description

`IDocumentContentSource`	ClaimCenter passes this interface metadata for one file, which returns its content.
	• Interface to a document storage system.
	• Contains methods for creating, updating, and retrieving document contents.
	• Supports several document retrieval modes:
	  • Document contents.
	  • Web page containing an ActiveX control (see "Working With Documents" on page 346).
	  • Gosu executed by client rules.
	  • URL to a local content store.

`IDocumentProduction`	• Interface to a document creation system. • Document creation process can involve extended workflow and/or asynchronous processes. • Can depend on or set document fields.
`IDocumentTemplateSource` and `IDocumentTemplateDescriptor`	• Basic interfaces for searching for and retrieving templates describing the document to be created. • Includes basic metadata (name, MIME type, and so on) and a pointer to the template content.

For import details about document management and related integration points, see "Document Management" on page 249 in the *Integration Guide*.

chapter 42

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 decreases deployment time for Metropolitan Reporting Bureau integration projects. This topic explains how to use MRB reports.

See Also

- "Metropolitan Reporting Bureau Integration" on page 389 in the *Integration Guide*
- For more information about Metropolitan's services, refer to their web site: `http://www.metroreporting.com`

This topic includes:

Metropolitan Reports Overview

ClaimCenter integrates with the Metropolitan Reporting Bureau so that you can request police accident and incident reports that may 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

With an adjuster handling thousands of claims year, the elimination of inefficient and time-intensive business processes is a major key to adjuster productivity. Adjusters can focus their energies on the prompt and equitable adjustment of the claim. In addition, the consistent application of investigative best practices is a requirement to achieve claims adjusting goals in a minimum leakage, cost appropriate manner. System enabled task recognitions, workflows, and follow-ups with premier third party claims business partners is an important part of achieving these goals.

You can also 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.

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. They 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 file user interface.
- **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 submits a request for another (new) report.

Working with Metropolitan Reports

You can order a report and view one. This section explains how to do both processes.

To View a Report

There are two ways to view the **Metropolitan Reports** detail page within the ClaimCenter user interface.

- Navigate to a claim and click the **New** button after the **Loss Detail** screen is in edit mode.
- Navigate to a claim and click the **Report Type** links from the list view of claims.
- **Type**: This column in the list view is the type of the report request. When clicking on the report type link, a page popup provides detail information about the report request.

- **Status**: This indicates the current status of the report request. The possible value for report status are explained in this section, *Metropolitan Report Status*.

- **Order Date**: This is the date that the report request was sent to MRB. The order date is empty if the report status is has a status of *InsufficientData*.

- **Document** and **Action**: This column contains the name of the document if the report status is received, and you can view the document by clicking the **View** button.

  You can also re-submit if the report request has insufficient data, after you update the claim and provide all the required fields. The request goes through the preupdate rules again and sends out the request if it passes the preupdate rules. To learn more about the preupdate rules, see *Preupdate Rules and Metropolitan Reports*.

  Note: Only the report request with *New*, *InsufficientData* or *Failed* status can be removed from the list view.

If you click the **Auto Accident** link, then the **Metropolitan Reports Detail** screen displays the data. However, clicking the **View Document** button displays the actual report in a new browser window as seen in the following example. Use this view if you need to print the report.

To Order a Report

Perform the following steps to order a report.

1. Create a new claim using the FNOL wizard.

2. In the **Loss Details** step of the wizard, navigate to the **At the Scene** section.

3. Click **Add Police Reports**. The Metropolitan Report Details screen opens where you can add details as seen in the following example. 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 and clicking **Edit**.

Preupdate Rules and Metropolitan Reports

ClaimCenter sends the report request only if the claim contains *all* of the required data. The claim preupdate rule checks the type of each report requested (singly) 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 required data is specified and the claim update completes successfully, then the report status changes. After the report status is validated, ClaimCenter starts a workflow which then changes the Metropolitan report status to Sending Order.

Activity Patterns and Metropolitan Reports

The following are activity patterns that affect Metropolitan Reports.

- **metropolitan_request_failed**: For any report requests that fail as `InsufficientData`, create an `metropolitan_request_failed` activity and assign it to the person that created the request. Include in the Activity Description text area information on the type of report that was requested and the data that must be supplied in order to successfully make the request.
- **metropolitan_report_unavailable**: For any report requests that fail after sending out the request, create an `metropolitan_report_unavailable` activity.
- **metropolitan_report_available**: For any report requests that successfully download and attach to the claim, create a `metropolitan_report_available` activity.
- **metropolitan_report_held**: For any report requests that the order is awaiting additional information from the requester before it can be processed, create an `metropolitan_report_held` activity.
- **metropolitan_report_deferred**: For any report requests that take additional time to process, create an `metropolitan_report_deferred` activity.

Metropolitan Reports Uses a 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.

Workflow are useful to define complex practices because:

- They contain a network of steps; the path taken can depend on the action or choice taken at each step. The path can include branches, loops and conditions.
- Each step in a workflow can execute immediately after its previous step completes, or can wait a specified time before proceeding.
- They can execute Gosu, access the logic in rule sets, and assign or complete activities.
- Workflow steps can execute immediately or wait for a specified time, an external event, or an activity to complete.
- Administrators can examine their status at any time.

Metropolitan Report Status

A report can have the following status:

Status	Description
New	The initial status of the report request.
Insufficientdata	Some of the required fields are missing.
Validated	The request is validated and ready to be sent out.
Sendingorder	The request is sent and waiting for the response from MRB.
Orderfaliled	The order request is failed based on the result sent back from MRB.
Accepted	The Report Order File is sent and accepted by MRB.
Pending	The order was received and is in process.
Hold	The order is awaiting additional information from the customer.
Deferred	An image was returned with a notice that the data source will take some additional time to provide the requested information.
Sendinginquiry	The Report Inquiry File is sent and waiting for the response from MRB.
Hasreport	The Report is ready on the external server.
Downloadingreport	The system is in the process of downloading the report.
Received	The Report is received and ready for viewing.
Inquiryfailed	The inquiry request is failed based on the result sent back from MRB.
Closed	The Report is closed.
Error	The Report request has errors.

The status (`MetroReportStatus`) is defined in the `tl_cc_claim.xml` file. `MetroReportStatus` is used internally to control the flow of the report request.

> **Note:** Guidewire does not recommend changing the `MetroReportStatus` typelist.

See Also

- "Guidewire Workflow" on page 423 in the *Configuration Guide* to learn more about workflows.

chapter 43

Reports

ClaimCenter Standard Reporting is an optional integration with InetSoft and requires the installation of the InetSoft StyleReport Enterprise Edition as the report server. Once integrated you can access a number of predefined reports available in the base configuration. These are organized into the following groups:

- Claim reports
- Claim Health Metrics reports
- Dashboard reports
- Financial reports
- Special Investigation Unit (SIU) reports

View these reports to see detailed information in a number of ClaimCenter areas so that you can make informed business decisions. If you have the correct permissions, then you can view these reports from within the ClaimCenter **Report** tab. In addition, if you have InetSoft administrative permissions, then you can view the ClaimCenter reports from within the InetSoft Enterprise Manager.

To learn more about reporting see the *ClaimCenter Reporting Guide* for details.

chapter 44

ISO and Claims

In the United States, ClaimCenter integrates with ISO, formerly known as the Insurance Services Office. ISO provides a service called *ClaimSearch* which 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.

ClaimCenter includes built-in integration to this service. In the base configuration, you can configure ClaimCenter for claim level messaging. However, ClaimCenter can be configured to integrate with ISO on the claim level *or* on the exposure level. ClaimCenter contains a special validation level for ISO. This means that ClaimCenter verifies 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 you to working with ISO and familiarizes you with its general processes.

This topic includes:

- "ISO Interacts with Claims and Exposures" on page 361
- "How Does ISO Work With ClaimCenter?" on page 362
- "ISO Permissions" on page 365

See Also

- "Insurance Services Office (ISO) Integration" on page 339 in the *Integration Guide*

ISO Interacts with Claims and Exposures

If you integrate ClaimCenter with ISO, then you must determine whether to send messages to ISO at the exposure or the claim level. If you choose to integrate with ISO at the exposure level, then the base configuration supports several exposure types such as:

- Vehicle damage
- Property damage
- Injury damage in workers' compensation line of business

These are commonly used for example, with personal auto or homeowner's or workers' compensation.

Benefits to Claim Level

- Other carriers can receive a more complete picture of what happened on a certain claim. This aids carriers in fraud detection.
- sends data to ISO at the claim level since there are additional fields required that are not contained at the exposure level.
- Support for *ClaimDirector* integration. This is a service used for fraud scoring and must be configured.

Benefits to Exposure Level

- If you currently have integrated ClaimCenter to ISO at the exposure level, you can continue to do so.
- You may decide to have certain lines of business, such as personal auto, send data to ISO at the exposure level.

How Does ISO Work With ClaimCenter?

This section 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 was changed
- the policy changed
- the claim contact changed
- key field information was changed

   Note: You can send data to ISO automatically after completing the New Claim wizard if it contains all the required ISO information and it passes validation.

This 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 as 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 which you can see in the *Viewing ISO Information* section. ClaimCenter stores the match reports as documents.

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
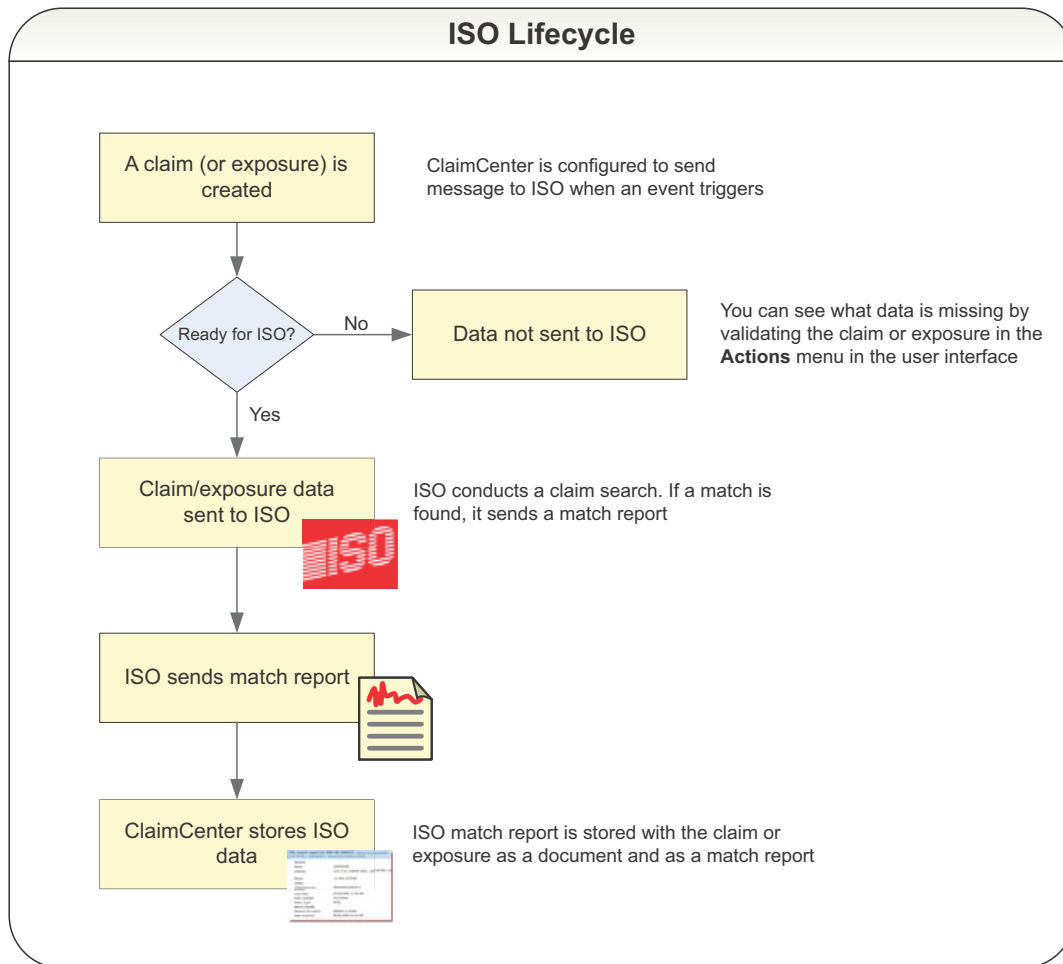
Viewing ISO Information

Depending on your configuration, you can see ISO information at two locations:

- The **Documents** link on the left pane, and
- The **ISO** tab, which can be in several locations:
    - If ClaimCenter has been integrated with ISO at the *claim* level, then you can see the **ISO** tab on the **Loss Details** screen.
    - If ClaimCenter has been integrated with ISO at the *exposure* level, then you can see the **ISO** tab on the **Exposure Details** screen. The exception to this is workers' compensation, which displays ISO information on the **Medical Details** screen.

The following workers' compensation claim example displays data that ISO has sent to ClaimCenter. If you click the link under the **Claim/Exposure Number** column, you can see the details.

If you prefer to see detailed information, then select **Documents** from the left pane and click **View** to see additional details. The following is an example of the ISO report (highlighted in red).

ISO Permissions

Who can work with ISO?

If you have the permissions to view the claim/exposure, then you can view the ISO match reports. This also includes editing the claim/exposure or clicking the **Send to ISO** button so that the message is sent to ISO.

However, the *Administer integration* permission (code = integadmin), can be appended to a role such as a supervisor or adjuster. Use this permission to see and edit information that is not of interest to most users but can help in rare cases. For example, you can edit information after the ISO state of the exposure/claim has become out of synch with the actual ISO server.

ClaimCenter Administration

chapter 45

Users, Groups, and Regions

ClaimCenter organizes people into *Users*, *Groups* and *Regions*. A user is someone with permission to use ClaimCenter. Users form work-related groups, which can be further aggregated into regions. The **Administration** tab models this structure and presents a tree view of it. These sections of the **Administration** tab also provide details on how to find and characterize them:

*   "Search for and Select Users and Groups" on page 400 and "Search For Regions" on page 402
*   "Create New Users and Groups" on page 401
*   "Users" on page 401
*   "Attributes" on page 402 and "Authority Limit Profile" on page 403
*   "Groups" on page 401
*   "Regions" on page 407

This topic includes:

*   "Groups" on page 369
*   "Users" on page 370
*   "Roles" on page 371
*   "Assignment Queues" on page 374
*   "Regions" on page 375

See Also

*   For additional details about how ClaimCenter uses this structure to enforce security, see "Security: Roles, Permissions, and Access Controls" on page 379.
*   To understand how ClaimCenter assigns work to groups and users, see "Assigning Work" on page 207.

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 as *virtual groups*. This 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 can 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 of the carrier's groups must form a regular hierarchy (tree structure) in which each group 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 businesses. These in turn have local offices as their children. Virtual groups can also be part of this hierarchy.

Groups have these additional properties:

- There can only be one group with no *parent*. This is the top-level (root) group.
- There is no limit to the number of members and *child group*s (subgroups) a group can have.
- A group always has one *supervisor*, who can or can not be a group member.
- A group can be associated with one or more *regions*, which assignment rules can consider.
- Groups control data security: each group is a member of a single *security zone* (see Security Zones can be used in Assignment, following.)
- A *default rule set* governs how work is assigned to a group. Each group can have its own default rule sets which assign try to assign activities, claims, exposures, and matters to it.
- A group is described further by its *group type* that helps rules decide whether to consider a group while assigning work.
- Similar to users having individual load factors that indicate the ideal distribution of work within 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, setting its region, group type, security zone, permissions to change load factors. You can only delete a group that is empty and has no child groups. Otherwise, you break the tree structure and create orphan users.

Users

Users are people who are permitted to log into ClaimCenter. This means 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:

- A *credential* that defines a user name and password for logging into ClaimCenter.
- *Roles*, which restrict what the user can view and work on. For more information, see "Role-Based Security" on page 380.
- *Authority Limits*, which cap the monetary amount of financial transactions the user can authorize.

These additional user characteristics help in the assignment process:

- Address book information, including name, address, email, and phone and fax numbers. The *address* can be used to assign based on proximity. See "Proximity Searches" on page 92 in the *Contact Management Guide* for more information.
- *Custom user attributes*, such as languages spoken or a special expertise, like familiarity with fraud investigation.
- A *user experience rating*, which could steer complex claims away from new adjusters.

- A *user role*, such as doctor, lawyer, vehicle inspector, fraud (Special Investigator) investigator, or police.

- A *load factor*, to give 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).

- A *Vacation status*, which can 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 above characteristics. Both the Team tab and the Administration tab contain User Profile screens that allow administrators to define and edit these characteristics. Users can also be imported into ClaimCenter.

It is 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, and

- A member of the local office group. This group mirrors her position in the company and her reporting relationship.

Multiple memberships make it easier to have assignment rules find the user as they take different paths down the group hierarchy.

Roles

Users possess one or more *roles*, which are a collection of permissions. Permissions enable users to view or edit different ClaimCenter objects. For example, assigning a claim to an adjuster guarantees that the user has the necessary permissions to complete the work.

Custom User Attributes

ClaimCenter provides a general way to describe any user attributes to help you decide how to assign work. There is also a rule which assigns work based on these attributes. It 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` typelist, which now contains just `Language`, `Expertise`, and `Named Accounts` attributes, but can be extended.

Custom user attributes themselves have optional attributes, which increase their usefulness.

- The *type* is a way to group custom user attributes. For example you can give French and Spanish the type *Language*.

- The *state* defines where the attribute is valid. An expert in workers' compensation claims usually has expertise in just one state.

- The *value* defines an integer value to an attribute. Language fluency might be rated on a 1-5 scale.

Custom user attributes show in the **Team** and **Administration** tabs, where, like all other characteristics of users, an administrator can create and them and bestow them on users.

User Roles

Users can also possess one or more *user roles*, which are distinct from 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 the `UserRole` typelist.

Use Gosu rules to assign work to a user with a specific user role. The `assignToClaimUserWithRole()` assigns work to a user with a specific user role, who is also a member of the group which owns the claim. This means that the claim must already be assigned to a group before this method is useful.

An example of user roles is assignment is a workers' compensation claim that needs 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 a 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 `UserRoles` typelist) is subject to conditions, or constraints, defined in the `UserRoleConstraints` typelist.

To Grant a User Role

1. Select a a claim. Navigate to **Claim → Parties Involved → Users**.

2. Select the user.

3. Click **Add**.

4. Click **Role** and 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 adjuster. The `ContactRoles` typelist contains all defined contact roles, and its categories are the constraints governing to whom they can be given. These constraints are in the `RoleConstraints` typelist.

To Grant a Contact Role to a Contact on a Claim

1. Select a a claim. Navigate to **Claim → Parties Involved → Contacts**.

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

3. Click **Add** and select the **Role** you want.

4. 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 such users from working on a claim unless they have the correct system permissions. You can also limit the number of users of contacts with a specific role. Do this using user role constraints:

User Role Constraint	Definition (the default setting for all of these is true)
ObjectOwner	The user given a user role on an object must have the same permissions needed to own the object.
ClaimExclusive	Each claim can have at most one user given this user role.
ExposureExclusive	Each exposure can have at most one user assigned to this role.

The `entityroleconstraints-config.xml` file defines how role constraints are used. For more information, see "Configuring Contact Permissions" on page 104 in the *Configuration Guide*.

User Experience Rating

All users can be granted an experience attribute by an administrator from the choices in the `UserExperienceType` typelist, which contains the typecodes low, medium and high experience. Assignment rules can use this characteristic to keep complicated work from inexperienced users.

Load Factors

All members of a group are not created 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 work loads, administrators assign each user a number (0-100) to reflect what percentage of the group's normal workload each user must have.

> **Note:** This *load factor* appears in manual assignment screens to help in manual assignment as well.

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.

> **Note:** The algorithm assigns equal amounts of items, because it cannot know how difficult each item is.

See Also
- "Vacation Status" on page 261 for information on how vacations work in ClaimCenter.

Workload Counts

After becoming a member of multiple work teams, you can be assigned a full workload as a member of each team. This is without accounting for the workload assigned as a member of the 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 through 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. It is broken down by whether each item is new, open, flagged, closed, or overdue, or completed today (not all of these types is shown for each work category). In each category, the table shows the total count of items assigned to the user as a team member, and the entire total. Supervisors can use this information to reduce overworked subordinates load factor.

Gosu functions can also return this information. For example, auto-assignment rules can be written to exclude overworked users from round-robin assignment or to reduce their load factors. See "Team Management" on page 325 for details.

ClaimCenter updates these global numbers hourly when running the statistics batch process. For details of batch processes, see "Batch Processes and Work Queues" on page 129 in the *System Administration Guide*.

Inactive Status

A user always has the status of **active** or **inactive**. After inactive, a user cannot log into ClaimCenter and cannot be assigned anything. Only an administrator changes this status, which is set in the **User Profile** screen, accessed from the **Administration** tab.

Related Users

Related users are users or contacts who either:
- Have a *user role* on the claim, See"User Roles" on page 371.
- Own the claim, or one or more of its exposures, activities, or matters.

By contrast, a *claim user* is a person meeting this second criteria of having been assigned work on the claim.

To View all Related Users on a Claim

To see all of a claim's related users, as well as all the claim's other users do the following.

1. Navigate to **Claim → Parties Involved** menu item.

2. Click **Users**.

This screen lists all users. 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 to the following.

1. Navigate to **Desktop → Claims → All opened related** or **New related (this week)** filters.

2. View all claims on which you are a related user.

> **Note:** If you own an exposure, this filter lists you as a related user on the claim.

3. **Desktop → Exposures → All open related** or **New related (this week)** filters.

4. View all *exposures* on where you are a related user.

> **Note:** Both these filters only return related users who own the claim or an exposure, but not those users owning an activity or matter.

Viewing All Your Assignments

You can also view all claims on which you are assigned work by substituting the **All open owned** or **New opened (this week)** filters in the **Exposure** screens. The **Activities** screen shows all activities, but there is no way to view all matters that you have been assigned to.

To View All Matters Related to a Specific Claim

1. Find a claim by navigating to **Claim → Parties Involved** menu item.

2. Click **Users**. Your matters (if any) appear in the **User Details** table.

3. Navigate **Claim > Litigation** menu item > all matters (assigned to anyone) appear in the main table

Assignment Queues

ClaimCenter creates, maintains, and displays queues of activities for each group.

The `assignActivityToQueue()` method assigns an activity (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. However, queues can be used to assign claims, exposures, or 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 explains how to use a queue to assign first notice of loss (FNOL) claims. After importing a FNOL, ClaimCenter triggers the rule sets in the following table. These rule sets generate review

activities and place them on a queue. A group member then grabs 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	in this rule set	which performs this action
Assign FNOL claim to an intake group	Global Claim Assignment	Select the *current group* which makes the final claim assignment.
Assign claim to the group supervisor	Default Group Claim Assignment	*Park* the claim with 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	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.

Pending Assignment Queue

After assignment selects a group, the `confirmManually` method places an activity to manually assign the work into that group supervisor's **Pending Assignment** queue. By completing this activity, the supervisor assigns the related work.

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.

Regions

A region is a named area that contains one or more states, ZIP 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, and these regions can overlap. State-level regions that describe the office to which a claim is sent, while a ZIP code or county-level region 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, if a claim has a loss location of *California*, ClaimCenter can determine that the responsibility falls within the *Western region*. It then assigns that claim to a group that covers that region.

A group can also cover multiple regions. If you define one region (Arizona and New Mexico), and another region (all counties in Southern California), then you can assign both these regions to your *Southwest Regional Office*.
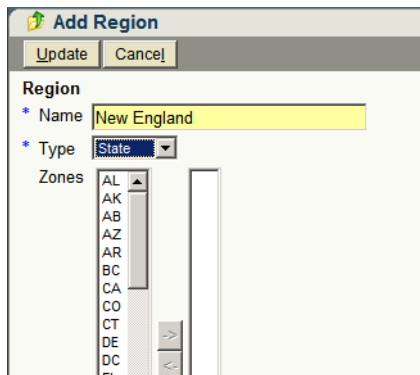
Regions are not Security Zones

Use regions for assignment. Administrators can define them and assign them to groups, using *Assignment by Location* rules. 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. Administrators do not create them, edit them, or assign them to groups. A group can belong to just one security zone. There is no user interface which creates them; they are defined in the `Security-zones` typelist.

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 as seen in the following example.

To Create a Region

1. Navigate to: **Administration → Regions → Add Region**.

2. Enter a name and pick a type: state, ZIP code, or county.

3. Pick the items and click **Update**.

If picking a group of items which are ZIP codes or counties, they can come from many states.

To Edit a Region

1. Navigate to: **Administration → Regions** and select a region.

2. Click **Edit** to add or remove states, ZIPs, or counties.

3. Click **Update** to save your work.

You can also rename a region, however, this effectively deletes the original region, and Guidewire recommends avoiding this. Instead, create a new region with the new name.

To Delete a Region

1. Navigate to: **Administration → Regions** and select a region.

2. Click **Delete**.

3. Click **Update** to save your work.

Avoid deleting regions. Instead, create and use new ones to avoid making users without a region.

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 → Search For Group** and select a group.

2. Select the **Region** tab.

3. Click **Add** and make your selection from the drop-down menu.

4. Click **Update** to save your work.

To Remove a Region From a Group

1. Navigate to: **Administration** → **Search For Group** and select a group.

2. Select the **Region** tab and pick a region.

3. Click **Remove**.

4. Click **Update** to save your work.

Security: Roles, Permissions, and Access Controls

Security is critical for both its general data and its financial information. For example, a carrier does not want the details of a famous client's claim to appear on the front page of the New York Times. 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 what *actions* you are allowed to do. This includes defining permissions, bundling groups of related permissions into roles, and carefully assigning these roles to users, based on the ClaimCenter work they must perform. This type of security applies to all entities, because if you can access one claim, then you can access all claims.

* **Data-based security** defines what *data* you have access to. ClaimCenter can segregate the claims and other entities it contains 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 also grants different levels of authority to users in different groups or Security Zones. For example, while certain claim summaries are visible to all adjusters in the same security zone, only the adjusters in the same office (group) handling the claim can edit them.

This topic includes:

- "Data Model for Access Control Profiles" on page 397

Security Examples

The 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.

The 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 their respective exposures.
- Control access to claims filed by your employees or 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 owns that claim.
- Grant users the ability to view a claim if they are in the same region as the user who owns that claim.

Role-Based Security

Permissions

The fundamental units of security in ClaimCenter are permissions. With proper authority, you can create permissions. After permissions exist, you can group them together into roles, and assign one or more of these roles to each user. You can also bundle them into claim security types and use Access Control to restrict users access to certain claims. See "Claim Security Types" on page 384.

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. See "Turning Off Access Control" on page 383).

There are two subcategories of permissions. These permissions can affect what *screens* of the user interface you can access, or they can restrict what *entities* you can view or manipulate:

- **Screen permissions** – Permissions controlling access to a particular screen, or section of a screen, of the application. With proper permission, an administrator can create new screen permissions, collect them into roles, and assign roles to users.
- **Domain permissions** – Permissions relating to a specific ClaimCenter entity, like a claim or a bulk invoice. The most important entities have these permissions associated with them. Only ClaimCenter can define these permissions, but an administrator can add them to roles, 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* restricts access to a screen that is part of the Loss Details screen. It contains information that tracks paper documents associated with the claim. People who store boxes of files need permission to edit this screen, to tell where the paper files have moved. But they are not adjusters. So they cannot have the broader *Permission to edit loss details*, which governs access to the entire loss details screen, including the screen they need 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 can have any number of roles, but has to have at least one.

Permissions 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. Some carriers have specific Contact Managers that manage certain subtypes of contacts and, therefore, need the system to enforce permissions at the contact subtype level. This level of enforcement 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.

The main permissions for ContactCenter (Address Book, or ab) are:

- `abview` – In this case, ab means address book.
- `abviewsearch` – Ability to view the screen of ContactCenter search results.
- `abedit` – Ability to edit contacts.
- `abcreate` – Ability to create contacts.
- `abdelete` – Ability to delete normal contacts.
- `abdeletepref` – Ability to delete preferred contacts.

If you log in as a user with administrator privileges, you can assign these permissions to particular users for certain contacts or contact subtypes. For example, you can grant one user the ability to manage the Auto Body Shops contact subtype, and another to manage other contact subtypes. If you grant a permission for a contact type, you grant the same permissions to all that contact's subtypes.

Working with Permissions and Roles

Although you must work with XML and PCF files to add or remove permissions, you create and modify roles, and assign roles to users by using the user interface. Through the user interface, you can modify roles and users at the same time.

To Create a New Permission

In general, to add a permission, you must:

1. Add the permission name and typecode to the `SystemPermissionType` typelist.

2. Add code to the display screen that checks for the new permission before displaying the screen. For example, set the `editable` attribute to a permission, so that it is `true` after a user has that permission:

   ```
   editable="perm.System.editSensSIUdetails"
   ```

You delete permissions by removing them from the same typelist, but if you do so, you must also remove all references to them from every PCF file that references them. The data dictionary helps in locating these references. It is safer to remove permissions from a role.

For more information on using the Data Dictionary, see "Data-based Security - Claim Access Control" on page 383.

To Add or Remove a Permission

To add permissions to an existing role:

1. Navigate to **Administration** tab → **Roles** and click a role.

2. Click **Edit** and select a permission from the drop-down list.

3. Click **Add** and then **Update**.

Select more permissions in the same way and **Add** each one before you click **Update** to finish.

To remove permissions from an existing role:

1. Navigate to **Administration** tab → **Roles** and click a role.

2. Click one or more permission check boxes.

3. Click **Remove** and then click **Update**.

> **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, rather than the old role, to those new users.

To Add or Remove a Role

To create a new role:

1. Navigate to **Administration** tab → **Roles**.

2. Enter a name and description and then click **Add**.

3. Select one or more permissions from the **Permission** drop-down list.

4. Click **Update**.

You can create additional roles in the same way and **Add** each one before you click **Update** to finish.

To add a new role and assign it to a user

1. Proceed as previously described in steps 1 - 3.

2. Prior to clicking **Update**:

    a. Click the **Users** tab and click **Add**.

    b. Select a user from the search screen and click the user's check box.

    c. Click **Select**.

3. Click **Update**.

To remove a role:

1. Navigate to **Administration** tab → **Roles**.

2. Click to mark one or more roles.

3. Click **Delete** and then confirm the deletion.

Removing a role is not usually a good idea, because doing so can cause users to unexpectedly lose permissions.

To Apply Permissions to Search Results

Normally, you never see either an entity's name or contents 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, even though you cannot view them individually.

You can set two configuration parameters in `config.xml` to prevent this behavior.

- `RestrictSearchesToPermittedItems` – If `true`, search results do not include items for which you lack the view permission.

- `RestrictContactPotentialMatchToPermittedItems` – After searching or using autocomplete for a contact, restrict the contacts to those for which you have view permission.

Security Hierarchy

By defining a large number of narrowly-defined permissions, grouping them together in different roles, and then assigning sets of roles to users, ClaimCenter contains a large number of security profiles. These profiles are tailored closely to user's needs. To make this grouping easier to manipulate, ClaimCenter uses the following hierarchy:

- **System permission** – The most atomic type of permission.
- **Role** – A grouping of system permissions.
- **Security profile** – The collection of roles assigned a user.

Besides role-based security, the following security mechanism uses parts of the previous hierarchy:

- **Access Control** – A data security mechanism that is parallel to the hierarchy and also uses system permissions.

Data-based Security - Claim Access Control

Role-based security controls access to all claims. 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 391
- "Access Control for Documents and Notes" on page 388))

How Access Control Works

- A user creating or editing a claim decides whether to restrict claim access by placing it into a special category of a restricted *claim security type*. There can be several to choose from. The claim owner can later place the claim in another subset or the *unrestricted* subset. See "Claim Security Types" on page 384.
- Users trusted to have access to a restricted claim have special permissions, or a role that contains them. See "ClaimOwnPermission and SubObjectOwnPermission Elements" on page 387.
- An Access Profile is defined for each restricted claim type. It then grants users with these special permissions to become a restricted claim or exposure owner, or have a special user role on the claim or exposure. The Access Profile grants an access level to these users, besides their groups and security zone. 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 385 and "Access Profiles" on page 385.

Configuration Parameters That Affect Access Control

The following configuration parameters in `config.xml` 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. Document and Exposure Access Control cannot be disabled. Even after Access Control is 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.

If Access Control is on, it can still be turned off for users with specific user roles. See "ClaimAccessLevel Elements" on page 387.

Access Control and Searches for Restricted Claims

The `RestrictSearchesToPermittedItems` system parameter determines the items that a user can view in search results. If this parameter is `false`, search results can include claims that the user cannot view or edit.

Inheriting Access Control Permissions

ClaimCenter supports downline access for supervisors, giving supervisors the same access as any user, group, or security zone that they administer. 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 users that the supervisor supervises. But if the system parameter `EnableDownLinePermissions` is `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, but they can be unimplemented. Access controls for documents and exposures also cannot restrict search results and do not support downline inheritance.

Elements of Access Control

This section describes claim access control. It covers:

- **Claim Security Types** – Claim subsets affected by access control, such as fraudulent, sensitive or litigated.
- **Claim Access Types** – Groupings of permissions, like roles, define what access means, typically View or Edit.
- **Claim Access Levels** – How access control affects claim owners, users with specific user roles, and their groups and security zone.
- **Access Profiles** – 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 as many subsets as you like in the `ClaimSecurityType` typelist. Any single claim can belong only to one claim security type. These subsets appear in the **Special Claim Permission** drop-down list of a claim's **Claim Status** screen. By clicking **Edit**, you can assign a claim a claim security type.

Claims not assigned any of these types are given the type **Unsecured**. Each claim security type has a matching Access Profile. ClaimCenter provides the following claim security types:

- **Employee** – A claim by one of your coworkers.
- **Fraud Risk**
- **Sensitive** – A claim one you would like to keep out of the newspapers.
- **Under Litigation**
- **Unsecured** – None of the previous types. ClaimCenter uses this type 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. In other words, `ClaimAccessTypes` are another way of grouping claim-specific

system permissions, and then granting groups of permissions. ClaimCenter defines these claim access types as follows:

- **View** – Can search for and see all claim information, including its exposures, activities and financial data.
- **Edit** – Cannot view, but can change and operate on claims. For example, closing or making payments on claims.

To create more claim Access Types, and group permissions into them, see:

- "To Create a new Claim Access Type" on page 386
- "To Map Permissions to a Claim Access Type" on page 386

Claim Access Levels

The following access levels can be defined as being required for getting on Access Control for a claim. They have slightly different meanings, depending on usage. See "ClaimAccessLevel Elements" on page 387. In general, they define the relationship one must have with the claim's owner.

Level	Allows access to
user	The 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. It also defines what Access Types they 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, a user must have to have access to that claim security type. See "ClaimOwnPermission and SubObjectOwnPermission Elements" on page 387.
- 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 "To Create or Edit an Access Profile" on page 386 for an example of an Access Profile and how it uses these special permissions and grants Access Types.

Working with Access Control

To Create a New Claim Security Type

Add a new typecode to the `ClaimSecurityType` typelist to create a new Claim Security Type.

To Add Access Control to a Claim

After creating a claim, navigate to the **Summary → Claim Status** screen. Then select the **Claim Security Type** (**Employee**, **Fraud**, **Litigated**, or **Sensitive**) from the **Special Claim Permission** drop-down list. You must click **Edit**. If you do not select

any of these security types, the claim will be assigned the **Unsecured** claim security type. The claim owner can later change this assignment.

Note: If you select a security type and do not have that access permission, after you exit the **Loss Details** screen, you return to the **Desktop**, unable to access that claim.

To Create a new Claim Access Type

Although `View` and `Edit` are the only claim Access Types in the base configuration of ClaimCenter, you can define others. They are typecodes of the `ClaimAccessType` typelist. 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, you can use Access Control to restrict them to few users.

To Map Permissions to a Claim Access Type

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 is an example:

```
...
<AccessMapping claimAccessType="view" systemPermission="claimviewres"/>
<AccessMapping claimAccessType="view" systemPermission="plcyview"/>
<AccessMapping claimAccessType="view" systemPermission="claimviewres"/>
...
```

In mapping, be careful to:

- Map only permissions that are related to claims. 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 (where it really belongs).

To Create or Edit an Access Profile

Access Profiles are in `config-security.xml`. Following is the Access Profile for the employee claim security type:

```
<AccessProfile securitylevel="employeeclaim">
    <!-- only users with these system permissions can be part of this Access Profile -->
    <ClaimOwnPermission permission="ownsensclaim" />
    <SubObjectOwnPermission permission="ownsensclaimsub" />
  - <ClaimAccessLevels>
        <AccessLevel level="group" permission="view" /> <!-- anyone in the user's group can view -->
        <AccessLevel level="group" permission="edit" /> <!-- or edit -->
        <DraftClaimAccessLevel level="securityzone" />  <!-- more users have access to a draft claim-->
        <ClaimUserAccessLevel role="attorney" level="user" permission="view" />
        <ClaimUserAccessLevel role="attorney" level="user" permission="edit" />
        <!-- level="region" and "all" are missing, so users outside the group  cannot view or edit-->
    </ClaimAccessLevels>
  - <ActivityAccessLevels>
        <AccessLevel level="user" permission="view" />
        <AccessLevel level="user" permission="edit" />
    </ActivityAccessLevels>
  - <ExposureAccessLevels>
        <AccessLevel level="user" permission="view" />
        <AccessLevel level="user" permission="edit" />
        <AccessLevel level="group" permission="view" />
    </ExposureAccessLevels>
</AccessProfile>
```

The previous example specifies the access to all claims with 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` elements, then you must give the Trusted For Sensitive Claims role. This role contains the following two permissions for that user. Otherwise, Access Control restricts that user from the claim:

```
<ClaimOwnPermission permission="ownsensclaim" />
<SubObjectOwnPermission permission="ownsensclaimsub" />
```

You can also create your own permissions, such as `ownEmployeeClaim`, grant them to trusted users, and add similar lines to the appropriate Access Profile to restrict access to those users.

ClaimAccessLevel Elements

The `ClaimAccessLevel` element must contain at least one of the following subelements. The previous example shows all of them:

- `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	Allows access to
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` – 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` typelist, are assigned by the claim owner while adding another user to the **Parties Involved** screen of the **Users** tab of a claim. For example, the chief physician treating a claimant can be assigned the **doctor** user role, as follows:

  ```
  <ClaimUserAccessLevel role="doctor" level="user" permission="edit" />
  ```

Level	Allows access to
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.

ExposureAccessLevel and ActivityAccessLevel Elements

The `ExposureAccessLevel` and `ActivityAccessLevel` elements grant claim access to users owning a claim exposure or activity. The above 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 391 and "Access Control for Documents and Notes" on page 388 for more details.

To Apply 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, then restore its original Access Type and re-save it.

To Join 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 (are 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 (are 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 `Unsecured` claim security type.

To Rebuild 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 this access. The only way to remove access is to redo, or rebuild, the ACL that allows access. Rebuilding can be a manual operation, using the previous descriptions to create ACLs. Finding and editing the correct ACL can be both time-consuming and can introduce errors. However, you can 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 document or note 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.

As described above, note and document access control requires:

- **Document Security Types or Note Security Types** – Document subsets, like `intonly` or `sensitive`, to be affected by access control. Analogous to claim access types, these security types are defined in the `documentsecuritytype` typelist. They appear in the **Security Type** drop-down list of the **Document** and **New Document** sections of a claim screen. You can assign a claim at most one of these security types. Similarly, the `Notesecuritytype` typelist, containing `private` and `sensitive` typecodes, 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. It cannot be disabled, always finds restricted documents in searches, and does not support downline access. See "Configuration Parameters That Affect Access Control" on page 383.

Working with Access Control for Documents and Notes

The following sections describe both how to define and how to 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 and special investigation documents and sensitive notes are confidential and are seen only by members of their respective groups. There is a single claim with 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 (three plus two) documents.
- Special Investigations see four (one plus three).
- 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 Create Document and Note Security Types" on page 389.
- "To Assign a Document or Note to a Security Type" on page 389.
- "To Create Document Access Profiles and Note Access Profiles" on page 389.
- "To Create and Assign New Permissions" on page 390.

To Create Document and Note Security Types

You set document type by using the document's **Security Type** field on the user interface or through Gosu. The DocumentSecurityType typelist contains the sensitive and unrestricted security types. You can add more, such as internalonly. Similarly to claims, documents that are not assigned a special security type are given the unrestricted security type. For example, add the following lines to DocumentSecurityType to create subrogation and special investigation security types:

```
<typecode code="subrogation" name="Subrogation Doc" desc="subrogation document"/>
<typecode code="specialinv" name="Special Inv Doc" desc="special investigations document"/>
```

For notes, add this line to NoteSecurityType to create the sensitive note security type:

```
<typecode code="sensitive" name="Sensitive Note" desc="sensitive note"/>
```

To Assign a Document or Note to a Security Type

After creating a new document with the **New Document** menu action of a **Claim** screen, choose the security type to assign the document from the **Security Type** drop-down list.

> **Note:** You cannot assign a document to a security type unless you possess the permissions defined in the corresponding document access profile.

To Create 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 do the same for notes. You must have a document or note access profile

for each document or note security type you want to put under document access control. Each document and note access profile has the following syntax:

```
<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-->
    <NotetDeletePermission permission="perm"/>       <!-- allow this permission to delete-->
  </NoteAccessProfile>
</NotePermissions>
```

In these definitions, `type` specifies a document or note security type, and `perm` is a system permission. ClaimCenter provides three document permissions, `viewsensdoc, editsensdoc,` and `deletesensdoc,` and for sensitive notes, `viewsensnote, editsensnote,` and `deletesensnote.` ClaimCenter provides a similar set of permissions for private note types. 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 are the document access profiles for unrestricted, subrogation, and SIU document types, bringing together the security type and permissions:

```
<DocumentPermissions>
  <DocumentAccessProfile securitylevel="unrestricted"/>
...
  <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. Set permissions for public (unrestricted), private, and sensitive note types in `security-config.xml:`, relating to `viewprivnote`, `editprivnote`, and `delprivnote` system permissions. There is a similar set of relationships for notes of `sensitive` type.

```
<NotePermissions>
  <NoteAccessProfile securitylevel="public"/>
  <NoteAccessProfile securitylevel="private">
    <NoteViewPermission permission="viewprivnote"/>
    <NoteEditPermission permission="editprivnote"/>
    <NoteDeletePermission permission="delprivnote"/>
  </NoteAccessProfile>
  <NoteAccessProfile securitylevel="sensitive">
    <NoteViewPermission permission="viewsensnote"/>
    <NoteEditPermission permission="editsensnote"/>
    <NoteDeletePermission permission="delsensnote"/>
  </NoteAccessProfile>
</NotePermissions>
```

To Create and Assign New Permissions

You must create and assign new system permissions that match the permissions used in the document or note access profile. For this example showing document permissions, add the following typecodes to the `SystemPermisionType` typelist, the normal way of creating permissions:

```
<typecode code="viewsubdoc" name="View subro documents" desc="Permission to view a subro document"/>
<typecode code="editsubdoc" name="Edit subro documents" desc="Permission to edit a subro document"/>
<typecode code="delsubdoc" name="Delete subro documents" desc="Permission to delete a subro document"/>
<typecode code="viewspecinvdoc" name="View SIU documents" desc="Permission to view a SIU document"/>
<typecode code="editspecinvdoc" name="Edit SIU documents" desc="Permission to edit a SIU document"/>
<typecode code="delspecinvdoc" name="Delete SIU documents" desc="Permission to delete a SIU document"/>
...
```

```
<typecode code="viewssensnote" name="View sensitive notes" desc="Permission to view sensitive notes"/>
<typecode code="editsensnote" name="Edit sensitive notes" desc="Permission to edit sensitive notes"/>
<typecode code="delsensnote" name="Delete sensitive notes" desc="Permision to delete sensitive notes"/>
```

An administrator can put these newly created permissions in roles and assign roles, if necessary, to users who can access these document and note subsets. In this example, based on the above access profile:

1. Add the three new subrogation permissions to the Subrogation role.

2. Add the three new special investigations permissions to the SIU role.

3. Add the note permissions to the Trusted Adjuster role.

4. Add all six permissions to the Manager role.

All subrogators, SIU experts, trusted adjusters, and managers have already been assigned these roles, so they have the correct permissions. Adjusters have none of them. To finish this example, managers are able to access all documents, and SIU inspectors have access to their documents and those added by adjusters, and so on.

Access Control for Exposures

Some jurisdictions demand that some kinds of claim data be protected, especially for personal injury, accident injury, and workers' compensation data. This data is almost always available at the exposure level rather than the claim level. For example, many Canadian insurers must insulate auto body and personal injury adjusters from the others' information. Exposure level security does this.

Exposure Level Security

Exposure access control restricts access to exposures within a claim. With this type of access control, 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.

After users attempt to view an object that they do not have access to, they receive a permissions error.

The exposure-level security feature guards against seeing the content, and sometimes even the existence, of various entities related to an exposure:

entity	hide existence?	hide contents?	hide in searches?
Exposure	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

entity	hide existence?	hide contents?	hide in searches?
all others	no	no	no

Static versus 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. The result is that a user must have permissions for both the claim's Access Control besides 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 "To Create Exposure Security Types" on page 392.

2. Assign exposures to these subsets. See "To Assign a Security Type to an Exposure" on page 392.

3. Give a new permission to trusted users. See "To Create and Grant New Permissions" on page 392.

4. Associate this permission with the security type. See "To Create Exposure Access Profiles" on page 393.

5. If you want static access control, independent of claim Access Control, you are finished.

6. If you want claim-based access control, see: "To Implement Claim-Based Exposure Access" on page 393.

To Create Exposure Security Types

Create any number of exposure security types by adding typecodes to `ExposureSecurityType`. This typelist is empty and contains no internal codes, so you have full control in defining different types.

Exposures not given a security type have the default type of `null`. This differs from claims and documents, where those objects have the type `unsecured` unless given a security type.

To Assign a Security Type to an Exposure

ClaimCenter does not provide a user interface to assign security types to exposures as it does to claims, explained in "To Add Access Control to a Claim" on page 385. You can modify an exposure screen to display a Security Type drop-down list, similar to the implementation for claims or documents. See "To Assign a Document or Note to a Security Type" on page 389.

If you have segmented exposures, you can use another pre-update rule to assign a security type to all exposures given the same segment. For example, a rule could state, "if an exposure segment is 'personal injury', set its security type to 'injury'."

To Create and Grant New Permissions

Two new system permissions have been added to control access to exposures - `expview` and `expedit`. To create more, see "To Create and Assign New Permissions" on page 390. You then add these permissions to the appropriate roles or create new roles, and then assign roles to users in the usual way.

You must also map these new permissions to claim Access Types. See "To Map Permissions to a Claim Access Type" on page 386. These permissions also grant the user to view the claim containing the exposure.

To Create Exposure Access Profiles

Just as in creating claim and document access profiles, create a block in `security-config.xml`, but call it `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.

To Implement Static Exposure Access

After you have completed the previous four topics, you have implemented static exposure access.

Static security applies to all exposures and is based solely on the Exposure Permissions element in `security-config.xml`. 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.

To Implement Claim-Based Exposure Access

First, implement the static form of exposure security:

1. Add a new `abexposure` exposure security type. See "To Create Document and Note Security Types" on page 389.

2. Add a new `abexposures` system permission. See "To Create and Assign New Permissions" on page 390.

3. Create an `ExposurePermissions` element in security-config.xml that associates them:
```
<ExposurePermissions>
    <ExposurePermission securitylevel="abexposure" permission="abexposures"/>
</ExposurePermissions>
```

Completing these steps implements static security for exposures.

For claim-based exposure security:

1. Create `abexposure` in the `ClaimAccessType` typelist. Create a claim Access Type and an exposure security type with the same typecode:
```
<typecode code="abexposure" name="auto body" desc="auto body exposure"/>
```

2. Create a mapping element in `security-config.xml` to map your new permission to your new claim Access Type. Compare to "To Map Permissions to a Claim Access Type" on page 386:
```
<AccessMapping claimAccessType="abexposure" systemPermission="abexposures"/>
```

3. Add this new claim Access Type to the Access Profile in `security-config.xml`. For example:
```
<AccessProfile securitylevel="sensitiveclaim">
...
    <ExposureAccessLevels>
        <AccessLevel level="user" permission="abexposure"/>
    </ExposureAccessLevels>
</AccessProfile>
```

After this access control is in place, users that attempt to access an exposure must have the `abexposures` permission controlling exposure security. Additionally, they must have access to `sensitive` claims, defined by the claim's Access Profile (claim access control).

Guidewire recommends that you implement the claim-based method only with custom claim Access Types. You need one custom claim Access Type for each exposure security type.

> **Note:** Many custom claim Access Types can put a performance load on your system, so use this security implementation with care.

You cannot use the default claim Access Types for claim-based exposure security. Mapping the default claim Access Type View to both the `abexposure` and the `expview` permissions would eliminate the distinction between all claim exposures and `abexposure` exposures.

Security Zones

Security for a small group of an organization might not need to be as tight as in the organization as a whole. 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, many carriers allow all claims to be seen, but only people within the claim's handling office have edit access. In this case, you could create security zones corresponding to offices so that people outside an office cannot edit another office's claims.

Claim Access Control is the only part of ClaimCenter that uses security zones. See "To Create or Edit an Access Profile" on page 386.

Security zones are just names. They are not defined as collections of geographical areas like regions, as described under "Regions" on page 375. 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 members of a group within that security zone. Thus, users in multiple groups can belong to more than one security zone.

You might want to make virtual security zones that are related to something besides geography. For example, you could define workers' compensation, auto, and property as security zones, thus restricting information flow between them.

To Create, Edit or Delete Security Zones

1. Navigate to **Administration** tab → **Security Zones**.

2. Click the **Add Security Zone** button or click a zone.

3. Add data and then click **Update**.

You perform the following operations in the **Security Zones** menu item of the **Administration** tab:

- To create a new security zone, click the **Add Security Zone** button and enter a name and description, and then click **Update**.
- To edit an existing security zone, click the zone you want to edit and change the name and description. Click **Update** to save your work.

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 → **Search For Group**.

2. Select a group.

3. C.ick **Edit** and then pick zone from the **Security Zone** drop-down list.

4. Click **Update**.

> **Note:** If permission is granted to a user on a claim that the user is related to, then ClaimCenter checks if the user is part of the right security zone. See "Related Users" on page 373.

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 demanding a password having a minimum and maximum length, ClaimCenter does not demand that passwords have any specific format, or that they be changed regularly.

A user can be locked out of ClaimCenter after entering an incorrect password 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, an administrator might have to manually enable the user to retry logging in. For details, see "To Change Password Behavior" on page 396.

After a browser connects to ClaimCenter, a session is created for that browser connection and has a time-out parameter.

- **You must always log in to ClaimCenter**. In the initial login screen, you must provide a valid user name and password, and then click **Submit** or type `Enter` before being allowed entry.
- **You can change your password**. After you are logged in, select the **Preferences** menu action from the **Desktop**. Click **Edit**. Enter information into the **Old Password**, **New Password**, and **Confirm Password** boxes, and click **Update**. This technique works only if you remember the old password. If you do not remember, an administrator must reset it.
- **Administrators can change a user's password**. On the **User** screen, click **Edit** from the **Basics** subtab, and then enter a new password in both the **New Password** and **Confirm Password** boxes. Click **Update**. This technique does not allow 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 be for a certain period of time, or until an administrator unlocks you.
- **Administrators can unlock and lock users**. On the **User** screen of the **Administration** tab, click **Edit** from the **Basics** subtab. Click either **Yes** or **No** beside the user's name in the **Locked** list. Click **Update** to save your work.
- **Administrators create passwords and user names after creating new users.** From **Administration**, click **New User**. Enter the new information—name, user name, initial password, roles, group assignments. Click **Add** and **Update** to save your work.

Forcing Password Changes

Although not a part of the default application, you can create a customization to force users to periodically change their passwords. ClaimCenter can store previous passwords and the time of the last change. Then, on login, if the password is old, the user is directed to the **User Preference** screen to change the password.

How to Force Users to Change Passwords

To force users to change passwords, do the following. Add one new column, and the Boolean `PwdOK` to the User entity. Add a new date of last password change and fields to store the previous five passwords to the `Credential` entity.

After a user logs in, a new `ForwardCondition` checks in `ClaimCenterStartupPage.pcf`. It checks the date in `Credential` to determine if the password is old. This date can be pre-defaulted to January 1, 2000, to force a first-time login change. If the password needs to change, the user must go to the `UserPreferencesScreen` and enter a new valid password.

Add a rule to check the new password. This rule prevents a match of any of the five previous passwords stored in `Credential`. A pre-update rule that triggers on a change to `credential.password` holds this rule.

Also, make the following important change: Modify `tabbar.pcf` to include the `PwdOK` Boolean in all the tab visibility attributes. If the password has expired, `PwdOK` is false and no tabs are visible. The user can access only the **User Preferences** screen and create a new password. Then all the user's regular tabs, governed by role permissions, become visible.

To Change Password Behavior

The following configuration parameters, in the `Security` section of the `config.xml` file, control login passwords:

Configuration parameter	Description	Default
`sessiontimeoutsecs`	How long a user's session remains active since the end of its last use.	10800
`MinPasswordLength`	The minimum length of a user's password.	2
`MaxPasswordLength`	The maximum password length.	16
`FailedAttemptsBeforeLockout`	How many login failures are allowed before user is locked out (-1=disabled).	3
`LoginRetryDelay`	How many milliseconds 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, or -1 if manual unlock is necessary.	-1

Security Dictionary

The ClaimCenter Security Dictionary is web-based documentation that can be generated as part of the ClaimCenter installation. Guidewire recommends that every time you change the data model, you regenerate this dictionary.

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 do on that entity when given that particular permission. For example, for the `Activity` entity, if you do not have the `create activity` permissions, you cannot access **New Activity** through the **Actions** menu.

- **Page configuration files (PCF files)**. Select a file to see which permissions are 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, select `catmanage`, the permission to manage catastrophes, to see the roles that use this permission: Catastrophe Admin, and Superuser. You also can create, delete, and edit catastrophes. Knowing which PCF files contain this permission is also useful for troubleshooting because you can see if the permission is used correctly on those pages.

- **Roles**. While you can see the same information by navigating to **Administration** → **Roles**, in the Security Dictionary you can see which other roles share that permission. For example, if you select **Adjuster**, you see the list of permissions that an adjuster has. If you select a permission such as `sendemail`, the permission to send email, then you would also see which roles share that permission. In this example, claims supervisor, clerical, customer service representative, manager, new loss processing supervisor, and superuser can send email too.

See also
- "Regenerating the Data Dictionary and Security Dictionary" on page 32 in the *Configuration Guide*

Data Model for Access Control Profiles

Files for Claims	Description
`config.xml`	See "Configuration Parameters That Affect Access Control" on page 383.
`security-config.xml`	Holds the mapping of system permissions to claim Access Types, besides Access Profiles.
`ClaimAccessType.xml`	Type of access Access Control provides to a claim—view or edit. These access types are extendable.
`ClaimSecurityType.xml`	Subsets of claims—sensitive, employee, litigated, fraud, or other. This typelist can be extended.
Files for Exposures	**Description**
`ExposureSecurityType.xml`	This typelist is similar to `ClaimSecurityType.xml`.

Administering ClaimCenter

Both users and administrators have permission to perform administrative tasks.

This topic includes:

- "User Administration Tasks" on page 399
- "The Administration Tab" on page 399

User Administration Tasks

There are some administrative actions you can do, such as view your statistics, change your preferences, and change your vacation status.

Use the **Action** button of the **Desktop** tab to perform these functions:

- **Statistics**: See an overview of how many claims and activities you have. The number of claims reflects all claims, including those that are incidents only. For an administrator, this screen also displays statistics for your team.
- **Preferences**: Change your password or your **Startup View,** the first display you see after you log into ClaimCenter. See "User Login and Passwords" on page 395. You can change the default display, which shows your current activities, to open the New Claim wizard instead. You can also show a claim search screen or a list of your current claims or exposures. If you are an administrator, you have other options, such as the **Dashboard** and your team's **Statistics**.
- **Vacation Status**: Change your vacation status from **At Work** to either **On Vacation** or **On Vacation (Inactive)**. You can also specify a backup to accept new work assigned to you. See "Vacation Status" on page 261 for more details.

The Administration Tab

The **Administration** tab is where you 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 roles and permissions for your users (adjusters, managers, supervisors, and so on), thus controlling who is allowed to perform certain ClaimCenter actions.

Groups and users within ClaimCenter represent mainly adjusters processing claims and using 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.

With administrator privileges, you have access to the **Administration** tab. Tasks to perform include:

- **Search for and Select Users and Groups** in your Organization Tree.

    - **Create New Users and Groups**

    - **Users**: You can also edit all aspects of users.

    - **Groups**: You can edit all aspects of groups.

- **Search For Regions**

- **Activity Patterns**: Edit or delete activity patterns or create new ones.

- **Attributes**: Define user attributes that can help in assigning work.

- **Catastrophes**: Add, deactivate, and edit catastrophes, as well as bulk-associate claims to a catastrophe.

- **Authority Limit Profile**: Add or edit authority limit profiles to a role.

- **Roles**: Add permissions to and delete them from roles, and add roles to or delete them from users.

- **Regions**: Define and edit regions.

- **Holidays**: Add holidays, which can be zone specific.

- **Event Messages**: Control the event message engine.

- **Script Parameters**: Edit script parameters without restarting the application.

- **Workflows**: Troubleshoot workflows that are in the application.

- **Importing and Exporting Administrative Data**: Some types of data can either be imported or exported through the user interface.

- **Report Admin**: See the *ClaimCenter Reporting Guide* for details.

- **Security Zones**.

    - Edit the **Coverage Verification Reference Tables**.

    - Edit **WC Parameters** to define benefit times and amounts

- **Coverage Verification**: ClaimCenter uses the policy of the claim and its coverages to verify that related exposures are valid. It warns you about, or prevents you from creating, exposures that are not valid for the policy.

- **WC Parameters**: Edit the tables of benefit parameters.

- **Reinsurance Threshold**: Edit the reinsurance tables based on treaty type, policy, threshold value, reporting value and dates.

- **ICD Codes**: Administer ICD codes for medical diagnosis.

- **Metrics and Thresholds**: Define metrics and large loss thresholds.

- **Business Week**: Define your business week, which can be based on zones.

Search for and Select Users and Groups

The **Organization Tree**, appearing in the upper left of the **Administration** main screen, can be expanded to display all groups and users in your organization. If you know the name of a group or user, you can select it by navigating through the tree and selecting it. If you do not know the location in the tree of a group or user, then use the **Search for Groups** or **Search for Users** menu items to locate them. Then select them from the search results.

Create New Users and Groups

Choose **New User** or **New Group** from the **Actions** button of the **Administration** tab to access screens where you can define a user or group.

Users

The **Search for Users** menu item of the **Administration** tab is not just for locating users, but is also for editing the properties of all users. After selecting a user and using the **Edit** button, you can change the user's:

- Name, user name, password and entire profile, including user attributes (from the screen's **Profile** tab).
- Active/inactive status: inactive users cannot be assigned work and they cannot log in. They remain inactive until an administrator changes their status to active.
- Locked status (unable to login because of too many login attempts). Depending on how security is set up in the `config.xml` file, locked-out users can try logging in again at a later time, or an administrator must unlocked them.
- Vacation status and a backup user to receive work assignments during vacation periods.
- User roles.
- Group memberships and characteristics, such as load factors.
- Authority Limits (see "Authority Limit Profile" on page 403).
- User Attributes (see "Attributes" on page 402).
- Regions (see "Regions" on page 407).

Deleting a User

You can delete a user if you have the correct permissions. However, the system checks if that user:

- Is the super user.
- Is the *default owner*, used as the assignee of last resort by the assignment system.
- Supervises any groups.
- Has any items are assigned, such as claims, exposures, or transactions.

If any of the previous conditions are not met, then ClaimCenter prevents you from deleting that user by not displaying the **Delete** button in the user interface. You can see some of the criteria for deletion in the data dictionary. The `User` entity's virtual property `SafeToDelete` lists these reasons.

Groups

The **Search for Groups** menu item of the **Administration** tab is not just for locating groups, but is also for editing the properties of all groups. After selecting a group and using the **Edit** button, you can change the group's:

- Name and Type
- Parent (the group of which it is a subgroup - its location in the Organization tree)
- Supervisor
- Security Zone (see "Security Zones" on page 412)
- Members (users in the group)
- Load factors
- Queues
- Regions (see "Regions" on page 407)

You can also delete a group with the **Delete** button. For information on creating a new group, see "Create New Users and Groups" on page 401.

Search For Regions

This menu item helps you find all regions defined in your installation. You can filter its search by Zone Type and Code. You typically use this search feature when working with regions, as described at "Regions" on page 407.

Activity Patterns

Use the **Activity Patterns** link to manage all activity patterns in your installation. You can:

- View all activity patterns in a table or select them 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.

> **WARNING** It is advisable to not delete an activity pattern because it can be used elsewhere. For details of how activity patterns work and what their fields do, see "Activity Patterns" on page 226.

Activity Patterns and Localization

If you have enabled localization in ClaimCenter, you can change the subject line of the activity pattern in the editable **Activity Pattern Detail** screen. For details on localization see "Localizing Guidewire ClaimCenter" on page 463 in the *Configuration Guide*.

Attributes

ClaimCenter provides a general way to describe any user attributes you want to help you decide how to assign work. ClaimCenter also contains rules that assign work based on these attributes, selecting a user with the desired attribute by round-robin.

Attributes are grouped by **Type**, listed in the UserAttributeType typelist, which contains **Language**, **Expertise**, and **Named Accounts** types as defaults and can be extended. The **type** is a way to group custom user attributes. For example, you can give French and Spanish the type **Language**.

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**.

Catastrophes

A *catastrophe* is a single incident or a 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 which affect the carrier's business and 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.

In the **Administration** tab, you can do the following:

- Add a catastrophe.
- Activate catastrophes.
- Deactivate catastrophes.
- Find claims to associate to a catastrophe.

To Add a New Catastrophe

1. Navigate to **Administration** → **Catastrophes** and click **Add Catastrophe**.

2. Enter the required fields, such as name, description, CAT number, type, and dates covered, and click **Update**.

The status of the catastrophe is active.

To Activate or Deactivate a Catastrophe

The **Catastrophe** menu item of the **Administration** tab displays a list of catastrophes. Check the checkbox and use the **Activate** or **Disactivate** button. If the catastrophe has been marked as inactive, then it does not show up in the user interface for you to associate a claim with.

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 display the **Catastrophe Details** screen.

2. Click **Find Related Claims**. The application searches only *active* catastrophes.

   ClaimCenter performs a search through a batch process 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 displays 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. You must find the claim and navigate to its **Loss Details** screen. Generally, the quickest way is to navigate to **Desktop** tab → **Activities** and change 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 it to the catastrophe.

   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" on page 115 to learn about catastrophes.

Authority Limit Profile

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, which together 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.

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 their limit, the action will require approval by a user with higher limits, who will be selected by the approval routing rules.

The `AuthorityLimitType` typelist contains these types of limits. You cannot add others.

Authority Limit Name	Description
`Claim total reserves`	The total reserves for all exposures on a claim. If the user's authority limit profile does not have Claim total reserves 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 total reserves`	The total reserves for a single exposure.
`Claim available reserves`	The available reserves for a claim.
`Exposure available reserves`	The available reserves for a single exposure.
`Reserve change size`	The size of a single reserve change.
`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 *Claim payments to date* limit type, then 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."
`Exposure payments to date`	The total amount of payments to date 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.

For each of these authority limit types, you can define a limit amount that applies to the whole claim or only for transactions with any 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 menu 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 will apply to all transactions, regardless of coverage.

> **Note:** : 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`.

Authority Limits 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 of 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 (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 (ALP) in different currencies to 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 ALP with a Currency of Euro, while a UK adjuster would have an ALP with limits defined in GBP.

No matter what the currency of the user's assigned ALP is, the user can still administer claims of any currency. If the currency of the user's profile does not match the currency of the claim for which the user is creating transac-

tions, the currency of the user's ALP 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 these complex sets of authority limits, ClaimCenter groups them into authority limit *profiles* and assigns the profiles to users. You can define other profiles or edit the following profiles, which are in the base configuration:

• Adjuster profile

• Claims Supervisor profile

• Regional Supervisor profile

To work with an authority limit profile

1. Navigate to the **Administration** tab → **Authority Limits Profile**.

2. In this screen, you can:

  • **Select an existing profile** – Click its name, or create a new profile with the **Add Authority Limit Profile** button.

  • **Change a limit** – Select a profile and select the limit, and then choose the limit type, coverage, cost type, and amount. All but the amount are selected from drop-down box choices.

  • **Create a new limit** – Select a profile and click the **Add** button, and then change the limit's values.

  • **Delete a profile** – Select its checkbox and click **Delete**.

3. Click **Update** to save your changes.

Assigning Authority Limits to Users

Once you have selected a user in the **Administration** tab, typically by selecting from its **Search For Users** menu item results, you can:

• **Assign an existing profile** to the user by opening the **Authority Limits** subtab of the **User Details** tab, and selecting a profile from the **Authority Limit Profile** drop down menu.

• **Customize the profile you have assigned** by adding or changing authority limits in the profile for that user. To customize a profile:

  • Select the profile closest to the one you want the user to have from the **Authority Limit Profile** drop-down menu.

  • After making your selection, select **Custom** from this same drop-down menu. The screen contains a table of the authority limits of the **Authority Limit Profile** you first selected.

  • Modify the profile's existing limits or add new ones or both. Although this screen behaves similarly to the screen that defines authority limit profiles, your changes affect *only* this user.

Setting Configuration Parameters

The following parameters in `config.xml` affect authority limits.

Parameter	Default/Set Value to...	Description
CheckAuthorityLimits	true/true	This parameter determines if authority limits are checked when approving a transaction set. If set to `false`, it disables authority limit checking.

Parameter	Default/Set Value to...	Description
`AllowPaymentsExceedReservesLimits`	`false/true`	While this parameter does not affect authority limit behavior, it is *related* to it in that the `PaymentsExceedReserves` only makes sense if the parameter is set to `true`.
		If set to `true`, you can submit payments that exceed available reserves up to the amount limited by the `PaymentsExceedReserves` authority limits. Otherwise, no partial or final payments that exceed reserves are allowed, other than first and final payments.
`MulticurrencyDisplayMode`	`SINGLE/MULTIPLE`	This parameter does not directly affect authority limit behavior. However, if it is not set to multiple, then the currency drop-down menu is hidden.

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 380.

This screen manages the roles themselves. You can create new roles, add or remove permissions from existing roles, and assign roles to users.

To Assign Roles to Users

After you have selected a user in the **Administration** tab, typically by selecting from its **Search For Users** menu item results, you can:

- **Add a role to this user**. Click **Add** in the **Roles** section of the user's **Basics** tab. Select a new role from the drop-down menu. Click **Update** to save your changes.

- **Remove a role from this user**. Check the box next to the role you want to delete. Click **Remove** and then **Update** to save your changes.

To Change Roles and Their Permissions

From the **Roles** menu item of the **Administration** tab, you access a screen that displays a table of all existing roles.

- **To add or delete a new role**. To add, click **Add Role**. Give the role a name and text description. The name you choose appears in the table of roles. You can also add permissions to the role in this screen, or click **Update** to add the new role to the list. To delete a role, check the box next to the role you want to delete and click **Delete**.

- **To add or delete permissions in a role.** Select the role either by clicking its name in the main **Roles** screen or by using the screen you used to add a new role. You can add these types of permissions from either screen:

  - **System Permissions**. Click **Add** near the table of permissions to add a **none selected** line to the table of permissions in the role. Choose a permission from this drop-down list. To delete a permission, check its box and click **Delete**. Click **Update** to save your changes.

  - **Report Permission Sets**. A box containing available **Report Permission Sets** appears below the table of permissions. Use the **Add** and **Remove** buttons to add or delete these sets.

To Change a Role's Sort Criteria

You can search for injured workers instead of claimants. A workers' compensation adjuster might find this useful as the claimant will be the carrier, and the carrier can have multiple injured workers.

Perform the following steps:

1. With administrator permissions, navigate to the **Administration** tab and select **Search for Users** from the left pane.

2. Find the user and select click the user's link.

3. Select the **Profile** tab and click **Edit**.

4. Under **Loss Type**, select **Workers′ Comp**.

5. Under **Policy Type**, select **Workers′ Comp**.

6. Click **Update**.

If you do not have these default settings, then 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 to that user's **Desktop Claims** link on the left pane and click it. You can see the sortable **Injured Worker** column.

Regions

Regions are geographical areas that are used to define groups' areas of responsibility. Assignment rules use them. Use the **Regions** menu action of the **Administration** tab to define and name regions. You assign regions to groups when you edit a group's attributes. Regions can be defined as collections of states, counties, or ZIP codes, and can use another address element, such as postal codes, if configured to do so.

You can assign more than one region to a group, and more than one group can be given the same region. You can make a group responsible for a region including both states and counties. To do so, create a region for the states and another for the counties and assign both to the same group. See "Regions" on page 375 for details.

Creating, Editing, and Deleting Regions

The **Regions** menu item of the **Administration** tab displays a list of all defined regions. If the region you seek is not visible, you can use the **Search For Regions** menu item to look for it.

To create a new region

1. Click **Add Region**.

2. In the editing screen, give the region a **Name** and select its **Type** (by default, either states, ZIP codes, or counties).

3. Two boxes separated by **Add-->** and **Remove-->** buttons appear. Use them to build the set of elements.

4. Click **Update** to save the new region.

To edit an existing region

1. Select the region, and click **Edit**.

2. Proceed as if creating a region.

3. Click **Update** to save the new region.

To delete a region

1. Select the region from the list.

2. Click **Delete**.

Assigning Regions to Groups

To assign a region to a group

1. Select the group either from the Group Tree or by finding it in the **Search Groups** menu item.

2. Select the **Regions** tab to see the list of regions associated with this group.

To add a region to a group

1. Select the region.

2. Click **Edit** and **Add**. In the **Browse Group Regions** screen that appears, search for regions. You can filter by **Zone Type** or **Code**.

3. Check the box next to the region or regions you want to add. Click **Select**. The **Search For Regions** menu item gives you the same search capability, but does not allow you to add or remove regions.

To disassociate a region from a group

1. Select the region.

2. Click **Edit**.

3. Click **Remove**.

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. Because holidays differ in different areas, ClaimCenter defines holidays associated with different regions.

See also

- "Specifying Holiday Dates" on page 256 for details.
- "Working with Holidays, Weekends, and Business Weeks" on page 256 for an explanation of how to create holidays in different regions, as well as how to edit and delete them.

    Note: Because many holiday dates change annually, it is good practice to edit these holidays at the beginning of each new year.

Event Messages

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. This includes Contact Center (to synchronize a contact), an email server, the Metro Bureau, or a payment system. 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, it is *pending*, or *in flight*, until the external system acknowledges its receipt. Only one message for a given claim and destination can be in flight at one time. Messages are ordered as first-in-first-out, since one message can depend on another message being received. ClaimCenter describes this as 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 messages is important when you try to resend a message that has failed because of an error.

Navigate to the **Event Messages** menu item of the **Administration** tab to monitor and manage the messages that ClaimCenter sends to these systems. This includes resending failed messages and suspending, resuming, and restarting the messaging system:

This topic is a very brief overview of ClaimCenter messaging. It is described in detail at "Messaging and Events" on page 139 in the *Integration Guide*, as well as in the *ClaimCenter System Administration Guide*.

To Monitor Event Message Statistics

The **Event Messages** menu item in the **Administration** tab displays several summary tables of messages:

- The summary table lists all external destinations for ClaimCenter messages. It also shows the traffic statistics: the number of in flight, failed, retryable, and unsent (queued) messages.

- You can also display the same statistics for a single destination. This table's columns list the statistics for messages relating to each claim, as well as all non-ordered messages to that destination. Use the filter to search for any claim in the list. This is useful if the table is large.

- Click the non-safe-ordered messages link to view the list of non-safe-ordered messages by claim. This table does not show any safe-ordered messages.

To Suspend or Resume Messaging

If you know that a message destination is not available, you can temporarily suspend sending any message to that destination. Messages are placed in a queue while 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 destination in the **Event Messages** menu item, then click **Suspend**. The user interface shows that messages to this destination are **Suspended**.

- **Resume messaging to a single destination**: You can similarly cancel a suspension by clicking **Resume**. The display shows these messages as **Started**.

- **Restart messaging to all destinations**: The **Restart Messaging Engine** button resumes sending messages to all destinations.

- **Skip a message**: If you know that a message cannot reach its destination or is no longer relevant, you can skip it by selecting it and then clicking **Skip first**. ClaimCenter stops trying to send it to the destination. Once you skip a message, you cannot retry it.

- **Skip all messages**: Choose all messages by filling the checkbox in the table header, and click **Skip**.

To Retry Messages

In any display, selecting one message from a single destination (check its checkbox) 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.

To Synchronize Contacts with ContactCenter

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 ContactCenter. If you select the checkbox above all the new or changed ClaimCenter contacts, the **Sync** button updates all contacts in ContactCenter.

Script Parameters

Script Parameters are variables that can be changed without restarting the application server. You create and delete them in Studio. Script parameters written in Studio are placed into the `scriptParameters-config.xml` file. On server startup, ClaimCenter compares the list of script parameters that currently reside in the database to those in the XML file. Any that are in the file but are not in the database are added to the database with the initial value that is set in the XML file. All other values are ignored and no changes to these values in the XML file are propagated to the database.

After a Script Parameter is in the database, you can edit its value in the **Script Parameters** menu item in the **Administration** tab. After you open this screen, you see a table of script parameters in your installation, as well as their **Value** and **Type**—Boolean, integer, text, and so on.

To Change a Script Parameter

To change a script parameter, select it from the list, click **Edit**, change its **Value**, and click **Update** to save your changes.

Workflows

A workflow is a multistep process that manages a complex business practice that rules cannot by themselves define. You define a workflow in Studio, and execute instances of it from buttons you place in PCF pages. Once invoked, a workflow handler executes the instance, performs its steps, and controls its status. You can edit a workflow even when instances of it are running. This creates another version of the workflow with an increments **Process Version**. New instances use the latest **Process Version**.

If you navigate to the **Workflows** menu item of the **Administration** tab, you can see a list of all workflow instances and their status. You can suspend and restart them.

To Find and Display Workflows

The upper part of the **Workflows** menu item lets you search for all workflow instances, or all instances of one **Type** (workflow name). Filter your search by a given start date or update date range, by the handler type it uses, by its current status, or if it is executing a specific step. The results reflect, for each workflow instance found, its type and its **Start Date**, Handler, **Status**, current **Step**, and **Process Version** (version).

To Start and Stop Workflows

Workflows proceed according to their internal schedules. The stop only on an error, or if you suspend them in this screen. You can only suspend instances with **Active** status. To suspend an instance, select it and push the **Suspend** button. To restart an instance with suspended status, click **Resume**. The **Resume-All** button resumes all instance in the current list.

Viewing Workflow Statistics

Workflow statistics are collected periodically. You define that period. The statistics capture the workflow steps that are completed during that interval. For each step that was completed, the elapse time and execution time is analyzed. This is extracting the minimum, maximum, mean, and standard deviation. To see this, navigate to the **Workflow Statistics** screen.

See also
- "Using the Workflow Editor" on page 419 in the *Studio Guide*
- "Guidewire Workflow" on page 423 in the *Studio Guide*

Importing and Exporting Administrative 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** menu action of the **Administration** tab provides a convenient way of moving administrative data, question sets, and role definitions 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

Exporting Data in the User Interface

Navigate to the **Export** subtab of the **Import/Export Data** feature of the **Administration** tab to export these different XML files. Each one contains all the data of a certain type in your installation. These files are:

- `admin.xml`. This file contains all administrative data, which consists of:

  ```
  Attribute
  AuthorityLimit
  Catastrophe
  Contacts (plus their associated Address and ContactIndividual objects)
  Group (and GroupRegion, GroupRuleSet, and GroupUser)
  GroupAssignmentState (and GroupUserAssignmentState)
  Region
  SecurityZone
  User (including AttributeUser and UserRole)
  UserPreference
  ```

- `questions.xml`. By default, this file contains both the SIU (fraud) and Service Provider Management question sets. You export question sets to modify them to create your own custom question set.

- `roles.xml`. This file is a mapping of system permissions to roles.

After you choose to export one of these files, ClaimCenter provides it with all relevant data. For example, the `questions.xml` file contains all the default question sets and all the question sets subsequently added.

The **Export** subtab of the **Import/Export Data** menu action of the **Administration** tab brings you to a screen where you:

1. Select the data file name to export from the **Data to Export** text drop down box. You can choose from one of these XML files: `roles.xml`, `questions.xml` and `admin.xml`.

2. Click **Export**.

See also

- "Question Sets" on page 263.
- "Claim Fraud" on page 101.
- "Service Provider Performance Reviews" on page 121 for details of the supplied question sets and how to modify them.
- "Exporting Data from the User Interface" on page 123 in the *System Administration Guide*.

Note: There is no method in the user interface to export an XML file containing other kinds of data, or to export a CSV or other file format.

Importing Administrative Data, Roles, and Question Sets

The **Import** subtab of the **Import/Export Data** menu action of the **Administration** tab brings you to a screen where you:

- Select a file of administrative data to import (upload). The **Browse** button can assist you in finding it. 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.

- Click **Next,** and follow the commands that appear on this 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 allow you to either accept the imported data or keep what is in the database.

- Click **Finish** to complete the import.

For more information, see "Importing Data From the User Interface" on page 122 in the *System Administration Guide*.

Other Ways to Import and Export Data

You may 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, then 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 above. APIs let you both import and export, but the command line permits importing, but not exporting.

Import and Export with APIs

Use the `IimportTool` and `IexportTool` APIs to create batch processes that move data in and out of ClaimCenter. These 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 121 in the *System Administration Guide* describes this topic.

Import from the Command Line

There are command line functions for importing, but *not* exporting, XML and CSV files containing data. These functions import any kind of data, not just the types of data allowed by the user interface. See "Importing and Exporting Administrative Data from ClaimCenter" on page 121 in the *System Administration Guide* for more details.

Report Admin

Navigate to the **Reports Admin** menu item of the **Administration** tab to view, add, remove, and run the reports you defined in your external report generation system. For details, see the *ClaimCenter Reporting Guide*.

Security Zones

Security zones are a way for ClaimCenter to relax security inside a defined area of your organization larger than a group, relative to security outside that area.

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 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. This is because all users are members of the same security zone as the owner of any claim.

Security zones are just names. They are not defined as collections of geographical areas, like Regions. Claim center provides two default security zones: Workers' Compensation and Auto and Property.

To Add, Edit, and Delete Security Zones

You perform the following operations in the **Security Zones** menu item of the **Administration** tab:

• 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, click the zone you want to edit and change the name and description. Then 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.

To Choose or Change a Group's Security Zone

1. After choosing a group, either by using the **Search For Groups** menu item of the **Administration** tab or by selecting the group from the group tree, click **Edit**.

2. Select the **Security Zone** from the drop down list.

3. Click **Update** to save your changes.

See also
- "Security Zones" on page 394.
- "Data-based Security - Claim Access Control" on page 383 explains how to use security zones in ACLs.

Reference Tables

You can create and manage reference tables, which are tables not connected to specific claims. Most entities in ClaimCenter are claim related. Bulk invoices, aggregate limits and reference tables are the few main entities that are cross-claim.

ClaimCenter implements two varieties of reference tables: tables that define the Coverage Verification feature, and workers' compensation tables that allow rules to calculate benefits. You can view these reference tables by selecting either the **Coverage Verification** or **WC Parameters** menu items in the **Administration** tab.

You can also create your own sets of reference tables. See the *ClaimCenter Configuration Guide* for details.

Coverage Verification Reference Tables

The Coverage Verification feature uses reference tables to define allowed coverages for specific losses, users, and exposures. For more detail, see "Coverage Verification" on page 75.

The coverage verification reference tables are:

- **Invalid Coverage For Cause**. This table is 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.
- **Incompatible New Exposure**. This table lists new exposures you try to create which are incompatible with other exposures 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.
- **Invalid Coverage due to Fault Rating**. This table is a list of invalid fault ratings and coverage 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 insured is not at fault.

To Work With Reference Tables

You can create new reference tables 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.

After you have a correct reference table, you write rules which read and use them. For workers' compensation tables, ClaimCenter provides a set of sample rules which give example of how to extract information and use it. These examples include:

- **Claim Pre-update Rules**, whose names begin with CPU000400 WC, ...420 WC, and so on.
- **Exposure Pre-update Rules**, whose names begin with EPU000400 WC, ...420 WC, ...43 WC, and so on.

Use these rules as models to create your own. They show the Gosu functions you use to access reference tables.

ClaimCenter uses the Coverage Verification tables to help prevent end users from creating unreasonable exposures.

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 (as seen on each tab) 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.

These are grouped by the following tabs:

- **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.

WC Parameters

One of the key components to handling workers' compensation claims is calculating workers' compensation payments for lost time. This is a multi-step process. First, you enter those amounts in the **WC Parameters** section in the user interface (**Administration** tab → **WC Parameters**). Next, ClaimCenter uses the Benefits Calculator, which is defined in Gosu code, to calculate those amounts. (Note that an adjuster can always override those amounts by entering a manual amount.) You can calculate four types of compensation, which are based on jurisdiction.

- TPD: Temporary Partial Disability
- TTD: Temporary Total Disability
- PPD: Permanent Partial Disability (might be deferred due to jurisdictional nonconformity)
- PTD: Permanent Total Disability

For example for TPD: (Temporary Partial Disability), a calculation might be: `WeeklyCompRate = JurisdictionRate x (Pre-injuryAWW (Amount Weekly Wage) minus Post-injuryAWW)`.

See also

- "Jurisdictional Benefit Calculation Management" on page 305 for an explanation of these four different types of compensation.

Lost-Time Benefit Calculations

The following screens pertain to workers' compensation lost-time benefit calculations:

- **Benefit Parameters** – See "Entering Benefit Parameters in the WC Parameters Section" on page 414.
- **PPD Min / Max** – See "Entering Benefit Parameters in the PPD Min/Max Section" on page 415
- **PPD Weeks** – See "Entering PPD Weeks Information" on page 415

Entering Benefit Parameters in the WC Parameters Section

This section defines the benefit parameters record, with jurisdictional state, start date, and end date. For example, there can be several entries for one state, each based on a specific time period.

- If you select a jurisdiction, ClaimCenter displays the **Benefit Parameter Detail** screen of that jurisdiction. This screen provides summary information.

- If you click **Edit**, you can modify this data. The sections on this page include:

  - **General** – Jurisdiction, start date, end date, and comments.

  - **Temporary Total Disability (TDD)** – For general considerations, see "Calculations" on page 415. For a definition of this category, see "Jurisdictional Benefit Calculation Management" on page 305.

  - **Temporary Partial Disability (TPD)** – For general considerations, see "Calculations" on page 415. For a definition of this category, see "Jurisdictional Benefit Calculation Management" on page 305.

  - **Waiting Period** – See "Waiting Period" on page 415.

  - **Permanent Total Damage (PTD)** – For general considerations, see "Calculations" on page 415. For a definition of this category, see "Jurisdictional Benefit Calculation Management" on page 305.

  - **Permanent Partial Disability (PPD)** – For general considerations, see "Calculations" on page 415. For a definition of this category, see "Jurisdictional Benefit Calculation Management" on page 305.

- **Applicable To** – An optional set of factors not available by default in every jurisdiction. If no factors have been entered, you see Add/Remove at the bottom of the screen in Edit mode. See "(Factors) Applicable To" on page 415.

Calculations

ClaimCenter can calculate benefits, for example, as Average Weekly Wage (AWW) times Percent of Wages. If the result of that calculation falls between the maximum and minimum, it becomes the benefit. Otherwise, use the maximum if the result was more or the minimum if it was less. 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.

Waiting Period

- **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.

(Factors) Applicable To

This listview can be used to track information about special rules that apply to claims within this jurisdiction. In the default configuration, this is used to inform adjusters that work on claims in this jurisdiction, although the information could be leveraged in rules. The information is presented on the time loss exposures for claims in the appropriate jurisdiction. The expectation is that the adjuster can take this information into account and modify the benefits and manage the claim as appropriate.

Entering Benefit Parameters in the PPD Min/Max Section

The disability percentage refers to the degree to which the injured worker is disabled. The **PPD Min/Max** screen provides a list of jurisdictions, each with start and end dates, for example, within a calendar year. You can add or delete jurisdictions. For each entry, you are required to enter 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 more granular data on the **PPD Min/Max** screen.

Entering PPD Weeks Information

This section defines the limit of how long the injured worker can receive the workers' compensation benefits, based on the disability. The **PPD Weeks** screen is based on jurisdiction with start and end dates. You also enter the disability percent and the number of weeks to which it applies.

Compensability Decision

The **Denial Period** screen pertains to *compensability decision*.

Entering Denial Period Information

The denial period defines the maximum time the carrier has to make the compensability decision. If the decision is not made in time, then 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, then the system uses the *Determine Compensability* activity pattern. It 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 a due date formula could be one of the following:

- The 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 either X or Y is. You can also select target include days which can be based on calendar or business days.

Using Gosu to Enter Your Calculations

For example, for a parameter of PPD with a maximum value of USD $2000, you could set 1500 in euros for a comp rate. The calculator interprets the 1500 Euros as $1500 USD. In other words, you must do the currency conversion inside the calculator implementation.

> **Note:** For benefit definitions refer to "Jurisdictional Benefit Calculation Management" on page 305.

Reference Tables

Reference data is contained in administration tables. The tables as seen in the tabs are:

- **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.

Workers' Compensation Permissions

In the base configuration, the Superuser role uses the following permissions.

Permission	Code	Description
Views workers' compensation disability rates	`wcrefview`	You can view the values on workers' compensation disability rate tables.
Manages workers' compensation disability rates	`wcrefmanage`	You can create, edit, and delete values on workers' compensation disability rate tables.

Reinsurance Threshold

Reinsurance is the process of insurance companies insuring underwritten policies with other institutions in order to offset exposure. This section explains how to administer reinsurance thresholds.

The standard reason for filing a reinsurance claim is when the gross total incurred approaches that threshold. This is because individual loss reinsurance treaties are based on losses going over a certain amount of money incurred. You can store those threshold values in a table.

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, which is the point at which the reinsurer is to be notified.
- Start and end dates, which allow for threshold life spans.

- List of loss causes and coverages included in the threshold calculations.

    Note: An empty list is considered to include *all* loss causes or coverages.

Administering the Reinsurance Thresholds

The base configuration contains default values that you can modify, remove, or add to.

1. Navigate to the **Reinsurance Threshold** link in the **Administration** tab and click **Edit**.

    The treaty type's are mapped to policy types with a threshold value and percentage.

2. Make any changes and **Update** your work.

See also
- "Reinsurance" on page 269 to learn about reinsurance.
- "Reinsurance Data Model" on page 271 to learn how to use the table.

ICD Codes

The *International Statistical Classification of Diseases and Related Health Problems* (ICD) are medical diagnosis codes that classify diseases. It 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, it is used for morbidity and mortality statistics, reimbursement systems, and automated decision support in medicine. There is value of 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 *apply* them in the **Medical Diagnosis** section of the ClaimCenter user interface.

Guidewire provides ICD-9 codes as reference data, which can be imported either through the command line or user interface (using the import tool in the **Administration** tab.) ClaimCenter stores this data in the `Ref_ICD` reference table. Once stored, you can use it immediately without doing additional configuration. Each year the administrator must either add or expire codes.

> **IMPORTANT** Guidewire does *not* provide ICD-10 codes in the base configuration and the link to the external web site does not work for ICD-10.
>
> If you implement this feature, you must disable the action in the ICD Code cell/input to the `icd9data` exit point re-configuring or disabling in Studio. Alternately, you can use an ICD-10 provider for similar functionality prior to production.

Working with ICD Codes

You can view, edit, or add new codes, as described in the steps that follow.

> **Note:** The additional information is provided only as an example. If you have a preferred service, the exit point can be re-configured.

To View ICD Codes

1. To see a code in ClaimCenter, first navigate to the **Administration** tab → **ICD Codes** located in the left pane.

2. Search by entering a code or by selecting a body system from the drop-down menu and clicking **Search**.

3. Select the code by clicking its link. The **ICD Code Details** screen opens, where you can get additional information about that code by clicking its link. (See previous Important note.)

To Edit ICD Codes

1. To edit a code, first perform the previous steps to view codes.

2. Click **Edit**. You can edit:

- Code number
- Description
- Body system
- Mark it as chronic
- Availability and expiration dates

Typically, you might edit the dates to activate or retire a code because you cannot delete codes.

3. When you are finished, click **Update**.

To Add New ICD Codes

The following steps explain how to add codes through the **Administration** tab. Codes can also be loaded annually through the **Administration** tab or through a command line.

1. To add a new code, navigate to the **Administration** tab → **ICD Codes** located on the left pane.

2. Click **Add new code**. The **New ICD Code** screen shows.

3. Enter the code and description, and associate it with a body system.

4. Click **Update**.

5. Optionally, if you want to mark it as chronic or associate dates with it, find the code and click **Edit**.

6. Make any edits and click **Update**.

ICD Permissions

You need the following permissions to work with administration reference data:

- `viewrefdata`: allows you to view administration reference data.
- `editrefdata`: allows you to edit administration reference data.

Metrics and Thresholds

You can define the metric targets as per the policy type through the **Administration** tab in the user interface. Metric targets can be defined for different tiers. When a tier is not defined, you are setting up the metric targets for the default tier. In the default configuration, metric limits are defined for some metrics to provide an example.

Selecting a policy type displays all the metric limits that apply to that policy type. Default limits are automatically created for every claim metric subtype. For money based metrics, 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. However, the default limits can be edited.

You add new claim metric limits through the menu items on the default limits. New limits can be added for each claim tier that applies to the policy type (the claim tier typelist is filtered by the policy type typelist). You can only add one limit per tier.

This section describes how to administer Claim Health Metrics and Large Loss Thresholds.

See also

- To learn more, see "Claim Performance Monitoring" on page 315.

- To see what reports are associated with Claim Metrics, see "Claim Health Metrics Reports" on page 92 in the *Reporting Guide*.

To Edit the Metrics

You need the *Manage Metrics Limits* permission (`metriclimitmanage` code) to edit the claim health metrics target values. Navigate to **Administration** tab → **Metrics & Thresholds**. There are separate tabs for **Claim Metric Limits**, **Exposure Metric Limits**, and for **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 is Personal Auto.

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. It 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, based on business requirements, you decide that the target for days open for red can be at a higher threshold number for one policy type.

Using Tiers Adds Granularity

Also, you can choose to have different target values for a particular metric with a specific policy type. This is accomplished by the use of *tiers*. Tiers are a way to have further granularity within the policy type. 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. Tiers help in identifying type, complexity, and size of the claim.

To Add A Tier

1. To add a tier, click the down arrow next to the claim metric in the **Attribute** column as seen in the previous example.

2. ClaimCenter displays the available tiers for you to select.

When you add a tier, the system defaults to the numbers used in the default.

3. Enter tier metrics and click **Update** to save.

To Remove A Tier

While you cannot remove a metric from the **Administration** tab, you can remove a tier.

1. Select the tier you want to remove.

This enables the **Remove** button.

2. Click **Remove** to delete the tier.

Claim Metric Limits

In the base configuration, you can administer the targets for the following metrics:

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.
• 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	This shows the Total Incurred Net financials calculation.
• Incurred Loss Costs as % of Net Total Incurred	Claim Cost Total Incurred net divided by the Total Incurred Net.
• Paid Loss Costs as % of Total Paid	Claims Cost Total Payment divided by Total Payment.
• 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, then all money based metrics use the default currency type. However, if multicurrency is configured, then all money based metrics such as Net Total Incurred or Total Paid, have a default 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, you must change the **Currency** typelist in Guidewire Studio.

1. Navigate to **configuration** → **Typelists** → **Currency.**

2. In the **Currency** typelist, select the **Filters** tab and click inside the `metriclimit` filter under the **Name** column. This displays additional fields on the **Filters** tab.

3. Under the **Includes** section, either add or delete the currencies you want to see in the user interface.

Exposure Metric Limits

In the base configuration, you can administer the following metrics for exposures. Note that tiering is based on the policy type exposure. For example, in the Personal Auto policy type, exposure tiering includes 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	This shows the Total Incurred Net financials calculation.
• Total Paid	The amount that has been paid on the claim. This can be in more than one currency.
• % of Escalated Activities	Number of escalated activities divided by total activities.
• Paid Loss Costs as % of Total Paid	Claims Cost Total Payment divided by Total Payment.
• Time to First Loss Payment (Days)	The number of days until the first loss payment occurs.

Large Loss Threshold

You can also set the **Large Loss Thresholds** on the tab in this section based on **Policy Type**. Claim amounts that are over your defined limit trigger the Large Loss indicator. Select **Edit** to change the amounts.

If PolicyCenter has been integrated with ClaimCenter, then you can also define the large loss threshold to PolicyCenter. This number does not need to match with the large loss threshold number in ClaimCenter. When that number is reached, then PolicyCenter is notified.

See also

• To learn more about large loss thresholds sent to a policy administration system, see "Large Loss Notifications" on page 337.

Claim Metrics Batch Processes

To run your existing claims against newly set claim health metrics, you must run the Claim Health Calculations batch process. ClaimCenter contains two batch processes:

• **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 is used for overdue activities.

See also

• "Batch Processes and Work Queues" on page 129 in the *System Administration Guide* to learn more about batch processes.

Business Week

Define your business week based on zones and times. For information on this feature refer to "Business Weeks" on page 258.