Chapter 6

Claims

On August 24, 1992, Hurricane Andrew devastated parts of southern Florida after causing millions of dollars of damage in the Bahamas the day before. The hurricane then moved across the Gulf of Mexico and, on August 25 and 26, caused further damage in Louisiana and other southeastern states. In southern Florida alone, Hurricane Andrew caused the deaths of thirty-eight people, destroyed more than 85,000 homes, and left at least 250,000 people homeless. Insured losses caused by Hurricane Andrew totaled more than $15 billion, making the hurricane the most costly catastrophe ever experienced by U.S. insurers.

Newspaper reports in the days following the tragedy described the difficulty people would have in rebuilding their lives. The reports also spoke of a more positive side of the catastrophe: the work that several insurance companies had performed to get people back on their feet as soon as possible after the tragedy. Throughout southern Florida, insurers established centers where insureds could walk in and receive emergency checks; some provided trailers for insureds whose homes had been destroyed. In less than a week, despite extensive damage to radio and telephone transmitters, a vast number of insureds were able to contact their insurers and receive emergency funds and other assistance. For most, such assistance was only a beginning. However, in the ensuing weeks and months, many people devastated by Hurricane Andrew were able to begin to reconstruct their homes, their businesses, and their lives.

The human tragedy that follows a catastrophe of this sort cannot be overstated. But the relief delivered through the claim-handling facilities of the insurance companies helped

enormously. The peace of mind created through the purchase of insurance is often taken for granted until a catastrophe causes people to realize the value of an insurance policy. And to those personally affected by the devastation, the existence of a policy that will help in rebuilding their lives is invaluable.

In a recent year, property and liability insurance claim payments and loss settlement expenses exceeded $198 billion. The responsibility for properly investigating, evaluating, and settling the hundreds of thousands of claims submitted annually to property and liability insurance companies rests with the people in various claim departments. This chapter examines how the claim handling process works.

Educational Objective 1

Analyze the claim representative's responsibilities in the claim handling process.

Responsibilities of the Claim Representative

The primary purpose of the claim handling process is to satisfy the insurance company's main obligation under the insurance policy: to pay **claims** for covered losses. To accomplish this objective, the insurer's **claim representative**, also called an **adjuster**, has certain responsibilities:

- To respond promptly to the submitted claim
- To obtain adequate information
- To properly evaluate the claim
- To treat all parties fairly

Respond Promptly to the Submitted Claim

Once a claim is submitted, the claim representative must respond quickly. For the insured or **claimant**, the loss experience might have been painful, frustrating, agonizing, or even embarrassing. These feelings might intensify if the claim representative delays in responding to the claim. The example described at the beginning of this chapter, while an extreme case, underscores the value of a quick response.

Obtain Adequate Information

Once the insurer responds to the first report of the claim, the claim representative must promptly obtain information that is

For insurance purposes, a **claim** is a demand by a person or business seeking to recover from an insurance company for a loss that might be covered by an insurance policy.

A **claim representative**, also called an **adjuster**, is a person responsible for investigating, evaluating, and settling claims.

The term *adjuster* is the traditional name for a person responsible for handling insurance claims; however, the current trend is to use the term *claim representative*. This text uses the term claim representative except to describe specific types of claim representatives where the traditional term adjuster is generally used.

A **claimant** is anyone who submits a claim to an insurance company. In some cases, particularly in liability claims, the claimant is a *third party* that has suffered a loss and seeks to collect for that loss from an insured. In other cases, particularly in property claims, the claimant is the insured (the *first party*).

The *first party* to an insurance contract is the insured. (Although the second party is technically the insurer, the term second party is rarely used in insurance.)

A *third party* to an insurance contract is a person or business that is not a party to the contract but who might assert a claim against the insured.

Insurance professionals generally use the term *claimant* to refer to a third party who submits a claim under an insured's policy. This text uses the term claimant to refer to a third-party claimant.

accurate and adequate to properly evaluate the claim. Although obtaining information is usually time-consuming, it is an essential step in the claim handling process.

A claim representative must verify whether the claim is covered under the insured's policy. If a question of coverage exists and the insurer wishes to continue its investigation, the insurer might send a **reservation of rights letter** to the insured. Failure to reserve its rights as facts are gathered might bar the insurer from denying coverage later. Examples of claims that might require a reservation of rights letter include occurrences that might have happened outside the policy period, intentional actions of the insured, and situations involving more than one insurer when there is a question of which insurer pays first.

A **reservation of rights letter** is a notice sent by the insurer to an insured advising that the insurer is proceeding with investigation of a claim but that the insurer retains its right to deny coverage later.

A reservation of rights letter serves two purposes:

- To inform the insured that a coverage problem might exist
- To protect the insurer so that it can deny coverage later, if necessary

Properly Evaluate the Claim

Valid and accurate information enables the claim representative to evaluate the claim. This evaluation hinges on two critical elements of the claim handling process:

1. Whether the claim is covered according to policy provisions
2. If the claim is covered, the dollar amount payable under the policy

The determination of whether coverage exists and the valuation of a covered loss are the central tasks involved in the claim handling process.

Treat All Parties Fairly

Throughout the claim handling process, the claim representative must remember that a loss often produces strong emotions. The claim representative is dealing with an insured or a claimant who has been through a trying, if not traumatic, experience, and good interpersonal communication skills are vital. Although constantly dealing with persons in such trying circumstances can be a challenge, the claim representative is often rewarded by his or her ability to help people through a difficult time.

The claim representative must treat all parties fairly by paying valid claims according to the policy provisions and denying uncovered claims. Failure to pay a claim that is covered by an insurance policy hurts the person who is denied a fair settlement. On the other hand, paying a claim that is not covered penalizes the insurer and all of the insurer's policyholders. If an insurer pays claims that are not covered by a particular insurance policy, it is likely that all of the insurer's policyholders will eventually pay higher premiums. It is important to individual policyholders and to policyholders as a group that insurers neither overpay nor underpay claims.

Educational Objective 2

Describe the role performed by each of the following in the claim handling process:

a. Staff claim representatives (inside and outside)
b. Independent adjusters
c. Agents
d. Public adjusters

Types of Claim Representatives

Who performs various claim handling activities? While it might seem obvious to say a claim representative, the answer is a bit more complex. Several different types of people participate in claim handling, depending on the circumstances:

- Staff claim representatives (inside and outside)
- Independent adjusters
- Agents
- Public adjusters

In addition, an organization that has established a self-insurance plan must make provisions to settle its own claims by using either an internal claim department or an outside administrator.

Staff Claim Representatives of Insurance Companies

A **staff claim representative** is an insurance company employee who performs some or all of the insurer's claim handling activities.

Most insurance companies have at least two kinds of **staff claim representatives**: those who work exclusively inside the office and those who travel to the site of the loss and elsewhere to perform claim investigations and evaluations.

Inside Claim Representatives

An **inside claim representative** is an insurance company employee who handles claims that can be settled, usually by telephone or letter, from inside the insurer's office.

The role of an **inside claim representative** is to gather information concerning a claim and to settle relatively simple and straightforward cases. Often, the inside claim representative takes the initial claim information from the insured or the producer. Inside claim representatives generally handle claims that are clearly either covered or not covered and that do not involve questions about the circumstances or validity of the claim.

The inside claim representative usually speaks or writes to the insured to obtain information concerning how and when the loss occurred. If a third party is involved, the inside claim representative might use a tape recorder to take statements

about the loss from the insured, the claimant, and any witnesses, after obtaining their permission to tape their statements. In many cases, the claimant's statement is taken first to get a record of his or her version of the occurrence.

For claims involving automobile accidents, the claim representative usually orders a police report and compares this report with the statements of the insured, the claimant, and any witnesses. The inside claim representative also requests repair estimates or assigns appraisers to inspect damaged automobiles. Some insurers have drive-in claim facilities where an appraisal of the damage can be made and the insured can receive payment for the damage. For simple cases, such as a broken window or a minor automobile accident in which no one is injured, the inside claim representative can usually arrange with the insured or claimant to have repairs made or can otherwise settle the claim without involving anyone else. Many cases, however, require an outside claim representative or the services of an independent adjuster.

Outside Claim Representatives

An **outside claim representative** (also called a **field claim representative**) is usually part of the insurer's staff located in a branch office, regional office, or other location, and is assigned to handle claims that occur in the area surrounding that location. An insurer assigns an outside claim representative when it is not practical to settle the claim by telephone or mail. In cases of significant damage, for example, an outside claim representative inspects the property to assess the damage. In addition, if anyone has suffered bodily injuries, an outside claim representative usually gathers information in person, taking statements from the injured parties and interviewing witnesses, physicians, and others.

An **outside claim representative** (also called a **field claim representative**) is an insurance company employee who handles claims that cannot be handled easily by phone or mail. Outside claim representatives spend much of their time visiting the scene of a loss, interviewing witnesses, investigating damage, and meeting with insureds, claimants, attorneys, and other persons involved in the claim.

Independent Adjusters

Insurance companies usually find it efficient to locate staff claim representatives only in those areas where the company has a significant number of policyholders who will presumably submit a large volume of claims. Generally, it is inefficient for an insurer to have a staff of claim representatives in an area where few claims are filed. To handle claims in areas where they do not have large numbers of policyholders, insurers often hire independent adjusters.

Independent adjusters are independent claim representatives who offer claim handling services to insurance companies for a fee. While some independent adjusters are self-employed, many independent adjusters work for one of several large, national independent adjusting firms. These firms have offices located throughout the country and handle all types of claims.

Independent adjusters are independent claim representatives who offer claim handling services to insurance companies for a fee. These independent adjusters can either be self-employed or work for an independent adjusting firm.

Although a particular insurance company might not have sufficient numbers of policyholders to set up its own staff of claim representatives in a specific area, it is feasible for an independent adjusting firm to open an office as long as there are sufficient numbers of people within a reasonable distance from the office. These firms offer their services to any insurance company needing claim handling services in that geographic area.

In some situations, an insurer might hire independent adjusters even if the insurer has staff claim representatives in the area. A staff claim representative might work with an independent adjuster when a claim involves a unique or complex situation and the staff claim representative does not have sufficient expertise to handle the claim. Many insurers, for example, use independent adjusters to handle particular types of claims, such as those involving business income or ocean marine insurance. By providing independent adjusters who have the expertise to handle such claims, independent adjusting firms can meet the special claim handling needs of insurance companies.

Insurers might also need independent adjusters in addition to staff claim representatives after a natural disaster, such as a severe hurricane. Because of the volume of claims generated by natural disasters, insurers not only send staff claim representatives to work with insureds, but also hire independent adjusters to assist in handling claims.

Agents

In an independent or exclusive agency, the agency usually receives the first notification of a claim. Depending on the size of the office, the agency can have one person, several people, or a department responsible for handling claims.

In some cases, the agency does little more than communicate the claim information to the insurer. Other agencies take a more active role in the claim handling process. The agent immediately sets up a claim file and collects information concerning the loss. In some cases, the agent's role is then to monitor the progress of the claim and the insured's satisfaction with the insurer's claim service.

If the agent has **draft authority**, he or she might actually settle claims. For example, an insurance company might give an agent draft authority up to a certain limit (such as $1,000 or $2,500) per claim. That authority allows the agent to settle claims and make payments on behalf of the insurer in cases involving settlements up to the specified limit.

Why do insurance companies grant draft authority to agents? Insurance companies have found that allowing agents to handle small or routine claims results in both expense savings and

Draft authority is authority expressly given to an agent by an insurer to settle and pay certain types of claims by writing a claim *draft* up to a specified limit.

A *draft* is similar to a check, but it requires approval from the insurance company before the bank will pay it.

increased goodwill. Without the direct involvement of the insurer on small claims, the claim can be handled more quickly and with less expense to the insurer. Since the agency personnel obtain the loss information, verify coverage, and issue the draft for the claim, delays and expenses involved in contacting the insurer's claim staff are eliminated. This reduction in claim handling expenses benefits both the agent and the insurer because it contributes to a more competitively priced product.

The insured benefits from the quick payment of claims, and the agent and the insurer also benefit from the goodwill thus created. The agent can give personal service to the insured, and both the insurer and the agent benefit from having a satisfied customer.

Public Adjusters

In certain circumstances, an insured might decide to hire someone to represent his or her interest in the claim handling process. This claim representative who represents the insured is called a **public adjuster**. Usually an insured hires a public adjuster either because a claim is complex or because the loss negotiations are not progressing satisfactorily. The public adjuster acts as an advocate for the insured in the negotiations. The insured generally pays the public adjuster a percentage of the settlement as compensation for this assistance.

A **public adjuster** is a person hired by an insured to represent the insured in handling a claim.

Internal Claim Administration

Many organizations have developed self-insurance plans to cover part or all of their loss exposures. Under a **self-insurance plan**, an organization uses its own funds to pay for losses. However, many companies with self-insurance plans purchase insurance to pay losses that exceed a predetermined amount. Organizations with self-insurance plans must make provisions for handling claims. Two options for this purpose are an internal claim department and a third-party administrator.

A **self-insurance plan** is an arrangement in which an organization pays for its losses with its own resources rather than purchasing insurance. However, the organization might choose to purchase insurance for losses that exceed a certain limit. For example, a firm might self-insure all losses up to $2 million and then purchase insurance to cover losses over $2 million.

Internal Claim Departments

If the organization is large enough, it might establish a separate claim department. A smaller organization might decide to hire one or two claim representatives to handle its claims. In either case, the organization uses its own personnel to investigate and settle claims.

Regardless of the number of claim representatives an organization employs, the internal claim staff should have the skill and experience necessary to handle many different types of claims. However, the employees of internal claim departments might have little or no experience in handling certain types of complex cases, such as products liability claims or workers compensation injuries. Furthermore, in workers compensation cases, a

problem could occur if the injured employee and the claim representative cannot agree on a settlement. In such situations, employees might feel that they must fight their own employers to reach a settlement. Because of the problems that can arise from the use of an internal claim department, many organizations with self-insurance plans have hired third-party administrators to handle the claims associated with self-insured exposures.

Third-Party Administrators

Third-party administrators (TPAs) are business firms that contract to provide administrative services to other businesses. Businesses that have self-insurance plans often hire TPAs to handle their claims.

The growth of self-insurance has created a need for **third-party administrators (TPAs)**. TPAs are business firms that contract to provide administrative services, including claim handling, to other businesses, particularly to businesses that have self-insurance plans. Large independent adjusting firms sometimes function as TPAs for self-insured businesses in addition to providing independent claim handling services to insurers. Many property and liability insurers have also established subsidiary companies that serve as third-party administrators. When a self-insuring organization hires a third-party administrator, that organization generally purchases more than claim handling expertise. Most TPAs offer claim record keeping and statistical analysis in addition to claim handling services.

Educational Objective 3

Identify the steps in the claim handling process.

The Claim Handling Process

Claim handling procedures can vary widely, depending on the type of claim involved. A minor, single-vehicle auto accident might require only verifying coverage, obtaining estimates of the damage to the automobile, and paying the claim. Little else is involved as long as the accident involves no bodily injuries and no other vehicles. Once the claim representative verifies that coverage applies and determines the cost of repairing the auto, the claim can be settled.

An auto accident involving two or more autos and several injured people can take months or even years to settle. In such cases, different persons might provide conflicting testimony concerning the events surrounding the accident, and difficult questions regarding legal responsibility can arise. The claim representative might need the perspective of a physician, a lawyer, an engineer, and a psychologist to understand all the issues involved.

Despite the unique challenges and variations from case to case, the same three steps are involved in the processing of most claims:

1. Investigation
2. Valuation
3. Negotiation and settlement

Although the claim handling process generally involves these three steps, the manner in which they are carried out is quite different for property insurance claims and for liability insurance claims.

Educational Objective 4

Describe the claim handling process for property insurance claims.

Property Insurance Claims

For several reasons, claim handling procedures are more defined for *property insurance claims* than for liability insurance claims. In property insurance claims, there are usually only two parties to the negotiation process: the insured and the insurer. In addition, many of the variables associated with liability claims are not a factor. Claim representatives usually do not have to determine who was at fault in a property insurance claim (unless the insured is suspected of an intentional act, such as arson). When handling a property insurance claim, the claim representative rarely has to worry about some unforeseen side effect manifesting months or years after the claim has occurred, which is often the case when bodily injury is involved. Finally, valuing property is usually easier than placing a dollar value on the income-earning ability or the life of a person who has been disabled or killed in an accident.

Jargon Alert!

The term *property insurance claim* generally refers to a claim for property, usually property that belongs to an insured, that is covered for certain causes of loss under an insured's policy.

In contrast, a claim for property of someone other than an insured that is damaged due to the insured's alleged negligence is a type of liability claim (called a *property damage liability claim*). Liability claims are discussed later in this chapter.

Step 1: Investigation

When the claim representative receives the initial report of a claim, he or she must investigate to gather further information relevant to the loss. This investigation is necessary to determine the cause of the loss, to assess the damage, and to verify coverage.

Determining the Cause of Loss and Assessing Damage

For a property insurance claim, investigation often involves visiting the site to inspect the damaged property. Whether it is real property, such as a house or an office building, or personal property, such as household furnishings or business inventory, the claim representative needs to inspect the property to determine the cause of the loss and to assess the damage.

The investigation must reveal sufficient information to verify whether coverage exists under the policy. One of the most important facts is the cause of the loss, such as fire, windstorm, vandalism, or some other cause. For some losses, the cause is obvious; in others, the cause is harder to determine. In all cases, determining the cause of loss is one of the most critical aspects of the investigation.

Another critical aspect of a loss, particularly with regard to real property, is the physical condition of the property before the loss occurred. This information is difficult to obtain when a building has been completely destroyed. The claim representative must consult with the insured, measure the building remains, study pictures that might be available, and examine blueprints showing the building's dimensions.

For personal property, the most critical information is what property was damaged or destroyed. Creating an inventory of damaged personal property can be a long and arduous task for some losses, such as serious fire losses. However, in order for the claim representative to determine the value of the loss, a detailed inventory is essential, and very specific information must be gathered. When the loss involves a business, historical valuation information often appears in the company's financial records. In addition, if a business income loss is involved, the financial records are useful in determining the proper valuation of the lost income.

The claim representative might also need to interview and take statements from witnesses to the loss, if any exist, to better understand how and why the loss occurred. When a building is totally destroyed, the best information concerning how the loss occurred often comes from witnesses. This information can help determine the cause of loss, which could be especially important in situations in which third parties might be responsible.

Verifying Coverage

In addition to determining the facts surrounding the loss, the claim representative must determine whether the coverage provided by the policy will pay any or all of the claim submitted. For a property insurance claim, the claim representative must seek the answers to several questions to verify that the claim is covered:

- Does the insured have an insurable interest in the property?
- Is the damaged property covered under the policy?
- Is the cause of loss covered under the policy?
- Do any additional coverages, endorsements, or limitations on coverage apply?

Do Any Additional Coverages, Endorsements, or Limitations on Coverage Apply? In many insurance policies, additional coverages and limitations modify the basic coverage provided. For example, under a homeowners policy, the definition of covered property does not include trees, shrubs, plants, or lawns. However, these items are covered under an additional coverage, which specifically states that trees, shrubs, plants, and lawns are covered up to a specific dollar amount if damaged by certain specified causes of loss.

The insured might have purchased an additional coverage, selected one or more optional coverages printed in the policy, or modified coverage through an endorsement (policy amendment). Such changes to the basic policy can eliminate or modify exclusions or limitations. The claim representative should recognize that such policy modifications might apply and must consider them when determining whether coverage exists.

There are also important limitations on coverage. Although a homeowners policy covers most types of personal property, certain types of property, such as jewelry and furs, are covered for only a specified dollar amount when the loss is due to theft. Similarly, a homeowners policy does not cover losses caused by vandalism if the dwelling has been vacant more than thirty consecutive days. Such policy limitations are critical in verifying coverage.

The claim representative must also check the policy to see whether a deductible applies to the loss, which would reduce the amount of the loss payment. Before determining whether a given loss is covered, the claim representative must confirm that the loss occurred during the period and within the territory described in the policy.

Step 2: Valuation

For claim representatives, the valuation of loss can be the most difficult aspect of settling property insurance claims. In order to indemnify the insured according to the policy provisions, the claim representative must be able to answer two questions:

1. How does the policy specify that the property be valued?
2. Based on that specification, what is the value of the damaged property?

How Does the Policy Specify That the Property Be Valued?

All property insurance policies include a valuation provision that specifies how to value covered property at the time of the loss. The most common property valuation methods are:

- Actual cash value
- Replacement cost
- Agreed value

Actual cash value (ACV) is the cost to replace the property minus an allowance for the property's **depreciation**. For example, assume a fire completely destroys a new television and a five-year-old sofa. The television has a **replacement cost** of $600 (its cost when it was purchased a week earlier), and the sofa would cost $800 to replace with a comparable new sofa. (A sofa that is five years old probably cannot be replaced with exactly the same sofa because styles change; therefore, its replacement cost would be the cost of a new sofa comparable to the one that was destroyed.) Under these circumstances, an ACV settlement includes $600 for the television because it has not yet had time to depreciate. For the sofa, however, the claim representative has to place a value on the used property.

Actual cash value (**ACV**) is the *replacement cost* of property minus *depreciation*.

Replacement cost is the cost to repair or replace property using new materials of like kind and quality with no deduction for depreciation.

Depreciation is an allowance for physical wear and tear or technological or economic obsolescence.

The claim representative must determine the extent of depreciation that should be taken into account. This determination is usually made by estimating the property's expected useful life. If, under normal circumstances, a sofa might be used for ten years and it is now five years old, a good estimate of depreciation from normal wear and tear is 50 percent. Therefore, with a replacement cost of $800 and depreciation estimated at 50 percent, the ACV of the damaged sofa is $400. A payment of $400 would indemnify the insured for the loss of the sofa. Certain types of property, such as computers, become obsolete after a certain amount of time, so obsolescence must also be estimated.

Another valuation method specified in some property insurance policies allows for valuation on a replacement cost basis. In this case, deduction for depreciation is not a part of the valuation, and the insured in the previous example would be paid $800 for the sofa.

Still another method for valuing property losses is **agreed value**, which is used to insure property that is difficult to value, such as fine arts, antiques, and collections. The insurance company and the insured agree on the value of the property at the time the policy is written, often on the basis of an appraisal, and that amount is stated in the policy declarations. If a total loss to the property occurs, the insurer will pay the agreed value, without regard to the exact value of the property at the time of the loss.

Agreed value is a method of valuing property in which the insurer and the insured agree on the value of the property at the time the policy is written, and that amount is stated in the policy declarations and is the amount the insurer will pay in the event of a total loss to the property.

In commercial lines insurance, various *agreed value* options exist for property insurance policies. In some policies, the term agreed value has a different meaning and relates to the amount of insurance that the insured must carry to avoid a penalty for underinsurance. Such agreed value options are discussed in more detail in INS 23—*Commercial Insurance*.

What Is the Value of the Damaged Property?

Once the claim representative has verified coverage and identified the valuation method specified in the policy, the valuation process begins. Claim representatives must use some guidelines to determine both replacement cost and ACV. Personal property and real property present different valuation problems.

Personal Property If the exact style and brand of the damaged personal property are available for purchase, obtaining the replacement cost is simple. If the particular item is no longer available, the claim representative identifies the closest substi-

tute in style and quality and uses that substitute's value as the replacement cost.

For ACV, however, depreciation must be estimated. While claim representatives have attempted to develop straightforward methods, such as the "useful life" procedure described in the case of the damaged sofa, these procedures are not perfect and do not fit every circumstance. For example, if a sofa has an expected life of ten years, the claim representative makes a reasonable estimate in considering the five-year-old sofa to be 50 percent depreciated. But what if the sofa is fifteen years old? Is the sofa considered worthless? The fifteen-year-old sofa has some value as long as it is functional, so the depreciation procedure must make allowance for that fact. The claim representative might have guidelines stating that property still being used is no more than 75 percent depreciated, no matter how old it is. While such guidelines might be developed to treat most cases, it is impossible to anticipate every situation the claim representative might encounter. Therefore, good judgment on the part of the claim representative is essential to determining depreciation.

Real Property The replacement cost of real property can usually be determined by using three factors:

- Square footage of the property
- Quality of construction
- Construction cost per square foot

The first factor is the square footage of the property. If the building has been badly damaged, its area can be determined from the original blueprints or by measuring the remains.

The second factor is the quality of construction. A one-family frame house with standard trim and fixtures costs far less to replace than the same size house built of stone with high-quality woodworking, skylights, and spiral staircases. The quality of the house or building is more apparent if part of the structure has escaped damage. Pictures of the house or building can be useful, particularly if the structure has been totally destroyed.

The final factor affecting replacement cost is the construction cost per square foot currently charged for the style and quality of the destroyed building. Contractors in the location of the damaged building can quote costs per square foot in various quality-of-construction categories, such as $60 per square foot for standard quality, $70 per square foot for medium quality, and $85 per square foot for superior quality. Multiplying the square footage by the appropriate cost per square foot yields the building's replacement cost.

If the building is only partially damaged, the claim representative usually prepares a repair estimate or obtains repair estimates

from one or more contractors. Replacing the property when a partial loss has occurred involves restoring the property to its previous state, as closely as possible.

Some policies specify that the actual cash value method should be used to measure loss to real property. For policies specifying ACV valuation, claim representatives estimate depreciation of real property using methods similar to those used for estimating depreciation of personal property. Other policies state that the insured can collect the replacement cost of damaged real property under certain circumstances. Often, however, these policies provide for immediate payment of the ACV of the property, and payment of the remainder of the replacement cost is made when actual repair or replacement is completed. Either type of policy requires a claim representative to calculate the ACV of damaged real property.

Step 3: Negotiation and Settlement

After completing the investigation and valuation steps of the claim handling process for a property insurance claim, the claim representative must conclude the settlement with the insured. This step usually requires that the claim representative and the insured discuss the details of the loss and the valuation of the damage in order to agree on an amount for the insurer to pay in settlement of the loss. The negotiation phase of claim handling can be relatively simple, as in the case of the fire-damaged television in a previous example, or it can be complicated because of a large number of damaged items, property of high value, or disagreement between the insured and the claim representative regarding the value or circumstances of the loss. Successful negotiation requires an understanding of human nature and good interpersonal skills.

Whenever possible, questions of coverage, valuation, and other matters should be discussed and resolved as they arise. In addition, investigation and valuation often continue while the negotiation is in progress.

After the claim representative and the insured agree on the amount of the settlement, two other factors can affect the insurer's cost for property claims: subrogation and salvage rights.

Subrogation

Subrogation refers to the insurer's right to recover its claim payment to an insured from the party responsible for the loss. Subrogation often applies in claims involving auto accidents. Once the insurer pays the insured for the repair or replacement of the damaged auto, the policy provides that any rights to collect from another party responsible for the damage to the auto belong to the insurer (up to the amount the insurer paid the insured for

Subrogation is the insurer's right to recover payment from a negligent third party. When an insurer pays an insured for a loss, the insurer assumes the insured's right to collect damages from a third party responsible for the loss.

the claim). Subrogation prevents an insured from collecting from both the insurer and the party at fault for the same loss.

The claim representative investigates whether another party involved in the accident is legally responsible for the damage paid by the insurer. If another party is at fault, the insurer can attempt to collect the repair or replacement cost from that person or that person's insurer. Formal legal proceedings might be necessary to determine who is legally responsible for the damage.

Salvage Rights

Salvage rights are the rights of the insurer to recover and sell or otherwise dispose of insured property on which the insurer has paid a total loss or a *constructive total loss*.

A **constructive total loss** exists when a vehicle (or other property) cannot be repaired for less than its actual cash value minus the anticipated salvage value.

The insurer also has **salvage rights** to the property once it pays for a total loss. For example, if an auto damaged in an accident cannot be repaired for less than its ACV minus the anticipated salvage value, the auto is considered to be a **constructive total loss**. In this case, the insurer pays the auto's ACV to the insured (or finds an auto similar to the insured's auto before it was damaged). While the settlement with the insured is paid as a total loss, the insurance company might be able to collect some salvage value for the damaged auto. Depending on the actual condition of the vehicle, an auto salvage dealer might be willing to pay for the auto in order to obtain scrap metal and undamaged parts that could be resold as used parts. In this way, the salvage value can offset some of the insurer's claim cost. For example, assume the ACV of the insured's car at the time of an accident is $10,000, and the repairs will cost $9,000. If the car could be sold for $1,500 to a salvage dealer, the insurer would consider the car a constructive total loss because it would cost more for the insurer to pay the repair cost than to pay the insured the ACV of $10,000 and then sell the salvage for $1,500. ($10,000 ACV – $1,500 salvage value = $8,500, which is less than the $9,000 cost of repairing the car.)

Educational Objective 5

Describe the claim handling process for liability insurance claims.

Liability Insurance Claims

Liability claim handling can be complex for several reasons. For liability claims, the claimant is a third party who has been injured or whose property has been damaged by the insured. The claimant might perceive the claim representative as an adversary, and this perception could cause the claimant to act in a hostile or unfriendly manner. Another complicating factor is the possibility that a liability claim might involve bodily injury. While it is not always easy to determine the amount of the loss in property damage liability claims, the problem becomes even more complex when the loss involves bodily injury or death.

Liability claim settlement sometimes involves a claim for damage to the property of others that the insured has allegedly caused. The process for handling property damage liability claims need not be described in detail here because it resembles the claim handling process for property insurance claims with the added difficulty of determining whether the insured is legally responsible for the property damage that has occurred. The following discussion concentrates on the issue of legal responsibility, which lies at the heart of the liability claim handling process.

Step 1: Investigation

After receiving the first report of injury or damage, the claim representative must gather more detailed information relating to the liability claim. The question of how much damage occurred might be secondary because the amount of the loss is relevant only if the loss is covered under the insured's policy and if the insured is legally responsible for the loss. The claim representative's initial emphasis must be on determining how and why the loss occurred and whether it appears that the insured is responsible.

Determining How the Loss Occurred and Assessing the Situation

In investigating a liability claim, the claim representative often inspects the scene of the occurrence. This inspection is particularly useful if a traumatic event has occurred, such as an auto accident, a building collapse, or a fire. By studying the scene of the occurrence and by interviewing the insured, the claimant, and any witnesses, the claim representative attempts to reconstruct the events that led to the loss. This reconstruction helps to determine, as closely as possible, how the loss occurred and who is responsible. While additional details are needed to determine the size of the loss, at this point the claim representative must collect enough information to determine whether the liability policy covers the loss and, if so, whether the insured might be legally responsible.

As soon as possible, the claim representative usually speaks directly with the injured party or that party's legal representative to hear that side of the story and to assess what injury or other damage has been sustained. Many times the events surrounding an accident are difficult, if not impossible, to reconstruct, so the claim representative often receives different interpretations from the injured party and the insured as to how the loss occurred. The claim representative also gathers reports from witnesses, if available. All of this information helps the claim representative to determine whether the insured might be legally responsible.

The injured party has the option of suing the insured, and the ensuing legal process could end in a legal decision concerning

who is responsible and to what extent. Because of the time, expense, and uncertainty involved in a trial, insurers often prefer to settle claims out of court. If the claim does go to court, the insurer is obligated to provide and pay for the insured's defense for a covered claim (until the insurer has paid the full policy limit for the occurrence involved).

Verifying Coverage

Liability policies usually cover the insured's liability arising from certain specified activities, such as owning or using an automobile or operating a business, subject to certain exclusions. Therefore, coverage verification depends on whether the activity leading to the claim comes within the scope of the policy's coverage and whether any exclusions in the policy apply to the specific case. Based on the information gathered, the claim representative must determine whether coverage exists.

If the claim representative's investigation establishes that no coverage applies, the insurer will deny the claim. For example, if the policy excludes injury intended by the insured and the insured purposely injures someone with a baseball bat, there would be no coverage unless the insured can establish that the injury was not intentional but merely a careless act. In that case, the claim representative would need to investigate further to determine whether the injury was indeed intentional on the part of the insured. If coverage does exist, the valuation aspect of liability claims settlement then becomes very important.

Step 2: Valuation

Damages refer to a monetary award that one party is required to pay to another who has suffered loss or injury for which the first party is legally responsible.

When bodily injury is involved, determining the amount of **damages** often depends on medical records and the reports and opinions of attending physicians. Properly evaluating medical information is critical in determining the amount of damages and is a distinguishing factor in the loss settlement process for bodily injury liability claims. This evaluation aspect of bodily injury claims requires experience and skill.

Legal liability cases might involve the following types of damages:

- Compensatory damages (which include both special damages and general damages)
- Punitive damages

Compensatory damages are *damages*, which include both *special* and *general damages*, that are intended to compensate a victim for harm actually suffered.

Compensatory Damages

Compensatory damages are intended to compensate a victim for harm actually suffered. Compensatory damages include *special damages* and *general damages*.

Special damages are compensatory damages allowed for specific, out-of-pocket expenses, such as doctor and hospital bills.

Special Damages Specific, out-of-pocket expenses are known as **special damages.** In bodily injury cases, these damages usually

include hospital expenses, doctor and miscellaneous medical expenses, ambulance charges, prescriptions, and lost wages for time spent away from the job during recovery. Because they are specific and identifiable, special damages are easier to calculate than general damages.

General Damages Examples of **general damages**, which do not have a specific economic value, include pain and suffering; disfigurement; loss of limbs, sight, or hearing; and loss of the ability to bear children. Because these losses do not involve specific measurable expenses, estimating their dollar value requires considerable experience and might still seem arbitrary to someone who is not experienced in injury evaluation. For the claim representative, the best guide is usually the analysis of past cases similar to the case at hand.

General damages are compensatory damages awarded for losses, such as pain and suffering, that do not have a specific economic value.

There is usually no direct relationship between the amount of general damages and the amount of special damages. In some cases, such as when a claimant loses an eye, the amount of special damages might be relatively low, but the general damages might be quite high because of the pain and suffering involved and the change in the claimant's quality of life. In other cases, such as for whiplash injuries, general damages might be minimal, but special damages might be considerable because the claimant has extensive physical therapy or other medical treatment.

In recent years, courts have often made large awards for general damages, particularly for traumatic incidents like automobile accidents. Claim representatives must be aware of the awards for damages made in their jurisdictions, because these awards provide a guideline for negotiating with the injured party.

Punitive Damages

When a court finds the defendant's conduct particularly reprehensible, it might award a third type of damages known as **punitive damages**. The purpose of punitive damages is to punish the wrongdoer and to deter others from committing similar wrongs. In some states, the insurer's payment of an award for punitive damages is not permitted because such payment by an insurer would not punish the insured. Some policies expressly exclude the payment of punitive damages.

Punitive damages are damages awarded by a court to punish wrongdoers who, through malicious or outrageous actions, cause injury or damage to others.

Step 3: Negotiation and Settlement

While the awards for damages described above might result from court decisions, a very large percentage of liability cases are settled out of court through negotiations between the claim representative and the claimant or the claimant's attorney. In most instances, neither party wishes to become involved in a formal legal action with the accompanying costs and delays. When negotiations do not bring about a settlement, however, the claimant has the option of suing for the alleged damages.

The court then decides who is responsible and determines the value of the injury or damage. Even after the claimant initiates a suit, however, the claim negotiation process usually continues. Many out-of-court settlements have resulted after some or all of the courtroom testimony has been given. Negotiating with the claimant while simultaneously preparing for proceedings in court requires a great deal of skill, patience, and understanding on the part of the claim representative.

Educational Objective 6

Describe the claim representative's role in establishing an insurer's loss reserves.

Establishing Loss Reserves

Claim representatives also play a vital role in establishing an insurance company's loss reserves. As stated in Chapter 3, loss reserves represent funds held by the insurance company to pay claims for losses that have occurred but have not yet been settled. Loss reserves are the largest and most important liabilities of property and liability insurers. They are liabilities because they represent an estimate of the amount of claim payments the insurer will make in the future.

After the claim representative receives notice of a loss, obtains initial information, and verifies coverage, a loss reserve for that claim is established. Assume, for example, that an insured had a minor auto accident in which her car hit a guardrail on a foggy night and that no injuries or other cars were involved. After obtaining initial information concerning the accident, verifying coverage, and receiving written estimates of the cost to repair the insured's car, the claim representative establishes a loss reserve of $1,500. This figure is probably a very accurate estimate because a single-car collision loss is relatively easy to evaluate. Two weeks later, the repairs are made to the insured's car, and the insurer issues a check for $1,500. Once the loss is paid, the reserve is reduced to zero because no future loss payment is contemplated. Therefore, the $1,500 claim paid by the insurer equals the initial loss reserve.

On the other hand, complex claims are often very difficult to estimate, especially liability claims. Assume that an insured was involved in a serious auto accident and that two persons in the other car are hospitalized with severe injuries. The cause of the accident is not immediately clear because of conflicting testimony of witnesses, and it is difficult to determine whether the insured is responsible for the accident. What loss reserve should be established? The amount eventually paid because of this accident could range from almost nothing (if the insured is not

found to be legally responsible) to hundreds of thousands of dollars (if the insured is responsible and the injured victims die or are permanently disabled). The eventual payment on this particular claim, which might not be made for several years, might vary significantly from the original reserve.

The calculation of the loss reserves is always an estimate—no one knows exactly how much the insurer will pay in the future for an individual claim or all claims for a particular period. Although actuaries calculate an insurer's overall loss reserves for inclusion on the insurer's financial statements, claim representatives generally estimate loss reserves for individual claims based on their knowledge and experience. Actuaries then use individual claim reserves in determining the overall claim reserves to show on the insurer's financial statements. No system of estimating overall loss reserves can be accurate unless the underlying reserves on individual claims are reasonably accurate. A claim representative who properly estimates a loss reserve for a given claim provides a valuable service to the insurer, who in turn is better able to report appropriate loss reserves to legislators, investors, and others.

The process of setting individual claim reserves varies by company. Often, the claim representative's input, based on an analysis of the many factors associated with a particular claim, is combined with the knowledge and experience of a claim supervisor or manager. Reserving is not a one-time activity for any particular claim; the loss reserve must be constantly evaluated and re-evaluated as new information becomes available. A good claim representative should be able to set appropriate loss reserves that accurately reflect the ultimate expected claim payment.

Educational Objective 7

Describe and, in a given situation, analyze the practices prohibited by unfair claim practices laws.

Unfair Claim Practices Laws

Although most claim representatives strive to treat insureds and claimants as fairly as possible while adhering to the terms of the insurance policy, the claim handling process is far from perfect. The task of the claim representative is a difficult one. Not only is it difficult to master some of the skills, such as understanding complex policy conditions and determining the value of the loss, but the entire process depends on skillful interpersonal communication in a situation that might involve stress and disagreements.

If the claimant perceives the claim representative as an adversary, this perception can lead to problems. Unfortunately, the claimant might have the misconception that the claim

representative's job is to pay as little as possible under the contract and that the only way to receive a proper recovery is through confrontational negotiation or by hiring a lawyer. A liability claim accentuates the adversarial aspect since the claimant, who has suffered a loss allegedly as a result of the insured's actions, views the claim representative as representing the "other side" (the insurer and the insured) and thus not being trustworthy.

Unfair claim practices laws are state laws that specify claim practices that are illegal.

Because of problems that have occurred in the claim process, most states have enacted **unfair claim practices laws**. These laws specify claim practices that are illegal. The prohibited claim practices usually include:

- Misrepresentation of pertinent facts or insurance policy provisions relating to coverage at issue in a claim
- Failure to acknowledge and promptly respond to communications with respect to claims arising under insurance policies
- Actions that compel an insured to sue to recover amounts due under insurance policies by offering amounts that are substantially lower than the amounts ultimately recovered in legal actions brought by such insureds
- Refusal to pay claims without first conducting a reasonable investigation based on all available information

Insurance regulators usually learn of unfair claim practices when they receive complaints from insureds and claimants. Claim representatives must be able to justify their actions and provide proper documentation when asked to do so by state insurance regulators. Some complaints are frivolous, often occurring because the claimant is annoyed that the policy does not cover a loss. On the other hand, some complaints are valid, and regulators might take action when a serious complaint occurs or when several complaints, especially of a similar nature, are registered against a claim representative or insurance company. The claim representative or insurance company must justify the practices that are under scrutiny or face a reprimand, a fine, a license suspension, or some other legal penalty.

Educational Objective 8

Define or describe each of the Key Words and Phrases for this assignment. (All Key Words and Phrases appear in bold print in the text and in boxes in the margins throughout this chapter.)

Summary

When an insurance company sells a policy, it promises to pay

claims covered by that policy. The purpose of the claim handling process is to fulfill that promise. A claim representative, the person responsible for handling claims, has several responsibilities:

- To respond promptly when a claim is submitted
- To obtain adequate information
- To properly evaluate the claim
- To treat all parties fairly

Depending on the circumstances, different types of claim representatives may handle claims, including:

- *Staff claim representatives*, who are insurance company employees and include inside claim representatives and outside (field) claim representatives
- *Independent adjusters*, who are independent claim representatives who offer claim handling services to insurers for a fee
- *Agents*, who often have draft authority to settle certain small claims
- *Public adjusters*, who are hired by and represent the insured in the claim handling process

A self-insurance situation can also require claim handling services. In that situation, the self-insuring organization may use its own personnel to settle claims, or it may use the services of a third-party administrator.

Regardless of who handles claims, the claim handling process involves the same three steps

1. Investigation of the claim
2. Valuation (establishing the amount of the loss)
3. Negotiation and settlement of the claim

For property claims, the investigation usually means inspecting the damaged property to determine the cause of loss and to assess the damage. The investigation also involves verifying coverage by determining whether an insurable interest exists, whether the policy covers the damaged property, whether the policy covers the cause of loss involved, and whether any additional coverages, endorsements, or limitations on coverage apply. The procedure for the valuation of the loss depends on whether the policy specifies actual cash value, replacement cost, agreed value, or some other method for valuing losses.

In liability claims, the claim representative's investigation focuses on whether the activity leading to liability comes within the scope of the policy and whether the insured could be legally responsible for the loss. The valuation of a bodily injury loss involves the examination of medical records and physicians' reports. If the case goes to court, the total liability loss can result in compensatory damages (which include special damages

and general damages) and, conceivably, punitive damages. Often, however, it is in the best interest of all parties to negotiate a settlement out of court rather than to incur the expense and delay of legal proceedings.

In addition to fulfilling the promise contained in the insurance contract, claim representatives play an important role in measuring the insurer's liabilities by establishing loss reserves for individual claims. A loss reserve for a particular claim is the best estimate of the amount the insurance company will eventually have to pay for that claim.

Many states have passed laws prohibiting unfair claim practices. Regulators also monitor complaints from insureds and claimants. A number of complaints about a particular insurance company or claim representative could lead to a reprimand, a fine, or some other legal penalty.