



CSC

INTEGRAL GROUP ADMIN

Training Manual

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CSC Technology Singapore Pte Limited

20, Anson Road

#11-01 Twenty Anson

Singapore 079912

Telephone +65-6221-9095

Facsimile +65-6436 7124

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1.0 INTEGRAL GROUP

1.1 Introduction

INTEGRAL GROUP is an integrated Group Insurance Administration system with functionalities that are fully matured having been evolved over the last 15 years. It is capable of handling employee benefits and managed care application.

It complements an existing suite of systems to offer a complete continuum of information flow in the financial services industry.

It enables the company to exercise full control over its day-to-day business activities from underwriting to claims, receipts and payments to debtor control as well as the financial postings into the general ledger.

2.0 New Business

2.1 Create New Business work with policy

From the Main Menu select <Group Policy Admin> followed by <New Business> which will bring you to the New Business Sub Menu screen:

The screenshot displays the 'New Business - Sub Menu' interface. On the left is a vertical 'Main Menu' sidebar with various administrative options. The main area contains two sections: 'Input' and 'Actions'. The 'Input' section includes fields for Policy Number, Policy Type (a dropdown menu), Effective Date, Clone From, Subsidiary (checkbox), Original Commencement Date, Pre-Validate Active (checkbox), and Default Data Template. The 'Actions' section contains several radio button options: Work With Policy, Work With Subsidiaries, Work With Products/Plans, Work With Members, Work With Headcount, Issue Policy, Decline Policy, and Issue Trial Bill. At the bottom right are buttons for 'Exit', 'Refresh', and 'Continue'.

Notes and comments:

- ❑ Policy numbers are automatically allocated and they are maintained in table T3642
- ❑ To create a policy, enter the policy type and the effective date (commencement date) of the policy.
- ❑ Valid Policy Types are held in T9799 and may be accessed by using the drop-down list.

On clicking <Continue> button, you will be brought to the Policy Header screen:

Policy Header NewBusinesses

Policy
35000206 GTL Group Term Life

Policy Owner
Owner Long Name
Payor
Default
Text
Split Commission
Despatch Address
Gen Page
Direct Debit

Policy Status
PN Pending New business

Original Commencement Date
01/01/2013

Effective Date
01/01/2013

First Billing Date
01/01/2013

Insured From
01/01/2013

Insured to
01/01/2013

Policy Currency
Singapore Dollars

Renewal Notice To
No Notice Produce

Subsidiaries
OnLine Renewal Rvw

Agent Details
Agent
Servicing Branch
10
Ext. Family
Former Broker
Former U/W
Broker Servicing Staff

Billing Details
Source of Business
Take Over
Marketing Staff
Statistical Code
Local Fund
Location
Sub-Location
Reference No

Buttons: Exit, Refresh, Continue ➔

Billing Details Information

Gen Page
Direct Debit

Functions

Billing Details

Tax Applicable

Exchange Rate
Billing Frequency
Annual Premium

LA-Owner

Pooling

Payment Method
Direct Billing (Ce)

Adjustment Frequency
Monthly Premium

Billing Currency
Singapore Dollars

Renewal Month
02 For Individual Policy

Notes and comments:

- ❑ The allocated policy number is displayed
- ❑ The pooling field is used to identify high risk contracts that may be pooled within the industry. It is for information purpose only and will default as N
- ❑ Commencement and renewal dates are in the format DD/MM/CCYY, but date conversion routines will allow D.M.YY or DDMMYY to be used as entry formats.
- ❑ Validation for fields, Renewal Notice to, Billing and Adjustment Frequency, Source of Biz, Servicing and Marketing Staff are held in tables T9774, T3590, T9768 and T9784 respectively. F4 on any of these fields will display a list of valid entries.
- ❑ Insured to field, this is the last date of the contract period. E.g. for a contract starting on

01/01/2009 for one year it will be 31/12/2009.

- ❑ Next Billing date: this is the date that the bill after the new business bill will be issued. For an annual case this will be set to the start date of the next contract as it is not billing in instalments. For instalment cases this should be set to the date of the next billing instalment E.g. for a monthly case starting on 01/01/2009 the 1st billing date will be 01/02/2009, for an annual case starting on 01/01/2009 the 1st billing date will be 01/01/2010. If the policy is back dated then the first billing date should be the anniversary date in the next billing period after the system date
- ❑ The Payment Method (the method of payment arranged between the client and the insurer for premium) stored in T3620. The drop down list will provide a list of valid entries and these include DD, cash.
- ❑ The billing commencement date will default, depending upon the Policy Commencement Date and the Billing Frequency.
- ❑ Statistical codes are shown, of which the first two are used in the base system. Field 1 denotes the territory of the risk and validates against T3595 and Field 2 defaults the Agent Type from the agent record.
- ❑ Click on <Owner Long Name> for entry of insured long name,
- ❑ Click on <Payor> when it is different from the policy owner
- ❑ Click on <Desp Address> to enter despatch address
- ❑ Click on <Gen Page> to add “Text” for free format general page.
- ❑ If the Payment Method is ‘D’ for direct debit, system will prompt for mandatory input in the Direct Debit field to ensure that DD mandate details are entered. As bank accounts require authorisation this will need to be done via client bank account set-up prior to using the bank account on the mandate for the policy.

Press <Continue> to proceed.

If the payment method is DD the DD Mandate Details screen will be displayed, otherwise we will continue to Policy Header Continuation.

Notes and comments:

- ❑ Use the scroll button on the mandate no. to see a list of mandates available for the policy Payor.
- ❑ If the mandate required is available it can be selected by clicking on the mandate no and the details will be returned to DD Mandate Details screen.

Press <Continue> to proceed.

The Policy Header Continuation screen is displayed:

Policy Header (continuation)

Policy
35000206 GTL Group Term Life

Owner
50000226 APPLE INC

Effective Date
01/01/2013

Age Calculation Method
Age - Member

Terminal Age

Persons Covered
Employees Only

Enrollment Type
-Select-

Client Branches

RI Applicable

RI Method Variation
----Select----

Renewal Provisional Bill

Surgical Schedule Method/Version
----Select----

Area Code Method/Version
----Select----

Medical Assistance Provider

Tolerance Shortage Rule
-Select-

Details 1 **Details 2** **Details 3**

Method of Providing New Members Data
Paper

Default Values for Member Enrolment

Member & Claim Admin Rule
MCA1

Default Claim payee Rule
Default Claim Payee Ru

Master Policy

Area Code for Premium Rating

O/r Comm Payable to

Free Cover Limit Level
Policy/product level

Exit **Previous** **Refresh** **Continue ➔**

Details 2 screen

Details 1 **Details 2** **Details 3**

Employer Group
----Select----

Industry
----Select----

Application Prefix
----Select----

Enter Age or DOB
S

Staff ID who Brought Business
----Select----

Inward Income Type
----Select----

Major Medical Method
----Select----

Application Type
----Select----

Premium Collection at Member Level

Details 3 screen

Details 1 **Details 2** **Details 3**

Dependent Members Details

Print Card

NML Variation

Membership

Spouse

Medical Assistance

Children

Field must be entered

Notes and comments

- ❑ Click <Continue> to confirm system mandatory fields for your product type, use scroll button or drop-down list to provide a list of valid values allowed. Select the appropriate details for the policy.
- ❑ The age calculation method chosen will determine when the age is determined to e.g. date of attachment of member or new business/ Renewal date of policy. It will also determine if the age calculated is Age next, last or nearest birthday.
- ❑ Options to enter eligibility details and follow-up details are available. Click on the link in the Extra Info box.
- ❑ IF RI applies put a "Y" in the "RI applicable" field.
- ❑ IF RI variation codes apply, include in the RI variation field

Press <Continue> to proceed.

The Policy Header Continuation Screen 2 is displayed:

Policy Header (Continuation-2)			
<input type="checkbox"/> Insurance Products Only <input type="checkbox"/> Expected Bill Due Date Formula <input type="checkbox"/> EFA Deduction Priority <input type="checkbox"/> First Reminder Due Date Formula <input type="checkbox"/> Fee Scale Level		<input type="checkbox"/> Effective Date For Contribution Processing <input type="checkbox"/> Contribution Due Date Formula <input type="checkbox"/> Number of Reminders <input type="checkbox"/> Second Reminder Due Date Formula <input type="checkbox"/> Third Reminder Due Date Formula	<input type="checkbox"/> Member Identification Field <input type="checkbox"/> EFA Investment Structure <input type="checkbox"/> EFA Contribution Rule <input type="checkbox"/> EFA Account Balance Rule
<input type="checkbox"/> Loyalty Bonus/Auto Renew <input type="checkbox"/> Premium Source FMC: <input type="checkbox"/> MET-1 <input type="checkbox"/> Last Contribution Period Processed <input type="checkbox"/> Last Risk Normal Premium Period Billed <input type="checkbox"/> Last Risk Adjustment Premium Period Billed		<input type="checkbox"/> Certificate Insurance Format <input type="checkbox"/> Cashless Admission <input type="checkbox"/> MET-2	<input type="checkbox"/> Fee Paid by Whom <input type="checkbox"/> TPA
<input type="button" value="Exit"/> <input type="button" value="Previous"/> <input type="button" value="Refresh"/> <input style="color: red; font-weight: bold;" type="button" value="Continue"/>			

Details 2 screen

Details 2		
<input type="checkbox"/> Billed to Date <input type="checkbox"/> Last Transaction Number <input type="checkbox"/> Last Expected Bill Print Date <input type="checkbox"/> Third Reminder Print Date	<input type="checkbox"/> Adjustment to Date <input type="checkbox"/> Expected Bill Due Date <input type="checkbox"/> First Reminder Print Date	<input type="checkbox"/> Last Member Number <input type="checkbox"/> Contribution Due Date <input type="checkbox"/> Second Reminder Print Date
<input type="button" value="Exit"/> <input type="button" value="Previous"/> <input type="button" value="Refresh"/> <input style="color: red; font-weight: bold;" type="button" value="Continue"/>		

Notes and comments

- ❑ Click on <Continue> to confirm system mandatory fields for your product type, Use scroll or drop-down list to provide a list of valid values allowed. Select the appropriate details for the policy.
- ❑ If the money for the payment of the policy has already been deposited into company suspense (CT SG), it should be applied to the policy here by placing an X in the “Apply Cash” option.
- ❑ Click <Continue> to proceed after completion of date entry. You will be returned to the submenu. The policy header details have been created.

2.2 Work with Subsidiaries

If subsidiaries apply to the policy you will next select <Work with Subsidiaries> to add subsidiary details. The policy number and action are required at the submenu.

Click on <Continue> to proceed and you will be brought to Work with subsidiaries screen:

Select	Subsidiary	Attachment	Schedule Print	Termination	
...	50000201	01/01/2013	<input type="checkbox"/>		Abbott Lal

Notes and comments:

- ❑ There are options to modify, add, reinstate, delete, terminate, lapse and mass member transfer.
- ❑ Select <Add> to add a subsidiary. You can use the scroll button to show a list of clients.
- ❑ The Attachment date is defaulted by the system
- ❑ Schedule Print indicate whether schedule printing is required at the subsidiary level
- ❑ For policies with bills to the subsidiary, the direct debit mandate for each of the subsidiaries is created or input under <Direct Debit>. If that subsidiary does not have any bank account or

mandate created, the system will assume that the mandate created at the policy header will be applicable and there will be 'an icon under the Dir Dbt column.

- The link <Undo MassTfr> can be used to undo a mass transfer if done in error.

Click <Continue> to proceed and return to the submenu when all subsidiary details have been entered.

2.3 Work with Products/Plans

Next we will enter the product and plan details for the policy. Select <Work with Product/Plans> from the submenu. The policy number is required.

Click <Continue> to proceed and you will be brought to the Work with Products/Plans screen:

The screenshot shows a software interface titled 'Work with Proposals NewBusiness'. At the top, there are fields for 'Policy' (35000206, GTL, Group Term Life) and 'Owner' (50000226, APPLE INC). Below these are fields for 'Effective Date' (01/01/2013). On the left, there are two tabs: 'Extra Info' (selected) and 'Functions'. The main area contains a table with columns: 'Select', 'Product Code', 'Contract Commencement Date', and 'Renewal Date'. A dropdown menu in the 'Select' column is set to '-----Select----'. In the 'Product Code' column, there is a text input field containing '35000206' and a magnifying glass icon. In the 'Contract Commencement Date' column, the value '01/01/2013' is displayed. At the bottom right, there are buttons for 'Exit', 'Refresh', and 'Continue'.

Notes and comments:

- In this screen, there are several options available. <Add> option is to add a new product. A list of available products can be displayed using the drop-down on an existing product.
- The deletion option is only available at new business time.
- Option for mass transfer of plans can be used during renewal or major alteration.

Click <Continue> to proceed.

2.3.1 Product definition (Life)

The Product Definition New Business screen (Non-medical product) will be displayed.

Product Definition NewBusiness

Policy
35000206 GTL Group Term Life

Effective Date
01/01/2013

Policy Owner
50000226 APPLE INC

Original Commencement Date
01/01/2013

Termination Date

Provisional Bill
No Provisional E

System
.00

Manual
.00

Free Cov Lt.
0 0 0 0

Up To Age
0 0 0 0

Key-PM06/08/09
Select %Limit to Waive U/W for Increases in Sums Assured

Detail 1 **Detail 2**

Select	Plan No	Plan Description	Long Plan Description	Minimum SI	Maximum SI
<input type="checkbox"/>	001		<input type="checkbox"/>	10000.00	1000000.00
<input type="checkbox"/>	002		<input type="checkbox"/>	10000.00	1000000.00

Buttons: Select, Add, Delete, Display, Terminate, Lapse, Exit, Previous, Refresh, Continue

Notes and comments:

- Click <Continue> to see a list of system mandatory fields, use the scroll button or drop-down list for a list of valid values for any field and F1 help
- Commission details are entered in the 1st year commission and Renewal Commission fields. This will be validated against the range allowed for the product.
- Applicable Premium Methods:-
 - 01 Group family rate
 - 02 Individual table rate
 - 03 Individual policy rate
- The Salary (Sal) field will be used to define if the salary entered for members is annual or monthly.
- The max sum insured (Max SI) entered here is the maximum sum insured allowed for any member on this plan.
- Members' who have been removed from a headcount group, because they were identified as requiring underwriting, will be set up on a new plan. As part of this plan creation the administrator will ensure that the Headcount indicator is set to N (No).
- For products with sum insured, Integral GROUP supports free cover limit at policy/product level.
- The system supports up to a maximum of 4 free cover limits based on age range.
- The system allows the free cover limit to be changed at any time. When free cover limit is changed, the new free cover limit is applied immediately for new members. However, for existing members, the new free cover limit is applicable only during the next renewal / policy

anniversary.

- ❑ If the free cover limit is entered incorrectly at new business, any members already set up will need to have the plan removed and reapplied to ensure the correct FCL is being applied
- ❑ For some policies, there is a requirement for free cover limit to be defined at policy/product/plan level. When free cover limit is defined at policy/product/plan level, it is independent of age. This means the free cover limit is the same for all age. This will be entered on the plan screen.

Click < Benefit Definition> to enter benefit definition.

Depending on product type you will be brought to the appropriate product definition screen.

2.3.1.1 Plan definition (Life)

Plan Definition screen (Life):

The screenshot shows the 'Plan Definition' page of the INTEGRAL Admin system. The URL is http://integral.csc.com/integral/Group/Web/CCR11. The page title is 'Plan Definition'. On the left, there's a sidebar with 'Extra Info' and 'Functions' sections. The 'Functions' section contains links for 'Add Plan Details' and 'Benefit Definition'. The main content area displays plan details: Policy (35000206 GTL Group Term Life), Owner (50000226 APPLE INC), Product (GTL1 Group Term Life Product), and Effective Date (01/01/2013). Below this is a table with columns: Plan No, Coverage Basis, Dependents, Fixed SI Amount, Coverage Limit Plan Level, Yearly Salary Multiplier, and Monthly Sal Multiplier. A single row is shown with '001' in the Plan No column. At the bottom, there are navigation buttons: Exit, Previous, Refresh, and Continue. The status bar at the bottom right shows '100%', '3:47 PM', and '14-Jun-13'.

Notes and comments:

- ❑ The cover basis determines how the sum insured is set. Available options can be viewed on the drop-down list. If calculated, the sum insured is calculated when the member is added and subsequently under the following situations:
 - When member's salary changes;
 - When member's plan changes;
 - Policy anniversary / Renewal;
- ❑ If unit rated the plan unit rate will be entered here.
- ❑ The Yrly/Mnth % fields are entered as a times value i.e. 2 for twice the annual salary. 48 for 48

time of monthly salary.

- If the FCL is at the plan level it should be entered here.

Click <Add Plan Details> to select the product benefit template details.

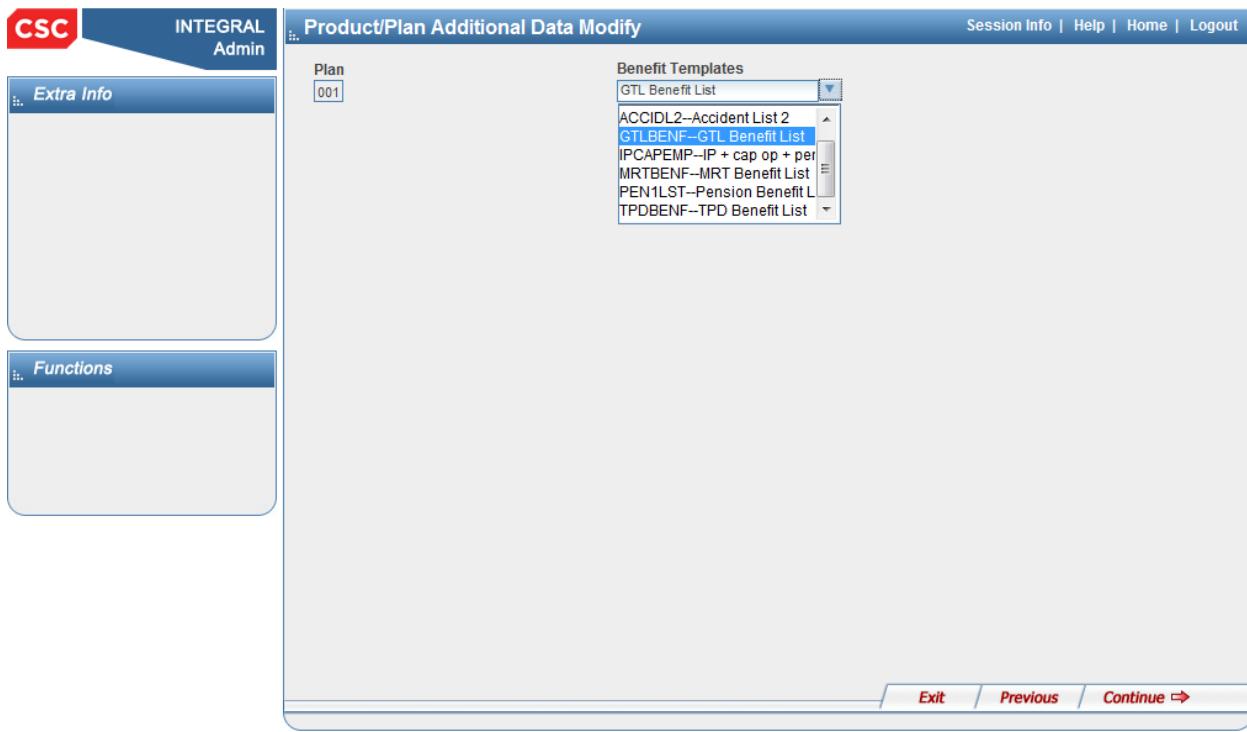
2.3.1.1.2 Product/Plan Additional Data (Life)

Select	Plan	Benefit Template
<input checked="" type="checkbox"/>	001	GTLBENF

More...

Click on <Select> checkbox then <Continue> to bring you to appropriate Benefit Template selection screen.

2.3.1.3 Benefit template selection (Life)



Click on drop-down list for a list of available benefit templates select the appropriate one for each plan

Click <Continue> to return to the Plan definition screen

Click <Premium Definition> to enter adjustment rates if applicable or F13 to accept benefit template details or modify them.

2.3.1.4 Premium Definition (Life)

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Premium Definition

Session Info | Help | Home | Logout

Policy 35000206 GTL Group Term Life	Effective Date 01/01/2013	Owner 50000226 APPLE INC
Product GTL Group Term Life Product	Apply Factor On Standard Rate ▾	Plan 002 Contract

Age From	Age To	Adult/Child	Current Policy Rate		Original Rate	
			Male	Female	Male	Female
0	21	C	120.00	120.00	120.00	120.00
17	24	A	130.00	140.00	130.00	140.00
25	29	A	230.00	240.00	230.00	240.00
30	34	A	250.00	260.00	250.00	260.00
35	39	A	270.00	280.00	270.00	280.00
40	44	A	290.00	300.00	290.00	300.00
45	49	A	310.00	320.00	310.00	320.00
50	54	A	330.00	340.00	330.00	340.00

Rating Factor 1.00 1.00

[Exit](#) / [Previous](#) / [Refresh](#) / [Continue ➔](#)

Notes and comments:

- Enter the appropriate adjustment factors required for each plans premium method

Click <Continue> to return to the Plan definition screen

Click <Benefit Definition> to accept benefit template details or modify them.

2.3.1.5 Benefit Definition (Life)

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Work with Benefits NewBusinesses

Session Info | Help | Home | Logout

Policy
35000206 GTL Group Term Life

Product
GTL Group Term Life Product

Effective Date 01/01/2013 **Original Commencement Date** 01/01/2013 **Terminate Date** []

Ind	Select	Plan	Benefit	Description	Start Date	End Date	
	<input type="checkbox"/>	001	TL01	Death	01/01/2013		DTH1
	<input type="checkbox"/>	002	TL01	Death	01/01/2013		DTH1

Functions

Add Benefit

Modify Delete Display Terminate Lapse Reinstate

Exit Previous Continue ➔

Click on <Add Benefit> on benefit definition will brings you to Work with Benefit Details where an additional benefit can be added if required,

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Work with Benefit Detail

Session Info | Help | Home | Logout

Plan
001

Start Date
01/01/2013

Benefit Code
Death

End Date []

Benefit List
Death Benefit List ▾

Exit Previous Refresh Continue ➔

2.3.1.7 Notes on completion of Option <Work with Product/Plan>.

If, when you attempt to enter members or headcounts, you receive the message “Prod/Plan Data Incomplete”, the system has determined that not all information has been entered for the plan. The plan must be properly set up before proceeding to add members or headcount details. Things to check for:

- Have I set up all benefit information? The steps to follow up for this are:
 - From Product Definition, select <benefit definition> for the plans, this brings you to Product Definition New Business and Plan Definition.
 - From Plan Definition, select <Add Plan Details> to select benefit template for each plan, and then return to benefit definition screen;
 - From Plan Definition, select <Benefit Definition> to review and accept benefit template details.
 - To accept benefits (Life) click <Continue> until it return to the sub-menu;
- Have I set up rates, this may require selecting individual rates, entering unit rates, entering adjustment rates.

2.3.2 Product definition (Medical)

If a Medical Product is selected, the Product Definition New Business screen (Medical product) will be displayed.

The screenshot shows the INTEGRAL Admin system interface. The top navigation bar includes 'CSC' and 'INTEGRAL Admin'. On the left, there's a sidebar with 'Extra Info' and 'Functions' sections. The 'Functions' section contains links for 'Additional', 'Premium Definition', 'Contributory', and 'Benefit Definition'. The main content area is titled 'NewBusiness' and displays various configuration fields: Policy (35000214, GHC, HealthCare-Group), Product (GHC1, Group Health - Hospital Care), Original Commencement Date (01/01/2013), Provision Bill (No Provisional E), Effective Date (01/01/2013), Terminate Date (empty), GST Type (Standard rated), and System (Manual). Below these are tabs for 'Plan Details' and 'Other Details'. A large table lists plan details with columns for Ind, Select, Plan Number, Description, Authorization Flag, and Network ID. The table rows show four plans: Gold (001), Silver (002), Bronze (003), and a partially visible fourth row (004). Action buttons at the bottom include 'Select', 'Add', 'Delete', 'Display', 'Terminate', and 'Lapse'. At the bottom right are links for 'Exit', 'Previous', 'Refresh', and 'Continue'.

Ind	Select	Plan Number	Description	Authorization Flag	Network ID
	<input type="checkbox"/>	001	Gold	Not applicable (ignored in ad)	KPJ - Inside
	<input type="checkbox"/>	002	Silver	Not applicable (ignored in ad)	KPJ - Inside
	<input type="checkbox"/>	003	Bronze	Not applicable (ignored in ad)	KPJ - Inside
	<input type="checkbox"/>	004			

Notes and comments:

- ❑ Click <Continue> to see a list of system mandatory fields, use the scroll button or drop-down list for a list of valid values for any field and F1 help
- ❑ Commission details are entered in the 1st year commission and Renewal Commission fields. This will be validated against the range allowed for the product.
- ❑ Pre-existing conditions – Before and After. These 2 fields capture the period the claims will not be paid due to pre-existing condition. The pre-existing condition is counted from the date of membership which is the date member or dependent first joins the policy against the date the medical condition is first known in the claim header.
- ❑ Valid Authorization Flag are:
 - ❑ C - Compulsory (used in adjudication)
 - ❑ O - Optional (ignored in adjudication)
 - ❑ E - Used only for exceptional case (ignored in adjudication)
 - ❑ N - Not applicable (ignored in adjudication)
- ❑ Network ID identifies the provider network. Every provider organization to whom an amount is payable by HMO should be defined in the network. Inside and outside organizations are part of the same network and differentiated by a network level.
- ❑ Waiting Period in months (from date of employment) before the cover commences.

- Member Type. Within a provider fee schedule, the member type is one of the variables that decide the fee basis and the fee amount for the procedure.
- MF Plan – Define the Member Plan no if Sub-Float is used
- Corporate Floater (CF) Allowed
- Premium Rating Factor is used to alter the standard premiums defined in premium method '02' and '04'. If the factor > 1 then it is premium loading while a factor < 1 will be a premium discount.
- Health Fixed Sum Insured is required when the Product is set-up requiring Sum Insured.
- Head Count Flag, default is N. Enter Y if it is a headcount plan.
- Applicable Premium Methods :-
 - 01 Group family rate
 - 02 Individual table rate
 - 03 Individual policy rate
 - 04 Premium rate by Industry/occupation
 - 11 Family rate / Sum Insured
 - 12 Family rate
- Class of Insured, defines who is eligible for coverage.
- Gate Keeping, valid values are 'Y' and 'N'.
- 'Whom to Pay' indicates whether the benefit limit applies to individual or to the whole family or to the sub-floater.
- Card Type 01/02 indicates what type of card is available.

Click <Additional> to select the product benefit template details.

2.3.2.1 Product/Plan Additional Data (Medical)

Select	Plan	Benefit Template A	Benefit Template B	Benefit Template C	Annual Aggregate
<input type="radio"/>	001	HEALTHC	HEALTHC	HEALTHC	
<input type="radio"/>	002	HEALTHC	HEALTHC	HEALTHC	
<input type="radio"/>	003	HEALTHC	HEALTHC	HEALTHC	

More...

[Modify](#)

[Exit](#) | [Previous](#) | [Continue ➔](#)

Click on <Select> checkbox then <Continue> to bring you to Benefit Template selection screen.

Plan
001

Benefit Templates
HEALTHC HEALTHC HEALTHC

Annual Aggregate Deductible

Dependent Rule-ID

Benefit Group Template-1

Benefit Group Template-2

[Exit](#) | [Previous](#) | [Refresh](#) | [Continue ➔](#)

Click on drop-down list for a list of available benefit templates select the appropriate one for each plan.

These Benefit Templates are set up in table TR9AE, TR9AF and TR9AG.

Click <Continue> to return to the New Business Product/Plan screen.

Click <Premium Definition> to enter adjustment rates if applicable.

2.3.2.2 Premium Definition (Medical)

The screenshot shows the CSC INTEGRAL Admin software interface. The top navigation bar includes links for Session Info, Help, Home, and Logout. On the left, there are two sidebars: 'Extra Info' and 'Functions'. The main content area is titled 'Premium Definition'. It shows policy details (Policy: 35000214, Owner: 50000226, Effective Date: 01/01/2013), product details (Product: GHC1, Group Health - Hospital Care), and a table for entering premium rates. The table has columns for Plan, Member/1 Child, Member & Spouse/2 Children, and Member & Children/3 Children. Data entered in the table is as follows:

Plan	Member/1 Child	Member & Spouse/2 Children	Member & Children/3 Children
001	500.00	600.00	
002	400.00	500.00	
003	300.00		

At the bottom of the screen are buttons for Exit, Previous, Refresh, and Continue.

Notes and comments:

- Enter the appropriate premium rates required for each plans and class of insured.

Click <Continue> to return to the New Business Product/Plan screen.

Click <Benefit Definition> to accept benefit template details or modify them.

2.3.2.3 Benefit Definition (Medical)

The screenshot shows the INTEGRAL Admin software interface. The top navigation bar includes 'CSC' and 'INTEGRAL Admin'. On the left, there's a sidebar with 'Extra Info' and 'Functions' sections containing links for 'Benefit Limits', 'Benefit Mapping', and 'Add Benefit'. The main content area is titled 'NewBusinesses' and displays policy and product information. It shows a table of benefits with columns for Ind, Select, Plan, Benefit, Description, Start Date, End Date, and Type (NO). The table contains 10 rows of benefit definitions. At the bottom, there are buttons for 'Modify', 'Delete', 'Display', 'Terminate', 'Lapse', 'Reinstate', 'Exit', and 'Continue'.

Ind	Select	Plan	Benefit	Description	Start Date	End Date	Type
	<input type="checkbox"/>	001			01/01/2013		NO
	<input type="checkbox"/>	001	A100	HRB	01/01/2013		NO
	<input type="checkbox"/>	001	A101	ICU	01/01/2013		NO
	<input type="checkbox"/>	001	A103	HRS	01/01/2013		NO
	<input type="checkbox"/>	001	A105	Surgery	01/01/2013		NO
	<input type="checkbox"/>	001	A106	IHPV	01/01/2013		NO
	<input type="checkbox"/>	001	A107	IHSp Cons	01/01/2013		NO
	<input type="checkbox"/>	001	A108	ANAS FEE	01/01/2013		NO
	<input type="checkbox"/>	001	A109	Pte Nurse	01/01/2013		NO
	<input type="checkbox"/>						

Notes and comments:

- ❑ Type of Deductible is used to indicate what type of deductible is used when calculating the member liability during claim processing. The values applicable:-
- ❑ NO – No deductible.
- ❑ 01 – Same deductible for member and dependent.
- ❑ 02 – Different deductible for member and dependent.
- ❑ 03 – A value for first x visits and a different value there after (same deductible for member and dependent)

Click <Benefit Limits> to display the benefit limits and to make any necessary changes.

CSC INTEGRAL Admin

Extra Info

Functions

Reg Claim
Add

NewBusinesses

Session Info | Help | Home | Logout

Policy 35000214 APPLE INCORPORATED NOT FACEBOOK	Product GHC1 Group Health - Hospital Care
Effective Date 01/01/2013	Original Commencement Date 01/01/2013
Terminate Date <input type="text"/>	

Benefit Mapping

Ind	Select	Plan	Benefit Code	Benefit Group	Short Description	Be
	<input type="checkbox"/>	001				
	<input type="checkbox"/>	001	A100		HRB	
	<input type="checkbox"/>	001	A101		ICU	
	<input type="checkbox"/>	001	A103		HRS	
	<input type="checkbox"/>	001	A105		Surgery	
	<input type="checkbox"/>	001	A106		IHPV	
	<input type="checkbox"/>	001	A107		IHS Cons	
	<input type="checkbox"/>	001	A108		ANAS FEE	
	<input type="checkbox"/>	001	A109		Pte Nurse	

Action Buttons: Copy, Modify, Delete, Display, Mod.Reg.cl, Enq.Reg.cl, Exit, Previous, Refresh, Continue ➔

Click <Continue> to return to the Benefit Definition screen after review and changes made.

Click <Benefit Mapping> to display the benefit code mapping and to make any necessary changes.

CSC INTEGRAL Admin

Extra Info

Functions

Add New

NewBusinesses

Session Info | Help | Home | Logout

Policy 35000214 GHC HealthCare-Group	Product GHC1 Group Health - Hospital Care
Effective Date 01/01/2013	Original Commencement Date 01/01/2013
Terminate Date <input type="text"/>	

Benefit Mapping

Ind	Select	Plan	Benefit	Claim Type	Provider Capacity	Network Level	Be
	<input type="checkbox"/>	001		NM	NA	IN	
	<input type="checkbox"/>	001	A100	NM	NA	IN	
	<input type="checkbox"/>	001	A101	NM	NA	IN	
	<input type="checkbox"/>	001	A103	NM	NA	IN	
	<input type="checkbox"/>	001	A105	NM	NA	IN	
	<input type="checkbox"/>	001	A106	NM	NA	IN	
	<input type="checkbox"/>	001	A107	NM	NA	IN	
	<input type="checkbox"/>	001	A109	NM	NA	IN	
	<input type="checkbox"/>	001	A112	NM	NA	IN	

Action Buttons: CpyExisting, Modify, Delete, Display, Terminate, Lapse, Copy New, Exit, Previous, Refresh, Continue ➔

Review the information and modify them if necessary.

Click <Continue> to return to the Benefit Definition screen after review and changes made.

2.4 Work with Members - Action D

If there are non-headcount plans on the policy or members requiring underwriting (extracted from headcount plans), we will need to set up member details. Select <Work with Members> from the submenu.

Work with Members screen is displayed:

The screenshot shows the 'Work With Members NewBusiness' interface. The top navigation bar includes links for Session Info, Help, Home, and Logout. On the left, a sidebar titled 'Extra Info' contains a single entry. Below it, a 'Functions' section lists: Add Member, Add Headcount Member, Reload All, and Undo All. The main workspace displays policy details (Policy No: 35000206 GTL Group Term Life, Policy Owner: 50000226 APPLE INC), search fields for Client No, Surname, and Subsidiary, and a large grid for managing members. The grid has columns for Select, Old Role, Member No, Dependent No, Client No, and Name. Below the grid is a row of buttons including Select, Add Child, Follow, Add Spouse(Mono)/Jt Life, Display, T/pro, Lapse, Delete, AddSpouse(Poly), Beneficiary, Annual Premium, PreExisting, Exclusion, Endt Note, Additional Data, Default Free Text, Text, T/part.ref, Member Subsidiary Transfer, Undo Changes, Reload, Reinstate, Cancel, Extended family Dependent, Previous Member, Previous History, and Benefit.Exclusions. At the bottom right are Exit and Continue buttons.

Notes and comments

- ❑ Click on <Add Member> to add member and Effective dates are defaulted to commencement date at new business, but can be overridden if member is to be added at a later date.
- ❑ If the policy has been set-up with subsidiaries the subsidiary will need to be selected here. This can be the policy owner.
- ❑ Option <Add Headcount Member> will only be used to add headcount member in the event of claim processing it will not be used for members that require underwriting.

On clicking <Add Member> Group Member Entry screen will be displayed

Member Details

Notes and comments:

- The member number is auto-generated
- Select a client number for the member; if one does not already exist, click on client scroll button and then <Add Personal Client> to create one.
- The Plan number field at the top right will assign the plan to the member and on clicking <Refresh> the products that are attached to that plan will be displayed against the member.
- Family cover is displayed as 'A' for member only.
- The option <Add products> will not be used.
- At times due to incorrect entry of product details on <Work with Product/Plan> option it may be

necessary to remove the products from a member using <delete> option. The product details can then be corrected under product plan details and reattached to the member. This will be necessary if the wrong FCL was set-up on the product, if the incorrect sum insured details were set-up on the product. It would not be necessary for an amended rate as we have not yet costed the premiums.

- Salary field is to be entered if the sum insured is based on salary.
- If the underwriters are accepting the cover sub-standard '3' we will need to enter the Extra mortality loading or occupational loading rate. For this fields to be made available for entry you must first change the flag and then click <Refresh> to amend the screen editing for the new decision flag.
- The underwriting history of the insured member for non-medical product can be viewed by putting an 'X' in the History field which leads to Underwriting History screen.

Click <Continue> to return to the Work with Member screen.

A number of options are available from this screen.

Select	Add Child	Follow	Add Spouse(Mono)/Jt Life	Display	T/pro	Lapse	Delete
Add Spouse(Poly)	Beneficiary	Annual Premium	PreExisting	Exclusion	Endt Note		
Additional Data	Default Free Text	Text	T/part.ref	Member Subsidiary Transfer	Undo Changes		
Reload	Reinstate	Cancel	Extended family Dependent	Previous Member	Previous History		
Benefit.Exclusions							
				Exit	Continue ►		

2.4.1 Follow Ups

Click on <Follow> button against a member will bring you to the follow-up screen:

The screenshot shows the INTEGRAL Admin system interface. On the left, there's a sidebar with 'CSC' and 'INTEGRAL Admin' branding, and sections for 'Extra Info' and 'Functions'. The main content area is titled 'Follow-ups'. It shows policy details (Policy: 35000206 GTL Group Term Life, Policy Owner: 50000226 APPLE INC) and member details (Member: 00001 00 Chua, Charles, Subsidiary: 50000201 Abbott Laboratories). Below this is a table listing follow-up items:

Select	Code	Status	Reminder Date	Completion Date	
<input type="checkbox"/>	Blood Test	Follow-Up Outs	01/01/2013		
<input type="checkbox"/>	Health Declaration Fd	Follow-Up Outs	01/01/2013		
<input type="checkbox"/>	Medical Examination	Follow-Up Outs	01/01/2013		
<input type="checkbox"/>	-----Select-----	-----Select-----			

At the bottom of the screen are 'Add' and 'Remove' buttons, and a navigation bar with 'Exit', 'Previous', 'Refresh', and 'Continue'.

Notes and comments:

- Member level Follow-up Specific Processing
 - Follow-ups will be defaulted based on the product parameter set-up for members
 - At the time when the follow-ups are being created at member level, the system will check against the table (T9776) which holds the follow-up types to see if a doctor is required to be input.
 - If the user tries to leave the screen with the status of the follow-up as outstanding and there is a requirement for the doctor's details, then a new error message will appear ("Doctor's Details required – enter details or change the status to "awaiting info""). It is then possible to change the status of the follow-up to "awaiting info" and return to the screen at a later date to enter the doctor's details.
 - If the user returns to the screen and adds the doctor details, then the status will automatically be set to outstanding.
 - Once the follow-up is received, the user enters the status of "received" against the follow up. This will enable the fee payment process.

Click on <Add> button to add follow-ups after entering the follow-up code.

2.4.2 Beneficiaries

Click <Beneficiary> button on the work with member screen brings the user to Beneficiaries screen to input the beneficiaries' details such as percent/fraction of share, relationship, and client number. In the event of a death claim, the system will then allow the beneficiary to be the payee.

Beneficiaries screen:

INTEGRAL Admin

Session Info | Help | Home | Logout

.. Beneficiaries

Policy

35000206 GTL Group Term Life

Policy Owner
50000226 APPLE INC

Policy Period
01/01/2013 to 31/12/2013

Member Number
00001 00 Chua, Charles

Select	Beneficiary Relation	Beneficiary Code	Beneficiary Percentage	B/A Flag	Beneficiary
<input type="checkbox"/>	-----Select-----	-Select-			

Add Remove

2.4.3 Annualised Premium

After adding members, using <Annual Premium> you are able to view the annualised premium and/extra premium of that particular member.

INTEGRAL Admin

Session Info | Help | Home | Logout

.. Annualised Premium

Policy No
35000206 GTL Group Term Life

Member No
00001 00 Chua,Charles

Prod	Plan	Normal Premium	Extra Premium	
			By Percentage	By Rate
GTL1	001	500.00	.00	More...

2.4.4 Work with Headcount

If there are any headcount plans on the policy we will need to set-up headcount details. Select <Work with Headcount> from the submenu. Work with Headcount screen will be displayed.

The screenshot shows the 'Work with Headcount NewBusiness' screen in the INTEGRAL Admin application. The top navigation bar includes links for Session Info, Help, Home, and Logout. The main area displays a table of headcount records:

Select	Type	Headcount	Attachment Date	Product Code	Plan No	Family Co
<input type="checkbox"/>		00001	[Attachment Date]	[Select]	[Select]	[Select]
<input type="checkbox"/>		00002	[Attachment Date]	[Select]	[Select]	[Select]
<input type="checkbox"/>		00003	[Attachment Date]	[Select]	[Select]	[Select]
<input type="checkbox"/>		00004	[Attachment Date]	[Select]	[Select]	[Select]
<input type="checkbox"/>		00005	[Attachment Date]	[Select]	[Select]	[Select]

Buttons at the bottom of the table area include Add, Delete, Terminate, Lapse, Allow to Reissue, Exit, Refresh, and Continue.

Notes and comments:

- ❑ The system automatically assigns unique five digits running numbers for each headcount group.
- ❑ This unique number will be needed to create a headcount member in the event of a claim.
- ❑ The details include attachment date, product, plan, family code, sum insured, number of members, average age, termination date, special terms, and subsidiary client number.

2.5 Issue Trial Bill

It is possible to issue a trial bill on a policy.

It is recommended that this be done at new business to ensure that all details are set-up correctly before issue. The trial bill will produce the bill and member movement listings but will not update the contract status or produce the financial records. Once details are verified as correct the policy Issue can be done.

2.6 Issue Policy

On entry of all details for the policy, select Action F to issue the policy.

We should set the pre-validate flag to active so that any pre-issue validation errors can be identified.

The Pre-Issue Product Count screen will be displayed: this screen summarizes the details for the policy being issued:

The screenshot shows the CSC INTEGRAL Admin software interface. On the left, there is a sidebar with 'CSC' logo, 'INTEGRAL Admin' title, 'Extra Info' section, and 'Functions' section. The main area is titled 'Pre-Issue Product Count'. It displays policy details: Policy Number (35000206 GTL Group Term Life), Policy Owner (50000226 APPLE INC), and Policy Status (PN Pending New business). It also shows the Insured Period (01/01/2013 to 31/12/2013). A table lists products: GTL1 with Headcount 100, Plan 3, and Effective Date 01/01/2013. At the bottom, there are navigation buttons: Exit, Previous, Refresh, and Continue (highlighted with a red dotted border).

Product Code	Headcount	Plan	Effective Date
GTL1	100	3	01/01/2013

Click <Continue> to proceed, the Pre-issue Validation screen is displayed

CSC INTEGRAL Admin

Pre-issue Validation

Session Info | Help | Home | Logout

Extra Info

Functions

Policy
35000206 GTL Group Term Life

Policy Owner
50000226 APPLE INC

Policy Status
PN Pending New business

Insured Period
01/01/2013 to 31/12/2013

Number of Subsidiary
0

Policy Currency
Singapore Dollars

Next Installment
[] to []

Number of Product
1

Billing Currency
Singapore Dollars

Number of Members (Named)
0

More...

Errors Detected

Exit / Previous / Refresh / Continue ➔

It will display any pre-issue validation errors, for example:

- ❑ The number of members on the product is less than the minimum allowed;
- ❑ The benefit definition screen has not been visited, or the premium has not been entered;
- ❑ Warning – Rates or factors at plan level are inconsistent.

Click <Continue> enter to proceed or F12 to review and change before issue.

If there are no errors the Issue Confirmation screen will be displayed.

CSC INTEGRAL Admin

Issue Confirmation

Session Info | Help | Home | Logout

Extra Info

Functions

Nature of Alteration
Financial ▾

Exit / Refresh / Continue ➔

Notes and comments

- GST will only display if it is applicable to the product
- Issue of new business will always be financial F.

The Issue processing will be done in batch job.

If the issue batch job fails, a review of the errors will be required. The changes made to the policy and the issue job restarted or a new issue completed.

On issue,

- The policy status will be either IF or XN
- The member premium will be calculated
- The commission will be calculated
- The financial accounting movements will be created

2.7 Policy Clone

On the New Business sub-menu, when setting up a new policy, it is possible to base it on another policy using the clone facility.

New Business Sub Menu Screen

The screenshot shows the 'Input' section of the New Business Sub Menu. It includes fields for Policy Number (35000206), Policy Type (Select), Effective Date, and Original Commencement Date. There are also fields for Clone From, Subsidiary, Pre-Validate Active, and Default Data Template. A search icon is present next to the Policy Number field.

A value must be entered in the “clone from policy number”, “reason for clone” (to the right of the Clone From field – 2 characters), and ‘Original commencement date’.

Policy cloning facility is available to cater for the following 3 business situations:

- a) Cloning similar policies
- b) New version of an existing policy
- c) Lapsed or terminated policy

Option	Description
01 – Copy similar ‘PN’ Policy	<p>Copy from a policy with pending status</p> <p>Checks that new policy original commencement date must be equal to Effective date</p> <p>New Policy expiry date can be different from old Policy</p>
02 – New version of an existing Policy	<p>Copy from a policy with Lapse status</p> <p>The effective date of new policy will be defaulted from the termination date of the old policy (lapse date).</p> <p>New policy original commencement date will follow the old policy original commencement date.</p>
03 – ‘CA’ or ‘IF’ Policy	<p>Copy from a policy with cancelled or in-force status</p> <p>Checks that the new policy original commencement date must be same as old policy original commencement date</p> <p>New policy effective date must be equal or greater than the old policy original commencement date</p>

3.0 Underwriting

All members whose sum assured is in excess of the FCL will be automatically included for underwriting. The lists of underwriting requirements are defaulted from table TR915 which is a user-controlled table. The requirements are set-up by range of age and bands of sum insured. This can be added or changed and monitored for each member through the follow-up screen <Follow>. The grouping of underwriting requirements is maintained in TR914 and the follow-up codes and status defined in T9776 and T9777 respectively. The underwriting decision is exercised only on the excess sum insured value.

Underwriting can be done at the following stages:

- New Business
- Policy Servicing (Major Alteration)
- Renewal
- Short Term Extension

3.1 Setting FCL

It is possible in Integral GROUP to define different FCL amounts at plan level (Policy/Product/Plan level) or at product level (Policy / Product level). This is set (parameterized) on policy input in the Policy Header second screen, by inputting one of the following options in the Free Cover Limit Level field.

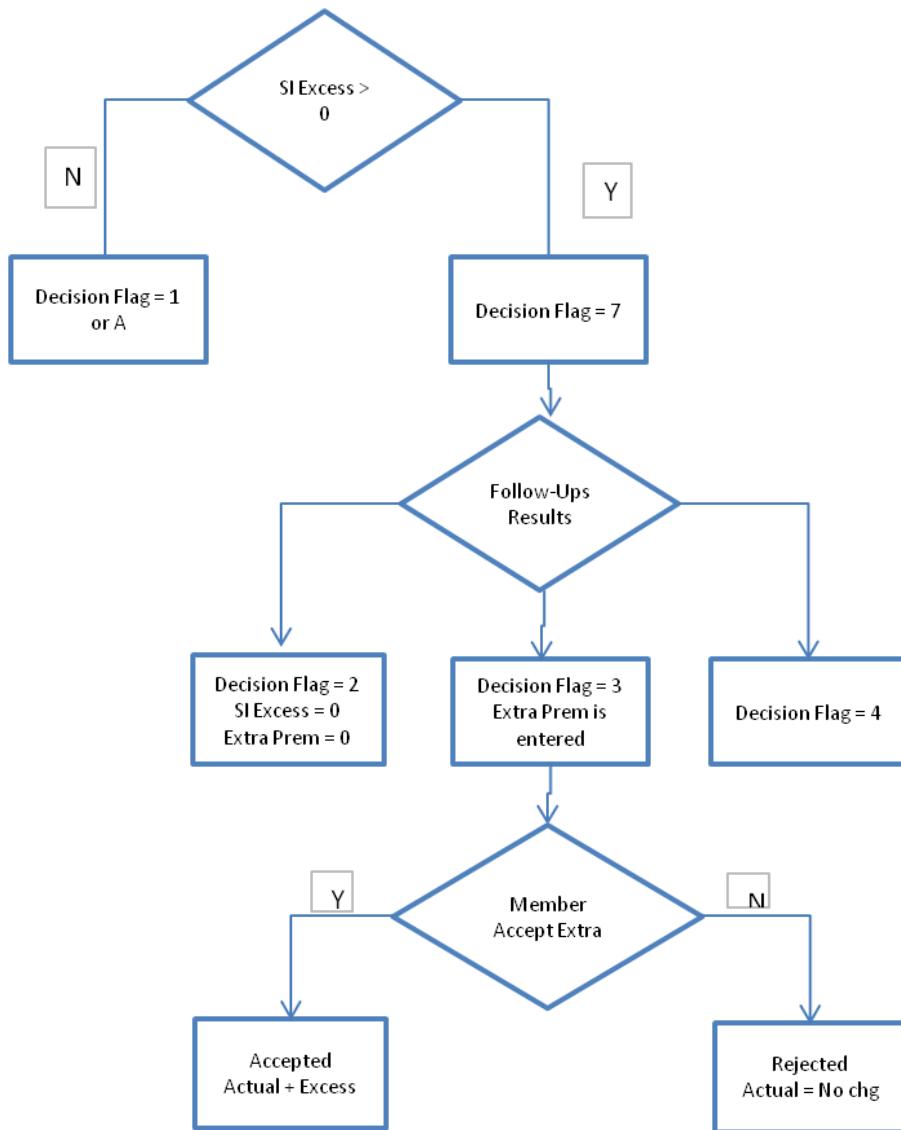
- PLN - policy/product/plan
- PRD - product/policy level
- N/A – not applicable

3.2 Underwriting Decisions

The following are the allowable values for UW decision codes:

UW Decision	Explanation
1	No underwriting required
2	The excess sum insured will be accepted at standard rates. No loadings
3	The excess sum insured has been accepted sub-standard with loadings
4	Cover is declined. The excess sum insured will not be covered
5	The policy owner/insured has not accepted the underwriting terms and the excess sum insured will not be covered.
6	The insured has accepted the sub-standard loadings for the excess sum insured.
7	Underwriting is pending
8	Underwriting not applicable.
9	Withdrawn by bank/member
A	Underwriting Below FCL.

The diagram below outlines the setting of Underwriting decisions.



There will be two automatic underwriting movements in GROUP:

- Status 1 – No underwriting,
- Status 7 – Pending Underwriting

All other decision codes are set manually.

3.3 Underwriting history

All Underwriting movements will be displayed in the Integral Group system on screen – Underwriting History. This will include all Underwriting movements including those that may happen in the same day.

Underwriting History is accessed through the Work with Members screen by selecting the member which will take the user to the Group member Entry screen. In Group member Entry screen, the administrator will then input an X in the history field, and by clicking <Continue> the user will see Underwriting History screen.

The screenshot shows the 'Underwriting History' screen within the CSC INTEGRAL Admin system. The top navigation bar includes links for Session Info, Help, Home, and Logout. On the left, there are two vertical menus: 'Extra Info' and 'Functions'. The main content area displays various details about an underwriting entry, including Policy Number (35000223 GTL Group Term Life), Owner (50000226 APPLE INCORPORATED NOT FACEBOOK NOT GOGLE), Client Number (50000385 Adam Harward), Product (GTL1 Group Term Life Product), Member Number (00001 00), Plan (002 Directors), Effective Date (01/01/2013), Subsidiary Number (empty), Start Date (01/01/2013), and a large decision table. The decision table has columns for Effective Date, Transaction Date, and Decision Code. It contains one row with values: 01/01/2013, 19/06/2013, 2, and Aprv. Std. At the bottom right, there are 'Exit' and 'Continue' buttons.

Effective Date	Transaction Date	Decision Code	
01/01/2013	19/06/2013	2	Aprv. Std.

This screen will hold the record of the levels of cover and effective dates that apply to each underwriting status.

3.4 Reversal of Underwriting decision flags

When an insured is on sick leave irrespective that his/her sum insured is within the FCL, he still has to be underwritten. Hence the system allows change of U/W flag from '1' to '7'. This is applicable in New Business, Major Alterations and Renewals.

3.5 Forward Underwriting

There are several methods in which forward underwriting are done. In Integral GROUP/Asia, we define a UW bar %. If FCL is 50,000 and underwriting bars is 20% then bars would be 60,000, 70,000, 80,000, etc. And if FCL is 250,000, then UW bar will be 300,000, 350,000, 400,000, etc.

If FCL is 250,000 and the member's cover is 260,000 after having gone medical examination for 10,000, then for an increase for another 40,000 i.e. till the cover granted is 300,000, the member need not go for medical examination within y months for standard cases and x months for sub-std cases where x & y are user defined parameters.

Example.

Underwriting Decisions	Increase in Sum Insured	Period when Sum Assured increased	Medical requirement
Standard	Within UW bar	Same policy year	No further medical reports required
Sub-standard	Within UW bar	Same policy year	No further medical reports required
Standard	Crosses UW bar	Within 1 year or renewal of policy	Differential medical reports required
Sub-Standard	Crosses UW bar	Within 6 months or renewal of policy	Differential medical reports required
Standard	Crosses UW bar	After 1 year	Full medical report required
Sub-Standard	Crosses UW bar	After 6 months	Full medical report required

On renewal of the policy (if Sum Assured has increased beyond the present underwriting bar)

Underwriting Decision	Period lapsed since last medical	Sum Assured	Medical Requirement
Standard	More than 1 year	FCL	Full medical
Sub-Standard	More than 6 month	FCL	Full medical

E.g. FCL for a group is 2,500,000. Suppose the plans are defined as:

Plan	Sum insured
1	2,000,000
2	2,500,000
3	2,800,000
4	3,100,000
5	3,400,000

Suppose a member was in Plan 1. No medicals are called when the member is first covered. Then the member's Plan changes to 2. No medicals are required for the sum assured of plan 2 is equal to FCL.

When plan changes to 3, then the member will go for medicals for 300,000 and until underwriters give decision, the member will be covered for 2,500,000 i.e. up to Plan 2. If the member's death takes place before the underwriting decision is received, then only 2,500,000 is payable.

Suppose the UW decision is given as "Accept at STD" or Accept with Health Extra", then the member move to Plan 3. The member move to Plan 4 and the next UW bars are at 3,000,000 and 3,500,000. The member will be covered for 2,800,000 until underwriting decision is given in for 300,000. If underwriter's decision is Charge Extra, then it would be applicable for 300,000 only and the member will be moved to next Plan 4.

If underwriter's decision is Decline, then the member will be covered up to Plan 3 i.e. for 2,800,000 or Plan 3. The member's plan further changes to plan 5 with one year, then that member will be covered for 3,400,000 without any medical requirement because the new sum assured is within next UW bar of 3,500,000. System should bill on pro-rata basis for additional 300,000 ($3,400,000 - 3,100,000$) immediately i.e. on the date underwriting decision is received. Depending on whether the member's plan changes within one year (or in case of sub-standard life within 6 months) differential prescribed medicals or full prescribed medicals are called for.

3.6 Premium loading calculations

The EM loading and OCCP loading are set on S9106.

The Premium calculation will then be:

$$\text{Premium} = (\text{Rate} * \text{Factor} * (1 + X\% \text{ loading}) + \text{Loading per mille}) * (\text{Sum Insured} / 1000)$$

Example:

Where the Sum Insured is a multiple of salary or a fixed benefit, assuming the following values:

- Plan = 3 times annual salary
- Normal Premium = 5 per mille
- Free Cover Limit = 40,000
- Effective Date = 1.1.09 (New Business)
- Member Salary = 20,000
- Sum Insured = 60,000
- Extra Mortality Loading = 50%
- Occupational Loading = 1.5 per mille
- Sum Insured on Cover = 60,000
- Std Normal Premium = $60 \times 5 = 300$
- Extra Prem calculated EM = $(60 - 40) \times 5 \times 50/100 = 50$
- Extra Prem calculated Occp = $(60 - 40) \times 1.5 = 30$

Note that in this example approval and acceptance by member is at new business issue stage, therefore the standard and extra premium for the excess sum insured are annualised. Should the member accept the loading at a later date, the extra premium will be pro-rated from the acceptance date by the system. I.e. Any underwriting loading will apply from the effective date of that decision as will reductions in cover due to the underwriters restricting or declining cover.

4.0 Alterations Processing

To make changes to an in force contract we use the Major or Minor alterations options. Minor alterations should be used for non-financial changes only.

Examples of policy servicing movements are:

- Mid-term addition of new members
- Entering underwriting decisions
- Update follow-ups at the policy or member level
- Decrease/Increase in sum insured
- Mass transfer of plans
- Termination of members
- Amendment to headcount details
- Change in plan details
- Change in policy details such as payment method or billing frequency

Integral GROUP handles both backdated and future dated alterations.

- Back-dated alteration – the effective date <= Billed-to-date (Can be in the same policy year or previous policy year)
- Future dated alteration – the effective date >= Billed-to-date

Integral GROUP recognizes that multiple changes could be made to the policy at the same time and all these changes need not have the same effective date. The system can cater for the following:

- One effective date for all the amendments being made at the policy, product, plan and headcount level.
- One effective date for each amendment being made at member, dependent, member/product/plan level.

Each of the actions available from the major alterations sub-menu has been outlined below to highlight sample changes.

The screenshot shows the INTEGRAL Admin software interface. At the top left is the CSC logo. To its right is the title "INTEGRAL Admin". On the far right of the header are links for "Session Info", "Help", "Home", and "Logout".

The main menu on the left is titled "Main Menu" and includes the following items:

- System Administration
- Batch Processing
- Clients & Groups
- General Ledger
- Receivables and Payables
- Windowing Codes
- Group Agent
- Group Policy Admin.
- Group Retail Type-1
- Group Retail Type-2
- Group Policy Admin Enq
- Group Policy Admin Setup
- Group Reinsurance
- Group Claims
- Group Claims 2
- Group Pension
- Diary System

The central panel is titled "Major Alterations - Sub Menu". It contains two main sections: "Inputs" and "Action".

Inputs: This section contains three fields: "Policy Number" (containing "35000346") with a search icon, "Effective Date" (a date input field with a calendar icon), and "Pre Validate" (a checkbox).

Action: This section contains five radio buttons:

- Work with Policy (selected)
- Work with Subsidiaries
- Work with Headcount
- Issue Policy
- Issue Trial Bill

At the bottom right of the central panel are buttons for "Exit", "Refresh", and "Continue ➔".

4.1 Work with Policy

Action <Work with policy> will bring us through the policy header screens. Policy details can be amended as at new business.

Sample amendments:

- To amend a mandate for a Direct Debit policy;
- To amend the servicing and or communication agent.

4.2 Work with Subsidiaries

Subsidiaries can be added, terminated, reinstated, have DD details added, lapsed or have a mass transfer done as part of major alterations.

A policy must have been set-up with subsidiaries at new business for subsidiaries to be added as part of alterations.

4.3 Work with Products/Plans

The screen flow is as per new business.

Plan details can be amended, terminated or lapsed as part of alterations. To reinstate a plan a new plan is added with the required details for the required effective date.

If a plan is terminated the system will automatically terminate the plan details on the member or headcount for the date of termination on issue

Any changes to a plan will only take effect for new members or at renewal for existing members.

Mass transfer of plans will be done automatically at the member level on issuing the plan change alteration.

Follow up details of the policy will be amended from here.

4.4 Work with members

If plan changes have been made that require issuing prior to adding new members or headcounts you will receive the following message: "High Lvl function exists". The alteration should be issued to put the plan changes into effect and then a 2nd alteration done to amend the members and headcount.

4.5 Work with headcount

If plan changes have been made that require issuing prior to adding new members or headcounts you will receive the following message: "High Lvl function exists". The alteration should be issued to put the plan changes into effect and then a 2nd alteration done to amend the members and headcount.

4.6 Issue policy/ Trial bill

The issue transaction will:

- Calculate all the adjustments and normal premiums for each member/product/plan or headcount group. Adjustment premiums are those resulting from alterations whose effective date < Billed-to-date. Normal premiums result from alterations whose effective date >= Billed-to-date.
- Produces the bill for immediate billing alterations
- RI Premiums are not calculated as part of issue but as part of the nightly G3RICOST batch job.

4.7 Premium calculation notes

- Premium associated with Underwriting decision changes take effect from the date of acceptance of the change
- For headcount changes it is the effective date of the change
- All premium changes will be calculated from the effective date of the change see Billing Section 9 for details on when we will bill for these premiums
- The system will calculate any adjustments required for backdated or inserted changes on a member.

5.0 Policy Servicing Transactions

5.1 Policy terminate

To terminate a policy take option Group Policy Admin from the system master menu. Click <Terminate Policy (Pro Rata)> and click <Continue> to proceed.

A second option Terminate Short Term is also available. This is generally used where only a percentage of the premium is paid back based on period insured. This is set on T9763.

You will be brought to the terminate policy sub-menu. Enter the policy you want to terminate and the effective date of the termination. Click <Continue> to proceed and you will be brought to Issue Confirmation screen to confirm issue of the termination.

A refund premium will be billed if required and the policy will be set to CA status with the insured to date set at the termination date.

The screenshot shows the CSC INTEGRAL Admin software interface. The top navigation bar includes the CSC logo, the title 'INTEGRAL Admin', and links for 'Session Info', 'Help', 'Home', and 'Logout'. On the left, a 'Main Menu' sidebar lists various administrative functions such as System Administration, Batch Processing, Clients & Groups, General Ledger, Receivables and Payables, Windowing Codes, Group Agent, Group Policy Admin, Group Retail Type-1, Group Retail Type-2, Group Policy Admin Enq, Group Policy Admin Setup, Group Reinsurance, Group Claims, Group Claims 2, Group Pension, and Diary System. The main content area is titled 'Terminate Policy (Pro-rata)'. It contains two sections: 'Input' and 'Actions'. The 'Input' section includes fields for 'Policy Number' (with a search icon), 'Termination Date' (with a calendar icon), 'Premium Effective Date' (with a calendar icon), and 'Terminated By' (with a dropdown menu showing 'C'). The 'Actions' section contains a radio button labeled 'Issue' which is selected. At the bottom right of the main window are buttons for 'Exit', 'Refresh', and 'Continue ➔'.

5.2 Lapse

The current Integral GROUP ‘Lapse’ function is a process that may only be applied using ONLY the insured from date of the policy year. Typically where no money has been received at policy anniversary (renewal), for the following period or where a client does not want to take up their renewal. The user will select the menu option Lapse and complete the action whereby the system will set the policy to a status of LA with the insured to date being the last date of the previous, paid up, policy year. A lapse can be reinstated with no break in cover.

5.3 Policy Reinstate

To reinstate a policy that is lapsed (LA) or terminated (CA) take option Group Policy admin from the system master menu. Take the option Reinstate policy and press enter to proceed.

You will be brought to the Reinstate policy sub-menu.

Enter the policy number and effective date of the reinstatement. This will be the date after the termination or lapse. Click <Continue> to proceed and you will be brought to Issue Confirmation screen to confirm issue of the reinstatement.

A premium will be billed if applicable for the reinstatement, the policy will be set to In Force (IF) and the insured to date will be set as per the date on the contract prior to termination.

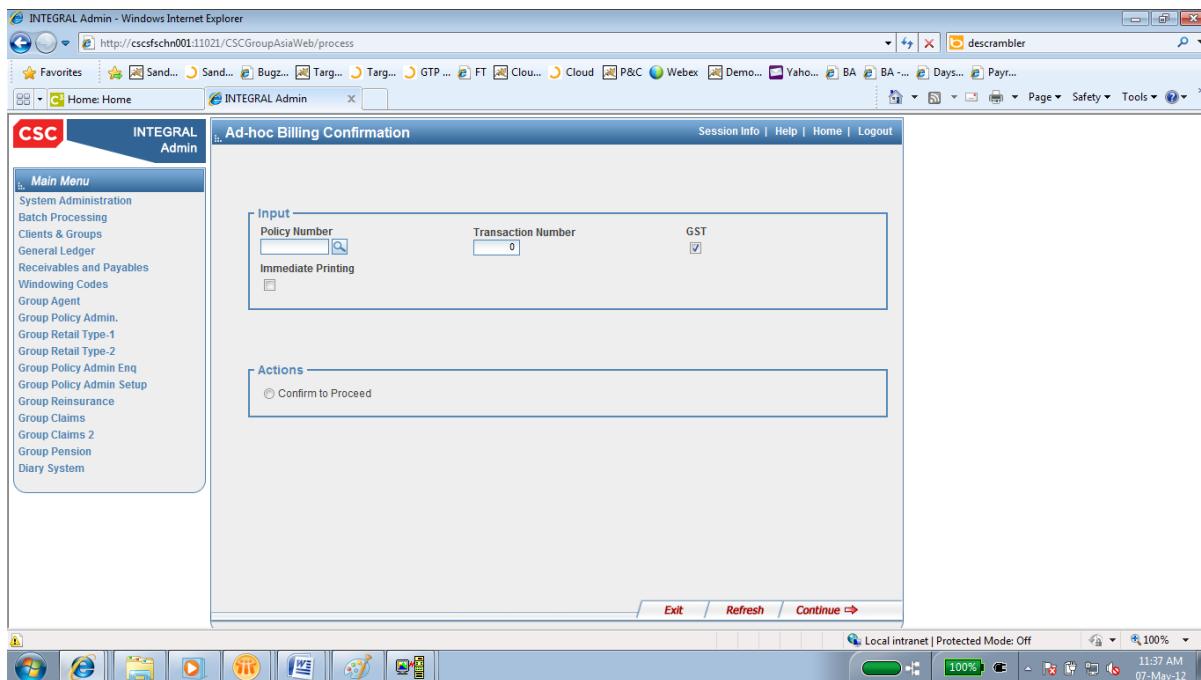
The screenshot shows the CSC INTEGRAL Admin software interface. The top navigation bar includes 'Session Info', 'Help', 'Home', and 'Logout'. On the left, a 'Main Menu' sidebar lists various administrative functions: System Administration, Batch Processing, Clients & Groups, General Ledger, Receivables and Payables, Windowing Codes, Group Agent, Group Policy Admin., Group Retail Type-1, Group Retail Type-2, Group Policy Admin Enq, Group Policy Admin Setup, Group Reinsurance, Group Claims, Group Claims 2, Group Pension, and Diary System. The main content area is titled 'Reinstate Policy - Sub Menu'. It contains two input fields: 'Policy Number' (with a search icon) and 'Effective Date' (with a calendar icon). Below these is a section labeled 'Action' containing a radio button for 'Issue'. At the bottom right are buttons for 'Exit', 'Refresh', and 'Continue ➔'.

5.4 Ad-hoc billing

To produce a bill for a deferred bill prior to the running of the next INSTBIL for the policy an ad-hoc bill can be run.

Select the policy number and transaction number that the bill is to be produced for and press enter.

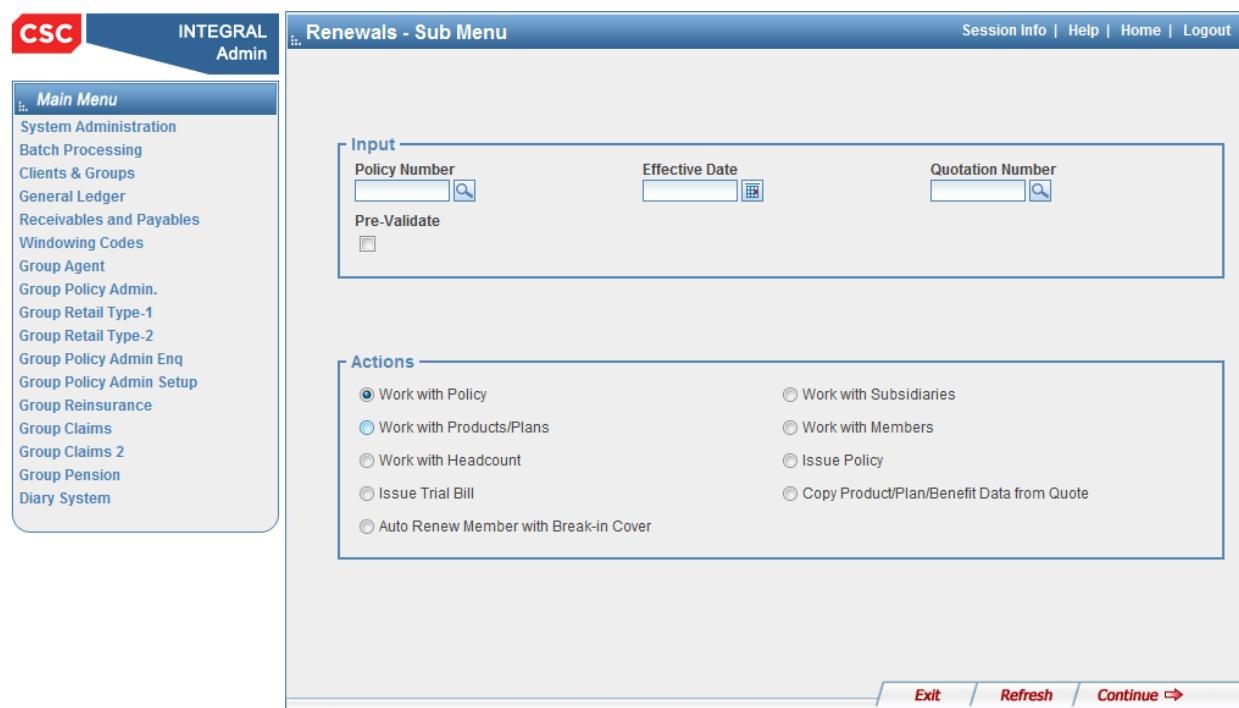
The system will validate that there is an o/s bill on the policy and trigger the bill.



5.5 Renewals

To process a renewal take the “Group Policy Admin” option from the system master menu. Select the renewals option from the Policy administration master menu.

You will be brought to the renewals sub-menu.



To process a renewal you will proceed through the various Work with options confirming the policy details for the renewal period. The effective date will be the insured to date of the last policy period +1.

It will not be possible to start the renewal process until all bills have been raised (but not settled) for the current period. As part of part of the renewal process:

- The insured to period for the renewal is set
- The payment method and billing frequency can be modified if required
- The first billing date will default as per new business if not defaulted it should be set
- The collection frequency for the renewal and first collection date should be entered if applicable.
- To remove any products, plans, benefits, headcounts, members as part of the renewals processing use the Lapse option.
- New members can be added at the correct attachment date for that member by setting the appropriate the effective date when adding the member. The system will cater for adding members back into the last policy period if required.

During the renewal processing the policy status will be set to PR. Click <Trial Bill> to issue a Trial bill or <Issue> to issue the policy.

As part of the renewal process the first normal bill will be raised for the renewal period.

5.6 Short term extension

To process a short term extension the user will select the “Group Policy Admin” option from the system master menu. Select the <Short-term extension> option from the Group Policy Admin sub-menu.

You will be brought to the Short Term Renewals sub-menu.

The screenshot shows the CSC INTEGRAL Admin software interface. The top navigation bar includes the CSC logo, INTEGRAL Admin, Session Info, Help, Home, and Logout. The left sidebar, titled "Main Menu", lists numerous administrative functions such as System Administration, Batch Processing, Clients & Groups, General Ledger, Receivables and Payables, Windowing Codes, Group Agent, Group Policy Admin, Group Retail Type-1, Group Retail Type-2, Group Policy Admin Enq, Group Policy Admin Setup, Group Reinsurance, Group Claims, Group Claims 2, Group Pension, and Diary System. The main content area is titled "Short Term Extension - Sub Menu". It contains two main sections: "Input" and "Actions". The "Input" section includes fields for "Policy Number" (with a search icon) and "Effective Date" (with a calendar icon). The "Actions" section contains several radio button options: "Work with Policy" (selected), "Work with Subsidiaries", "Work with Products/Plans", "Work with Members", "Work with Headcount", and "Issue Policy". At the bottom right of the main panel are buttons for "Exit", "Refresh", and "Continue" with a right-pointing arrow.

To process a short term extension you will proceed through the various Work with options confirming the policy details for the extended period. The effective date will be the insured to date of the last policy period +1.

As part of part of this process you can amend all areas as with Major Alteration plus you will need to set:

- The new insured to date
- The next collection date/first billing date

During the short-term extension processing the policy status will be set to PE.

Action G can be taken to issue a Trial bill and Action F to issue.

6.0 Billing

6.1 When to Bill

The Billing Frequency and Adjustment Frequency which are set up on the policy header screen, determine when we should bill for normal premiums (non arrear billing).

The deferred/immediate indicator on the issue screen determines when we should bill for adjustment premiums (arrears).

6.1.1 Billing Frequency

The Billing frequency and the Adjustment Frequency are set on the first policy header screen.

Notes and comments

- The adjustment frequency cannot be less frequent than the billing frequency;
- Valid frequencies are:
 - 01 – Annual (Yearly)
 - 02 – Half-Yearly
 - 03 – Quarterly
 - 04 – Monthly

6.1.2 Immediate / Deferred Billing Indicator

The Immediate / Deferred Billing indicator will determine whether the system bills for adjustments immediately or defer until the next system determined adjustment bill date based on the adjustment frequency set for the policy.

When issuing a new business policy or a major alteration the Immediate/Deferred Billing indicator can be found on the Issue Confirmation screen.

- Defer means that any business events that occur during the policy year are calculated immediately but the accounting and billing is deferred until the adjustment frequency.
- Immediate means that any business events that occur during the policy year are calculated accounted for and billed immediately.

6.2 How to Collect

The payment method on the policy header will determine how to collect bills. The available options are

- Cash; cash is Chq, Standing Order, Direct Credit
- Direct Debit

6.3 Billing cash process overview

6.3.1 Normal and Adjustment Premium

Normal premium bills are billed in advance. Adjustment premium bills are billed in arrears. To illustrate this, consider a policy with the following values:

- Insurance from Date : 01-01-2009
- Insurance To Date : 31-12-2009
- Billing Frequency : 04 (Quarterly)
- Adjustment Frequency : 04 (Quarterly)

When a normal bill is sent for the 2nd quarter (from 01-04-09 to 30-06-09), say sometime in the first week of April, the adjustment bill will be sent for the previous quarter i.e. the first quarter (from 01-01-09 to 31-03-09). Hence there is always one instalment lag between the adjustment and normal bill. If there has been a major alteration which consists of different effective dates (back and future dated), then when the adjustment bill is raised it will only bill those dates that fall within the normal billed period. Those effective dates after the billed period will be picked up in the next billing frequency.

The system maintains two control fields in the policy header record for every policy. These two fields are not entered by the user but automatically updated by the system.

- Billed-to-date – the date up to which normal bills have been sent
- Adjustment-to-date – the date up to which adjustment bills have been sent.

6.3.2 Processing overview

Transaction	Bill Processing	Float suspense processing	Cash settling	Commission processing
New Business	A bill is created for 1 st normal bill	Debit is raised in float suspense	Debit Bill will be o/s or settled if cash (journal credit) available	Commission will be triggered on settling of bill
Alterations Immediate billing	A bill is raised for adjustment bill if required	Debit or credit is raised in float suspense	Debit Bill will be o/s or settled if cash (journal credit) available Credit bill will be o/s or settled if payment	Commission will be triggered on settling of debit bill Commission will be clawed back on

Transaction	Bill Processing	Float suspense processing	Cash settling	Commission processing
			(journal debit) available	settling of credit bill.
Alterations deferred billing	No bill is processed	N/A		
Ad-hoc billing	A bill is raised for adjustment bill if required	Debit or credit is raised in float suspense	Debit Bill will be o/s or settled if cash (journal credit) available Credit bill will be o/s or settled if payment (journal debit) available	Commission will be triggered on settling of debit bill Commission will be clawed back on settling of credit bill.
G3INSTBILL	A bill is raised for any normal and adjustment bills due	Debit normal bills are raised in float suspense Debit or credit adjustment bills are raised in float suspense	Debit Bill will be o/s or settled if cash (journal credit) available Credit bill will be o/s or settled if payment (journal debit) available	Commission will be triggered on settling of debit bill Commission will be clawed back on settling of credit bill.
Cash receipts	Cash receipt applied to system for FLS	Credit is raised in float suspense	Cash will settle any o/s debit bills starting at earliest first If no bills to settle or cash remaining it will remain in suspense till a bill is raised or it is refunded	Commission will be triggered on settling of debit bill
Payments	Payment Created for FL dissection Authorised and processed	Debit raised in float suspense	Payment will be used to settle any o/s credit bills	Claw back commission will be triggered on settling of refund bill

Transaction	Bill Processing	Float suspense processing	Cash settling	Commission processing
			If no bill to settle or overpayment on refund to client any o/s amount will remain in suspense till a refund bill is raised or cash comes in	
Cash and payment journals	Journal created authorised and processed	Debit/credit raised in float suspense	Debit/Credit will be used to settle bills o/s If no bills o/s balance will remain till bills , cash received or payment paid	Commission will be triggered on settling of debit bill Claw back commission will be triggered on settling of refund bill
Bill reversal	Bill marked as reversed O/s bill raised	Balance not affected in float suspense, as a plus and minus bill amount go through float suspense Float suspense will be held	The new bill raised will be unsettled. Float suspense held till manually released	Commission is clawed back for reversed bill as amount is o/s again.
Cash receipt reversal	Reverse cash amount applied to system for FL S Dissection	Debit is raised in float suspense	The cash amount will no longer be available to settle any o/s debit bills	There is no impact on commission
Cancel Cheque	Reverse amount applied to system for FL S dissection after approval and processing	Credit raised in float suspense	The payment amount will no longer be available to settle any o/s credit bills	There is no impact on commission

6.4 Billing DD process overview

6.4.1 Normal Premium

All normal bills can be extracted to go to the bank on the due date. All adjustment bills (immediately billed or deferred) will not be extracted for Direct Debit processing. These bills will have to be paid manually by cash/cheque.

6.4.2 Processing Overview

Transaction	Bill Processing	Float suspense processing	Cash settling	Commission processing
New Business	A bill is created for 1 st normal bill	Debit is raised in float suspense	Debit Bill will be o/s	Commission will be triggered on settling of bill
Alterations Immediate billing	A bill is raised for adjustment bill if required	Debit or credit is raised in float suspense	Debit Bill will be o/s unless settled with credit o/s on account Credit bill will be o/s unless settled with debit on account	Commission will be triggered on settling of debit bill Commission will be clawed back on settling of credit bill.
Alterations deferred billing	No bill is processed	N/A		
Ad-hoc billing	A bill is raised for adjustment bill if required	Debit or credit is raised in float suspense	Debit Bill will be o/s unless settled with credit o/s on account Credit bill will be o/s unless settled with debit on account	Commission will be triggered on settling of debit bill Commission will be clawed back on settling of credit bill.
G3INSTBILL	A bill is raised for any normal and adjustment bills due	Debit normal bills are raised in float suspense Debit or credit adjustment bills are raised in float	Debit Bill will be o/s unless settled with credit o/s on account Credit bill will be o/s unless settled with debit on account	Commission will be triggered on settling of debit bill Commission will be clawed back on settling of credit bill.

Transaction	Bill Processing	Float suspense processing	Cash settling	Commission processing
		suspense		
GBILLING, triggers bills to go to bank	N/A	N/A	N/A	N/A
G3DC01 sends details to bank	N/A	N/A	N/A	N/A
G3DDAPPLY01	Cash receipt for assumed payment from bank applied to system for FL S	Credit is raised in float suspense	Cash will settle any o/s debit bills starting at earliest first If no bills to settle or cash remaining it will remain in suspense till a bill is raised or it is refunded	Commission will be triggered on settling of debit bill
G3DISH01 Processes dishonours created online	Step 1. Bill marked as reversed O/s bill raised Step 2 Reverse cash amount applied to system for FL S Dissection	Balance not affected in float suspense, as a plus and minus bill amount go through float suspense Debit is raised in float suspense	The new bill raised will be unsettled. The cash amount will no longer be available to settle any o/s debit bills	Commission is clawed back for reversed bill as amount is o/s again. There is no impact on commission
Payments	Payment Created for FL dissection Authorised and processed	Debit raised in float suspense	Payment will be used to settle any o/s credit bills If no bill to settle or overpayment on refund to client any o/s amount will	Claw back commission will be triggered on settling of refund bill

Transaction	Bill Processing	Float suspense processing	Cash settling	Commission processing
			remain in suspense till a refund bill is raised or cash comes in	
Cancel Cheque	Reverse amount applied to system for FL S dissection after approval and processing	Credit raised in float suspense	The payment amount will no longer be available to settle any o/s credit bills	There is no impact on commission
Cash and payment journals	Journal created authorised and processed	Debit/credit raised in float suspense	Debit/Credit will be used to settle bills o/s If no bills o/s balance will remain till bills , cash received or payment paid	Commission will be triggered on settling of debit bill Claw back commission will b e triggered on settling of refund bill

7.0 Inquiry

There are a number of different inquiry options available on the Integral GROUP system. Key options are highlighted below with their expected usage.

7.1 Policy Inquiry

This option can be accessed via “Group Policy Admin Enq” on the system menu and then select “Policy Enquiry”

The Inquiry sub menu will be displayed

The screenshot shows the 'Inquiry - Sub Menu' window. At the top left is the 'CSC INTEGRAL Admin' logo. To its right is a navigation bar with links: 'Session Info | Help | Home | Logout'. On the far left is a vertical 'Main Menu' sidebar with a list of administrative functions. The main content area is titled 'Inquiry - Sub Menu' and contains two sections: 'Input' and 'Actions'. The 'Input' section includes fields for 'Policy Number' (with a search icon) and 'Effective Date' (with a calendar icon). The 'Actions' section contains four radio button options: 'Work with Policy' (selected), 'Work with Subsidiaries', 'Work with Products/Plans', and 'Work with Members'.

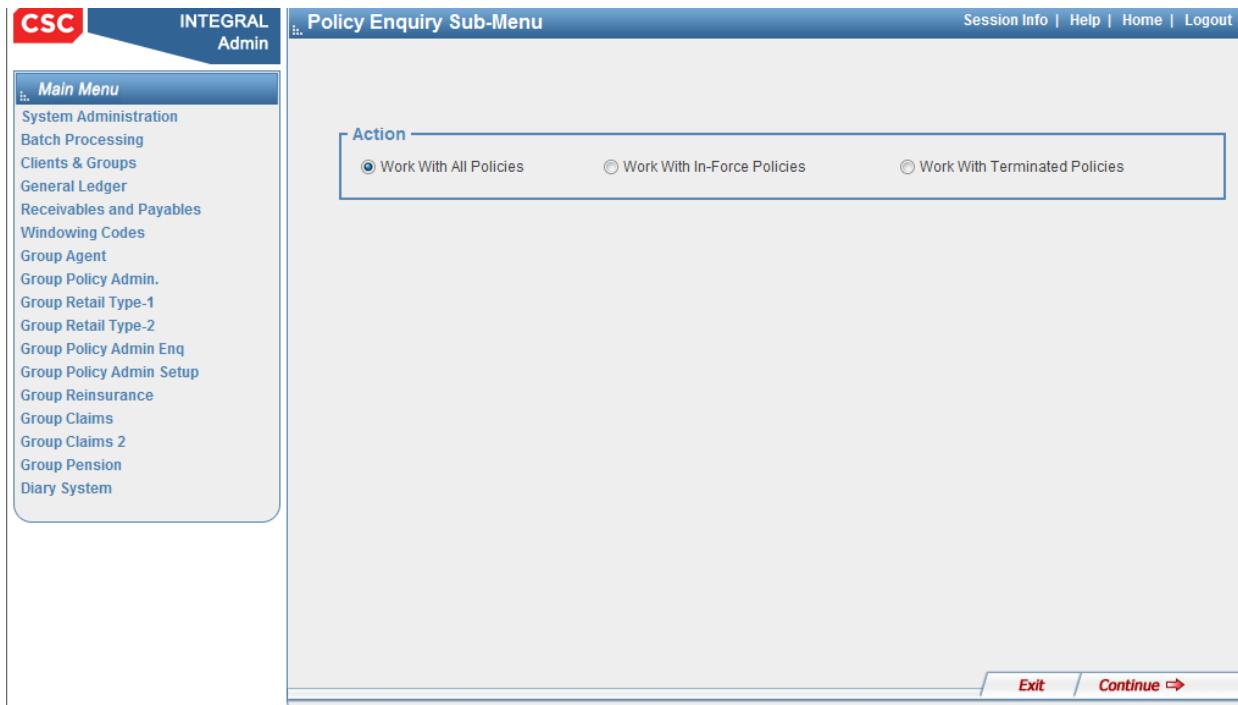
The various Work with Options allow you to view the policy information as per the effective date selected.

The information is displayed as entered during new business and alterations.

7.2 Policy Inquiry 2

This option is accessed via “Group Policy Admin Enq” on the system menu, and then selecting “Policy Enquiry 2”

The Policy Enquiry submenu will be displayed:



On clicking <Work with All Policies> you will be brought to Work with All Policies screen where a number of inquiry options are available.

Filters by policy number, status, policy type and agent number are available

CSC INTEGRAL Admin

Work With All Policies

Session Info | Help | Home | Logout

Policy: 35000100

Select	Policy	Branch	Owner Name	Status	Type
<input type="checkbox"/>	35000100	10	Advantica Restaurant Group Inc	IF	GTL
<input type="checkbox"/>	35000101	10	ABM Industries Incorporated	IF	GTL
<input type="checkbox"/>	35000102	10	Advanced Micro Devices Inc.	IF	GTL
<input type="checkbox"/>	35000103	10	ACT Manufacturing Inc.	IF	GTL
<input type="checkbox"/>	35000104	10	Advance PCS Inc	IF	GTL
<input type="checkbox"/>	35000105	10	Ace Hardware Corporation	IF	GTL
<input type="checkbox"/>	35000106	10	ABC INCORPORATED NOT FACEBOOK NOT GOOGLE	IF	GTL

Filter By:

Policy:

Branch Owner:

Status:

Type:

Agent:

Click on the <More options> to display more options



To view a transaction history on the policy use <Trans Hist> button. The “Transaction History Inquiry” screen will be displayed, listing all the transactions that have occurred on the policy. You will be able to view specific member changes during the transaction using <Wrk Member>, headcount changes using <Wrk Hdcnt> and premium details for the transaction using <Wrk Prem>. A filter is available for the transaction number.

CSC INTEGRAL Admin

Transaction History Inquiry

Session Info | Help | Home | Logout

Extra Info

Policy Number: 35000106 GTL Group Term Life

Policy Owner: 50000226 APPLE INCORPORATED NOT FACEBOOK NOT GOGLE

Agent Name: AON Brokers

Status: PE Pending Endorsement Original Commencement Date: 01/01/2012

More...

Select	Bill Number	Transaction Number	Issue Date	Transaction	Document From	Document To	Issued By
<input type="checkbox"/>		9	07/03/2013	Instl.Bill			INDIADEV
<input type="checkbox"/>		8	05/03/2013	Instl.Bill			STANG20
<input type="checkbox"/>		7	19/02/2013	Instl.Bill			STANG20
<input type="checkbox"/>		6	19/02/2013	Instl.Bill			STANG20
<input type="checkbox"/>							INDIADEV

Start From Transaction Number:

Wrk Member | Wrk Hdcnt | Wrk Prem | A/C Movmnt

Exit | Refresh | Continue ➔

To view billing history on the policy click on <Bills>, you will be brought to the 'Billing Enquiry' screen.

A summary of billing information is displayed. <Details> will show you the billing details, <Mbr Brkdwn> will show you the member-level premium breakdown including any loading, <A/C Movmnt> will show you the receipt details if the bill has been settled. Filters are available by policy number, bill number, date range, o/s flag, and reversed flag.

CSC INTEGRAL Admin

Billing Enquiry

Session Info | Help | Home | Logout

Extra Info

Select	Bill Number	Policy	Subsidiary Member	Type	Period From	Period To	Year	Month	Premium	GST(Service Tax)
<input type="checkbox"/>	17	35000106		N	01/01/2012	31/12/2012	2012	12	580.00	29.00
<input type="checkbox"/>	18	35000106		A			2012	12	32606.56	1630.33

More...

Details | Mbr Brkdwn | A/C Movmnt

Total Premium: 33186.56 Total GST: 1659.33

Filter By

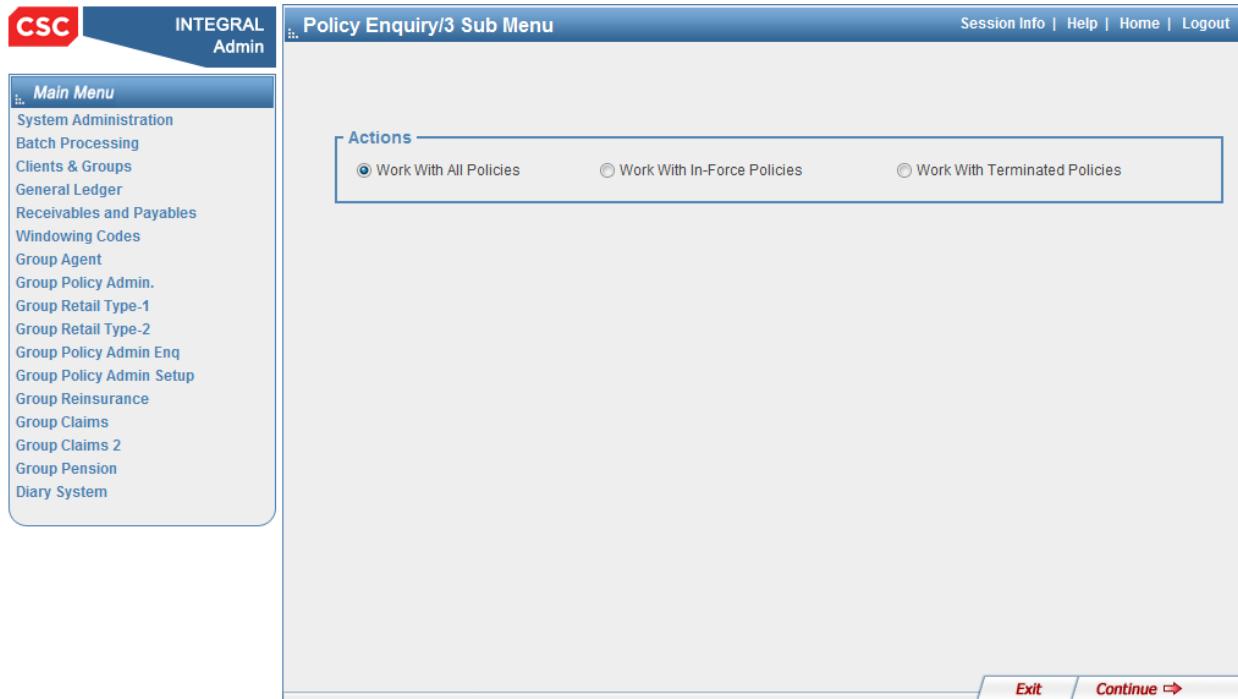
Bill Number: <input type="text"/>	Policy: 35000106 <input type="button" value="🔍"/>	Subsidiary Member: <input type="text"/>	Type: <input type="text"/>
Period From: <input type="text"/> <input type="button" value="📅"/>	Period To: <input type="text"/> <input type="button" value="📅"/>	Year: <input type="text"/>	Month: <input type="text"/>

Exit | Previous | Refresh | Continue ➔

7.3 Policy Inquiry 3

This option is accessed via “Group Policy Admin Enq” on the system menu and then taking “Policy Enquiry/3”.

The Policy Enquiry/3 submenu will be displayed.



On clicking <Work with All Policies> you will be brought to Work with All Policies screen where a number of options are available.

Filters are available by policy number, branch, policy status, policy type and agent.

INTEGRAL Admin

Work With All Policies

Session Info | Help | Home | Logout

Policy: 35000100

Select	Policy	Branch	Owner Name	Status	Type
<input type="checkbox"/>	35000100	10	Advantica Restaurant Group Inc	IF	GTL
<input type="checkbox"/>	35000101	10	ABM Industries Incorporated	IF	GTL
<input type="checkbox"/>	35000102	10	Advanced Micro Devices Inc.	IF	GTL
<input type="checkbox"/>	35000103	10	ACT Manufacturing Inc.	IF	GTL
<input type="checkbox"/>	35000104	10	Advance PCS Inc	IF	GTL
<input type="checkbox"/>	35000105	10	Ace Hardware Corporation	IF	GTL
<input type="checkbox"/>	35000106	10	APPLE INCORPORATED NOT ELIGIBLE NOT GOOGLE	IF	GTL

Filter By:

Policy: Branch Owner: Status: Type: Agent:

7.4 Member Inquiry

This option is accessed via 'Group Policy Admin Enq' on the system menu and then selecting 'Member Inquiry'.

CSC INTEGRAL Admin

Member Enquiry Sub-Menu

Session Info | Help | Home | Logout

Actions

Work With All Members Work With Non-Terminated Members Work With Terminated Members

Exit **Continue ➔**

Clicking on <Work With All Members> will bring you to “Work With All Members” screen where a number of options are available.

Select the client details for the member you want to inquire on. Filters are available by policy number, subsidiary number, member number, employee number.

CSC INTEGRAL Admin

Work With All Members

Session Info | Help | Home | Logout

Extra Info

Functions

More Options

Client No

Name

More...

Select	Policy	Status Code	Subsidiary No	Client Number	ID	Member No
<input type="radio"/>	00050014	QP	50000198	50000272		00001 00
<input type="radio"/>	00050015	QP	50000198	50000277		00001 00
<input type="radio"/>	00050016	QP	50000236	50000309		00001 00
<input type="radio"/>	00050017	QR		50000385		00001 00
<input type="radio"/>	00050017	QR		50000339	S1234001A	00002 00

Client **Member Dta** **Follow** **Be'ficiary** **PreExisting**
Exclusion **Susp Hist** **Endt Note** **Prod/Plan** **U/W Hist**

Filter By

Policy	Status Code	Subsidiary No	Member No	Department No	Employee No
<input type="text"/>	-----Select----- <input type="button" value=""/>	<input type="text"/> <input type="button" value=""/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

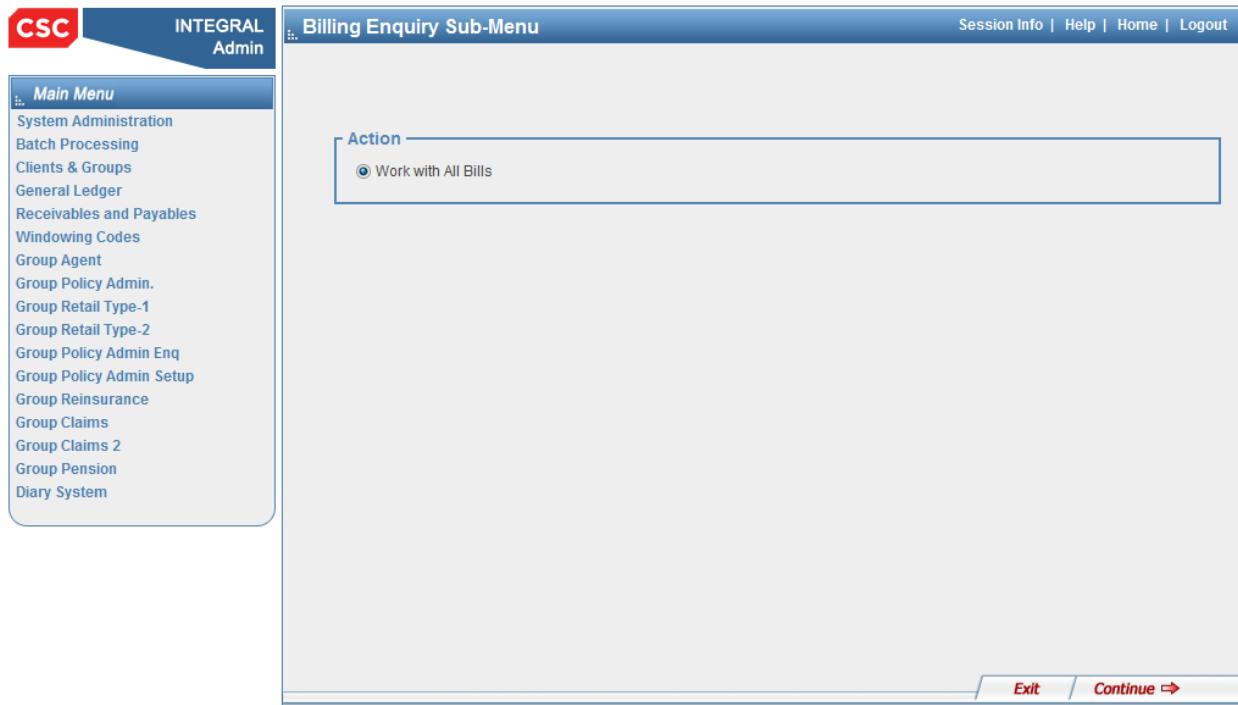
Exit **Previous** **Refresh** **Continue ➔**

You can inquire on a members underwriting history, follow ups, member data and name and address information from here.

7.5 Billing Inquiry

This option is accessed via “Group Policy Admin Enq” on the system menu and then taking “Billing Inquiry”

The Billing Enquiry submenu will be displayed:



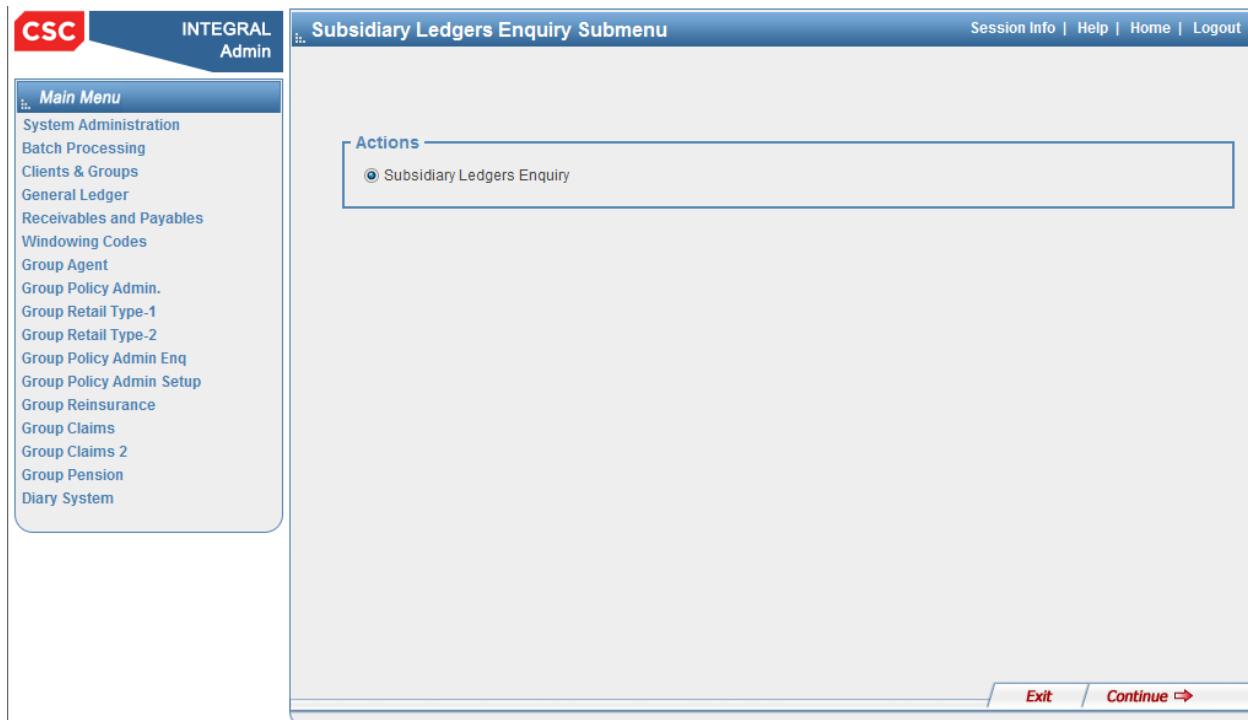
On selecting action A the Billing inquiry screen SR9GN will be displayed.

- Option 1 will show you the bill details;
- Option 2 will show you the member-level premium breakdown including any loading;
- Option 3 will show you the receipt details if the bill has been settled;
- Filters are available by policy number, bill number, date range, o/s flag, and reversed flag.

7.6 Sub ledger inquiry

Sometimes it may be necessary to review a particular sub ledger in detail. For example we may want to view the float suspense sub ledger, in order to be able to manage money owed to the company and refunds due to clients.

This option is accessed via “Group Policy Admin Enq” on the system menu and then selecting “Subsidiary ledgers’ the Subsidiary Ledgers sub menu will be displayed.



On clicking <Subsidiary Ledger Enquiry> the system will display a list of all subsidiary ledger account codes.

For float suspense select FL S (FL SB for subsidiaries). Subsidiary Ledgers-Balance Enquiry will be displayed where you can filter by policy number, and float frozen y/n to decide the action required on any balances in float suspense.

Screenshot of a web-based administrative interface titled "INTEGRAL Admin". The URL in the address bar is <http://cscsfschn001:11021/CSCGroupAsiaWeb/proc>. The main content area is titled "Work with Subsidiary Ledgers".

The interface includes a sidebar with "Extra Info" and "Functions" sections. The main content area displays a table titled "Work with Subsidiary Ledgers" with the following data:

Select	SACS Code	SACS Type	Description
<input type="checkbox"/>	AE	TL	Administrative Expenses
<input type="checkbox"/>	CT	SG	Company Suspense (Employer)
<input type="checkbox"/>	CT	SM	Client Suspense (Member)
<input type="checkbox"/>	FL	S	Float Acc-Policy Suspense
<input type="checkbox"/>	FL	SB	Float Acc-Pol/Suba Suspense

Buttons at the bottom of the table include "More...", "Balance Enq", "Exit", and "Continue ➞".

The system tray at the bottom shows various icons and the date/time: 10:44 AM 18-Jun-13.

8.0 Reinsurance

8.1 Treaty / Arrangement set-up

For Treaty set-up refer to the RI clerical guide

8.2 Policy servicing requirements

As part of policy servicing the system will automatically apply the RI arrangement as configured for the product if the RI flag on a policy is set to Y. It will only be necessary to enter RI details if FAC RI is to apply to a member.

For details of RI premium calculations see Appendix D.

8.2.1 FAC set-up

On setting up a member that requires facultative reinsurance, click <Fac RI> option from the <Work with Member> screen.

You will be brought to Work with Facultative Reinsurance.

The screenshot shows the 'Work with Facultative Reinsurance' screen. On the left, there's a sidebar with 'Extra Info' and 'Functions' sections. The 'Functions' section contains a 'Build Default List' button. The main area has input fields for Policy, Owner, ID, Product, Plan, and Ceding Basis. To the right, there are fields for Member No, Start Date, Effective Date, and Sum Insured. Below these is a table with columns: Sel, Reassurer, Arrangement, Risk Class, RI Sum Insured, and Premium Method. One row is visible in the table. At the bottom, there are 'Exit', 'Refresh', and 'Continue' buttons.

Click on <Build Default List> to select predefined FAC arrangements and modify as required. You will be brought to Facultative Reinsurance Screen.

CSC INTEGRAL Admin

Facultative Reinsurance Details

Session Info | Help | Home | Logout

Extra Info

Functions

Reassurer	xxxxxx	xxxxxxxxxxxxxxxxxxxx
Arrangement	xxxx	xxxxxxxxxxxxxxxxxxxx
Risk Class	xxxx	xxxxxxxxxxxxxxxxxxxx
Ceding %	999.99	
RI Sum Insured	999999999999.99	
Premium Method	XX	XX
Rate Variation	X	X
EC %	999.99	
Commission Meth	XX	XX
xxxxxxxxxxxxxxxxxxxx		

Continue

Enter either the ceding % for the FAC participant or the fixed RI sum insured amount.

If pre-defined arrangements are not set up you will need to add the RI participants as required.

8.2.2 RI inquiry for policy

To inquire on the annualised RI premium for a policy/member take 'Group Policy Admin enq' from the system master menu and select Policy Enquiry/2. Click <RI Prem> against your required policy and Policy RI Annualized Premium History screen will be displayed. Filter as required.

CSC INTEGRAL Admin

Policy RI Annualised Premium History

Session Info | Help | Home | Logout

Policy Number 35000222 3Com Corp	Intermediary 20045	Policy Type GTL Group Term
Branch 10 Branch 10	Status IF In Force	Original Commencement Date 07/06/2013

More...

Member	Product	Sum Insured	Reinsurer	Group RI Arrangement Code	Risk Class	Pi
00001	GTL1	5000.00	20051	GVNY	DTHC	
00002	GTL1	5000.00	20051	GVNY	DTHC	

Filter by:

Member <input type="text"/> <input type="button" value=""/>	Product <input type="button" value="Select"/> <input type="button" value=""/>	Reinsurer <input type="text"/> <input type="button" value=""/>	Arrangement <input type="button" value="Select"/> <input type="button" value=""/>
Risk Class <input type="text"/> <input type="button" value=""/>	Transaction Number <input type="text"/>	Plan <input type="text"/>	

Exit | Previous | Refresh | Continue ➔

CSC INTEGRAL Admin

Policy Posted RI Premium History

Session Info | Help | Home | Logout

Policy Number 35000222 3Com Corp	Intermediary 20045	Policy Type GTL Group Term
Branch 10 Branch 10	Status IF In Force	Original Commencement Date 07/06/2013

More...

Member	Product Code	Group Reassurer Code	Risk Class	
00001	00 GTL1	20051	DTHC	GVNY
00002	00 GTL1	20051	DTHC	GVNY

Total Premium 10.02 Total Extra Premium

Filter by:

Member <input type="button" value="Select"/> <input type="text"/>	Product <input type="text"/>	Reassurer Code <input type="text"/>	Risk Class <input type="text"/>	Arrangement Code <input type="text"/>
Transaction Number <input type="text"/>	Plan <input type="button" value=""/>	RT <input type="text"/>	MC <input type="text"/>	BT <input type="text"/>
Credit Note <input type="text"/>				

RT-Record type (N,R) BT-Bill type (N,A,P) MC-Movement code (,N,C,T)

Exit | Previous | Refresh | Continue ➔

8.3 Inquiry on Reinsurance accounts.

To Inquire on Reinsurance details of RI participants, take the 'Group Reinsurance' option from the system master menu. From the Group Reinsurance master menu take 'Enquiry'. You will be brought to Reinsurance Inquiry submenu

CSC INTEGRAL Admin

Main Menu

- System Administration
- Batch Processing
- Clients & Groups
- General Ledger
- Receivables and Payables
- Windowing Codes
- Group Agent
- Group Policy Admin.
- Group Retail Type-1
- Group Retail Type-2
- Group Policy Admin Enq
- Group Policy Admin Setup
- Group Reinsurance
- Group Claims
- Group Claims 2
- Group Pension
- Diary System

Reinsurance enquiry sub-menu

Session Info | Help | Home | Logout

Actions

- Work with Reassurance

Exit | Previous | Refresh | Continue ➔

Select <Work with Reinsurance Enquiry> and the system will displayed with a list of all reinsurer participants.

CSC INTEGRAL Admin

Extra Info

Work With Reassurers - Enquiry

Session Info | Help | Home | Logout

Filter on Reassurer

Sel	Reassurer	Start Date	Currency	Client No	Account Name
20047	01/12/2012	GBP	50000240	AXA FAC OUT	
20047	01/12/2012	SGD	50000240	AXA FAC OUT	
20047	01/12/2012	USD	50000240	AXA FAC OUT	
20048	01/12/2012	GBP	50000249	AVIVA QUOTA SHARE	
20048	01/12/2012	SGD	50000249	AVIVA QUOTA SHARE	

More...

Client | Account | Arrangement | Costed Prm | Costed Clm | Member Prm

Clim Recrvy | Ledger | Balance Enq

Exit | Refresh | Continue ➔

The following options are available for inquiry.

8.3.1 Arrangement Inquiry

If you select <Arrangement> you will be able to drill down on all arrangements for the RI account.

Reinsurance Arrangement screen will be displayed. To view the risk on a given arrangement click on checkbox against Arrangement

The screenshot shows the 'Reinsurance Arrangement' screen. At the top, there are fields for 'Reassurer' (20051 Sing Re) and 'Currency' (SGD). Below is a table with the following data:

Sel	Arrangement	Reassurance Type	Treaty Type	Cession Type	Quota
<input checked="" type="radio"/>	GVGN	T	G	Q	
<input checked="" type="radio"/>	GVNN	T	G	Q	
<input checked="" type="radio"/>	GVNN				

At the bottom right are buttons for 'More...', 'Risks', 'Exit', 'Refresh', and 'Continue'.

8.3.2 Premium Inquiry

To view RI premiums that have been costed for an RI account click on <Costed Prem>. Reinsurance Costed Premium will be displayed. Filter as required.

This will only show premiums where the financial records have been produced, i.e. the nightly RI costing job has run.

8.3.3 Cost claim inquiry SR9E8

To view claims that have been costed for an account click on option <Costed Clm> against the Reinsurer. Reinsurance Costed Claim screen will be displayed. This will show all claim recoveries that are due, i.e. The claim has been admitted and the payment requested.

CSC
INTEGRAL Admin
Session Info | Help | Home | Logout

Extra Info
Reinsurer
20051 Sing Re
Currency
SGD

More...

Sel	Claim No	Inst No	Product	Risk Class	Arrangement	Year	Month	

Total Claim Paid
Total RI Claim Recovery

Filter By
Claim No
Inst No
Product
Risk Class
Arrangement
Year
Month

[Exit](#)
[Refresh](#)
[Continue ➔](#)

8.3.4 RI Member/headcount Premium

To view the RI premium breakdown at the member/headcount level, click on <Member Prm>.

Reinsurance Member Premium screen will be displayed. This will show RI premium for the member once the bill has been raised for the premium.

The screenshot shows the 'Reinsurance Member Premium' screen. At the top, there are search fields for 'Reassurer' (20051 Sing Re), 'Policy Number' (with a search icon), 'Currency' (SGD), and 'Member Number' (with a search icon). Below these are tabs for 'More...', 'Sel', 'Policy', 'Member', 'Subsidiy', 'Product Type', and 'Transaction Number'. A large grid table is present, though no data is visible. Below the grid are buttons for 'Total Premium' and 'Total Commission'. At the bottom, there are buttons for 'Pol Detail', 'Client', 'Mbr Detail', and 'Hdcnt Dtl'. A 'Filter' section contains fields for Policy, Member, Subsidiy, Product Type, Transaction Number, Plan Number, Bill Type, Risk Type, MM, Risk From, Arrangement, Due Flag, Year, and Month. At the very bottom are buttons for 'Exit', 'Refresh', and 'Continue ➔'.

8.3.5 Claim Recovery SR9EA

To view all claims recoveries due for a reinsurer, including those not yet admitted click on <Clm Recvry>. Reinsurance Claim Recovery screen will be displayed.

For the claim recovery to show here before admittance the claims administrator will have had to visit the claims recovery screen on exiting the claims and agreed or overridden the defaulted claim recovery amounts.

CSC
INTEGRAL
Admin
Session Info | Help | Home | Logout

Reinsurance Claim Recovery

Select	Claim No	Reassurer No	Account Name	More...

[Clim Detail](#) [Pol Detail](#) [Client](#)

Total

Filter By

Claim No	Reassurer No	Currency
<input type="text"/>	<input type="text"/> 20519	<input type="text"/> Singapore Dollar
Year	Month	Contract No
<input type="text"/>	<input type="text"/>	<input type="text"/>
Risk Class	Arrangement Code	RI Seq Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Status

-----Select-----

Product Code

-----Select-----

8.3.6 Ledger Inquiry S2339

To view all accounting movements against a Reinsurer click on **Ledger**. Statement Page Enquiry screen will be displayed.

This will reflect the RI accounts statement of account, all RI premiums payable (GP NP), Claims recovery (GO CR) due, Cash receipts received (GO NP, GO CR) and payments paid (GO PP, GO CR) will be displayed here. A net account balance will show at the bottom the screen.

Details will only show on this screen after the financial records created as part of the RI Costing job are posted to debtors.

CSC INTEGRAL Admin

Extra Info

Functions

Statement Page Enquiry

Session Info | Help | Home | Logout

Account 20519 Munich Reinsurance	Account Type 14 Group RI	Accounting Currency <input type="text"/>			
Debtor Type AG					
More...					
Sel	Transaction Date	Effective Date	Policy	Class	Accounting Amount

Net Account Balance
00

Filter By

Transaction Date <input type="text"/>	Policy Number <input type="text"/>	Class <input type="text"/>	Client <input type="text"/>
Document Ref <input type="text"/>	RF <input type="text"/>	Effective Date <input type="text"/>	Currency <input type="text"/>

Detail Inquiry **Reconciliation Inquiry**

Exit **Refresh** **Continue ➔**

8.3.7 Balance Inquiry S2523

To view the balance of the reinsurer account, click on <Balance Enq>. Debtors Balances Select screen will be displayed.

This will display take the RI account statement of account balance as at the last month end rollover.

To view aged balances click on checkbox against item you will see the summary of how the balance is aged.

CSC INTEGRAL Admin

Debtor Balances Select

Session Info | Help | Home | Logout

Account 20519 Munich Reinsurance	Debtor Type <input checked="" type="checkbox"/> AG
Account Type 14 Group RI	Account Recon <input checked="" type="checkbox"/> 01 Open Item

More...

Outstanding in Original	Currency	As At Month	Currency	As At Month	

Exit | Previous | Continue ➔

8.3.8 Receipt and Payments for RI

See section for 0 10.0 Receipts for Receipt entry and Section 0 11.0 for payment entry.

Money received from the Reinsurer will be entered as GO CR for claims recoverable. To offset against premiums owing use GO NP.

Money paid to the reinsurer will be entered as GO PP. To offset against claims recovery due, use GO CR.

All receipts and payments will be posted to the Reassurance accounts sub ledger and shown/reflected in the statement of account inquiry.

9.0 Claims

9.1 Sum Insured Claims Overview

Claims notification and claims admittance are performed via Group Claims selected from the Group System Master Menu.

Claim Payments, although automatically created as part of the claims sub-system, are managed under the payment sub-system (see section 0 "11.0").

Claims – Sub Menu screen:

The screenshot shows the 'Claims - Sub Menu' interface. On the left is a vertical navigation bar with the 'Main Menu' expanded, listing various administrative functions. The central area is titled 'Claims - Sub Menu' and contains two main sections: 'Input' and 'Actions'. The 'Input' section includes fields for Policy Number, Product Code (with a dropdown menu), Member Number, Claim Number, and Client Number. The 'Actions' section contains several radio button options: Create New Claim (selected), Create New Claim Occurrence, Modify Claim, Display Claim, Work With Reserves, Enquire Reserves, Clear Reserves, and Reject Pending Instalments. At the bottom right are buttons for 'Exit', 'Refresh', and 'Continue'.

9.2 Register Death claims

9.2.1 Add member for headcount

If the member is a part of headcount we need to first add them using major alterations, <Work with Members>, <Add Headcount Member> to add headcount member.

We will also modify the headcount details to remove the member from cover if required for the scheme administration rules.

9.2.2 Terminate member

Using major alterations, <Work with Member> and <T/Pro-rata> against selected member, to terminate a member. The date of termination should be the day after the date of death.

9.2.3 Create claim

To create a new claim from the claims submenu click on <Create New Claim>.

Enter the policy number, product code, RI risk class, member number or client number and press enter to proceed.

Claim header will be displayed.

The screenshot shows the CSC INTEGRAL Admin software interface. The top navigation bar includes links for Session Info, Help, Home, and Logout. On the left, there's a sidebar with 'Extra Info' sections for Follow Up and Additional Data, and a 'Functions' section. The main content area is titled 'Claim Header' and contains various input fields for claim details:

Policy	Inception	Expiry Date
35000182 APPLE INCORPORATED NOT FACE	01/01/2012	31/12/2012
Product	Special Terms	Reversal Link
GTL1 Group Term Life Product		
Claim Number	Relationship	Status
55000040 00		CP Claim Pend
Claimant	Plan	Age
00001 00 Chua, Charles		34
Member	Until	Special Terms
00001 00 Chua, Charles	30/12/2012	
Claimant Period	Outstanding Loan Amount	Incurred Date
01/01/2012	000000000	01032013
Family Code	Claim Currency	Exchange Rate
	Singapore Dollar	1.000000000
RI Risk Class	Bank Charges	Claim Secondary Status
		Select
First Report Date	Death Claim	
	<input checked="" type="checkbox"/>	
Cause Code	Claim Condition	
Death due to Heart attack	Death	
Benefit	Remarks	
Death	Suffered Heart Attack during morning jog	

At the bottom right are buttons for Exit, Refresh, and Continue.

Notes and comments:

- ❑ Enter the date of death in the incurred date click <Refresh> and plan details will default. If there is no plan on cover at that date you will be given the option to accept the claim as ex-gratia.
- ❑ Enter the date claim first reported.
- ❑ Click on death claim checkbox
- ❑ Cause code, benefit and claim condition are also required fields
- ❑ To enter follows up for claim click on <Follow Up> in the Extra Info box. Based on system parameters some follow ups may default.

Click <Continue> to proceed. The claims payable screen will be displayed

CSC INTEGRAL Admin

Claim Payable Screen - Non Medical

Session Info | Help | Home | Logout

Extra Info

- Outstanding Premium
- Installments Claims
- Claim Reserves
- Unrealized Cheque
- General Page

Functions

- Calc

Claim Number: 55000040 00 **Reversal Link:**

Policy: 35000182 APPLE INCORPORATED NOT FACEBOOK NOT GOGGLE

Claimant Name: 00001 00 Chua, Charles

Product: GTL1 **Plan Number:** 001 Staff

Benefit Code	Description	Sum Insured	Benefit % Payable	Total Claim Authorised	Paid
TL01	Death	300000	100.00	<input type="text"/>	<input type="text"/>

Interest Paid on Late Pay: **Deductible Amount:** **Type:**

Coinsurance:

Total Payable:

Buttons: Exit | Refresh | Continue ➔

Notes and comments:

- The system will default the total claim to be authorised based on the sum insured if you click <Refresh>, this can be overridden
- To enter a reserve for the claim click on <Claim Reserves> in the Extra Info Box. Claims Reserves screen will be displayed. Enter the correct reserve and click <Continue> to approve and return to the claim payable screen.

Click <Continue> to proceed. The claims exit screen will be displayed:

The screenshot shows the 'Claims Exit Screen' within the INTEGRAL Admin application. The left sidebar has sections for 'Extra Info' (Payee, RI Claim Recovery) and 'Functions'. The main area contains fields for 'Current Status' (set to 'CP Claim Pending'), 'New Status' (a dropdown menu currently showing 'Claim Pending'), 'Reason for Change' (a dropdown menu currently showing 'Select'), 'Instalment Number' (set to '00'), and 'Authorise Instalment Payment' (an unchecked checkbox). At the bottom right are buttons for 'Exit', 'Refresh', and 'Continue'.

The claim status will be pending. Click <Continue> to return to the submenu and create the claim.

9.3 Modify Claim

The claim can be modified using <Modify Claim> at any time to amend reserves, update follow ups, amend status or note a reason for status.

9.4 Admit claim

When ready to admit and settle a claim we need do a number of steps.

- Set up payment details
- Amend claim status
- Review RI if applicable

Once payments have been triggered by the claim system they will be managed by the payment subsystem.

9.4.1. Authorise and Pay claim

To authorise and trigger claims payments:

- Click <Modify Claim> to modify claim from the submenu
- Confirm the details are correct on the claim header, then access the follow up screen to ensure no outstanding follow ups.
- Confirm the details are correct on the claims payable screen, access the claims reserve screen to update the reserve to amount of payment if required.

- On the claims exit screen, Amend the claims status to CA approved, update the reason for change and click on <Payee> in the Extra Info box.

Click <Continue> to proceed. You will be asked to double confirm: click <Continue> again.

Claims payee details screen

The screenshot shows the 'Claim Payee Details' screen in the CSC INTEGRAL Admin software. The top navigation bar includes links for Session Info, Help, Home, and Logout. On the left, there's a sidebar with 'Extra Info' and 'Functions' sections, the latter containing a single item 'Calc'. The main content area is titled 'Claim Payee Details' and contains several input fields and dropdown menus. In the 'Policy' section, the policy number is 35000182 and the product is 'APPLE INCORPORATED NOT GTL1 Group Term Life Product'. Under 'Claimant', the name is Chua, Charles. In the 'Claim Amount Payable' section, the amount is 300000.000. The 'Instalment Number' is 00. The 'Product' section shows 'GTL1 Group Term Life Product' and 'Plan Number' 001. The 'Status' is CP. The 'Claim Fee (Calculated)' and 'Reversal Link' fields are empty. The 'Total Amount' is also empty. Below these fields are two tabs: 'Advance Payment' (selected) and 'Normal Payment'. A large table below lists five payees, each with a search icon. The columns are Payee, Name, Payment Type, Bank Code, and Request Type. All entries show 'Select' in the Payment Type and Bank Code dropdowns, and 'Machine Cheque' in the Request Type dropdown. The table has scroll bars on the right and bottom. At the bottom of the screen are buttons for Exit, Previous, Refresh, and Continue.

Notes and comments:

- Enter the payee under normal payment. If this is not the policy owner or subsidiary you will need to have entered the client as a beneficiary against the member first. See 0

- 2.4.2 Beneficiaries.
- Enter the payment type of C for claim.
- Enter the bank code to make the payment from
- Enter the payment type e.g. cheque, direct credit
- Enter the amount to be paid.

Click <Continue> to accept payment details and return to the exit screen. The status should now be CA to authorise

If there is RI on the policy the RI recovery screen will be displayed. The RI recovery amounts will be defaulted based on the treaty for the policy but can be overridden if required.

Click <Continue> to process authorisation of claims, trigger payments, clear reserves and return to submenu.

9.5 Advanced Payments

To make a payment on a policy prior to admitting the claim, the advanced payments can be used. The advanced payment is set up as under the Payee option on the Claims exit screen and the advanced payment, not the whole claim, is authorised to trigger payment.

9.6 Claim inquiry

Claim enquiry is available from the claims master menu.

It is possible to inquire on: all claims for a policy number; all claims for a claimant; all claims for a member within a policy.

9.7 Claim Corrections

It may be necessary due to error or mis-information to make changes to a claim post authorisation.

The following outlines some common scenarios and a best practice action to take. This should be used as a guideline for business procedures on claims reversal and correction.

9.7.1 Incorrect date of death

If there is no impact on the claim or payment amount modify the client status to apply the correct date of death. See section **Error! Reference source not found. Error! Reference source not found..**

9.7.2 Incorrect payment amount or payee

If the claim has been paid for the wrong amount there will be a different process depending on the status of the payment.

Note for IP claims: you are working with instalment amounts: you will be paying and approving each of the instalment amounts only when they become due.

9.7.2.1 Payment unapproved

If the payment has not been approved or authorised the payment can be modified within the payments system, see section **Error! Reference source not found.** **Error! Reference source not found..** Note that this has no impact on the details in the claims system but will amend any payment GL posting and payment details.

A journal may also be required to adjust the RI claim recovery amount. The recovery is set at the time of claim authorisation. See Appendix A, GL accounting movements for T965 RI recovery for details required for journal.

Consider if a journal is required for other claims postings at the time of claim authorisation See Appendix A, GL accounting movements at the time of claims authorisation (admittance).

9.7.2.2 Payment approved or authorised

Prior to a payment being processed it may be removed from the system see **Error! Reference source not found.** **Error! Reference source not found.** and a new payment created for the correct details In Integral Group Admin system, medical claims are entered against procedures and drug codes and the system will automatically map the procedure code to the benefit code(s) in a process known as benefit mapping.

To create a Procedure code or a Drug code, select <Group Claim 2> and select <Procedure, Drugs & Medic>option.



11.1 Procedures

Select the <Work with Procedures> option and click <Continue> to bring you to the Work with Procedures screen.

The screenshot shows the 'Work With Procedures' screen. At the top, there are search fields for 'Locate By Procedure Code' and 'Search By Description'. Below these is a table listing procedures:

Ind	Select	Procedure Code	Long Description	Short Description	Action
	<input type="checkbox"/>	*****	Catch All - Procedure code	Catch All	A0E
	<input type="checkbox"/>	A01000	Removal whole/> half stomach	Rem Stomch	A0E
	<input type="checkbox"/>	A06000	Gastro-jejunocolostomy	Gastro	A0E

At the bottom of the table are buttons for 'Modify', 'Delete', 'Surg Catg.', and 'Fee SchMth'. Navigation links at the very bottom include 'Exit', 'Previous', 'Refresh', and 'Continue ➔'.

Click on the function <Add new procedure> to create a new procedure code.

The screenshot shows the 'Work With Procedure - New' screen. It has three main input fields: 'Procedure Code' (with a search icon), 'Procedure Class' (with a search icon), and 'Description' (a large text input field). Below these are 'Short Description' and 'Long Description' fields, each containing a multi-line text area. Navigation links at the bottom include 'Exit', 'Previous', 'Refresh', and 'Continue ➔'.

Notes and comments:

- All procedure and drug codes are user defined.
- Select the appropriate procedure class for the new procedure (setup in TR9A2).
- Enter the relevant description

11.1.1 .

Note that this has no impact on the detail in the claims system but will amend any payment GL payment postings and payment details.

A journal may also be required to adjust the RI claim recovery amount. The recovery is set at the time of claim authorisation. See Appendix A, GL accounting movements for T965 RI recovery for details required for journal.

Consider if a journal is required for other claims postings at the time of claim authorisation See Appendix A, GL accounting movements at the time of claims authorisation (admittance).

9.7.2.3 Payment Processed

If a payment has been processed it should only be cancelled if the cheque has been returned or the funds have been returned in the case of a direct credit.

Cancel the payment see section **Error! Reference source not found. Error! Reference source not found..** This will reverse the payment and all payment GL postings records. Note that this has no impact on the detail in the claims system.

A new payment can now be created for the correct details. In Integral Group Admin system, medical claims are entered against procedures and drug codes and the system will automatically map the procedure code to the benefit code(s) in a process known as benefit mapping.

To create a Procedure code or a Drug code, select <Group Claim 2> and select <Procedure, Drugs & Medic> option.

The screenshot shows the CSC INTEGRAL Admin application interface. At the top left is the CSC logo. To its right, the text "INTEGRAL Admin" is displayed. On the far right of the header are links for "Session Info", "Help", "Home", and "Logout".

On the left side, there is a vertical "Main Menu" list containing the following items:

- System Administration
- Batch Processing
- Clients
- General Ledger
- Receivables and Payables
- Windowing Codes
- Group Agent
- Group Policy Admin.
- Group Retail Type-1
- Group Retail Type-2
- Group Policy Admin Enq
- Group Policy Admin Setup
- Group Reinsurance
- Group Claims
- Group Claims 2
- Group Pension
- Diary System

In the center, under the heading "Procedure, Drug & Medical Supplies Database", there is an "Actions" section with two radio button options:

- Work With Procedures
- Work With Drugs/Medical Supplies

At the bottom right of the main content area are "Exit" and "Continue" buttons.

11.1 Procedures

Select the <Work with Procedures> option and click <Continue> to bring you to the Work with Procedures screen.

The screenshot shows the "Work With Procedures" screen. At the top left is the CSC logo. To its right, the text "INTEGRAL Admin" is displayed. On the far right of the header are links for "Session Info", "Help", "Home", and "Logout".

On the left side, there is a vertical "Extra Info" list containing the following items:

- Add new procedure

In the center, there are search fields for "Locate By Procedure Code" and "Search By Description". Below these is a table listing procedures:

Ind	Select	Procedure Code	Long Description	Short Description	More...
	<input type="checkbox"/>	*****	Catch All - Procedure code	Catch All	A0E
	<input type="checkbox"/>	A01000	Removal whole/> half stomach	Rem Stomch	A0E
	<input type="checkbox"/>	A06000	Gastro-jejunocolostomy	Gastro	A0E

At the bottom of the table are buttons for "Modify", "Delete", "Surg Catg.", and "Fee SchMth".

At the very bottom of the screen are "Exit", "Previous", "Refresh", and "Continue" buttons.

Click on the function <Add new procedure> to create a new procedure code.

The screenshot shows the 'Work With Procedure - New' screen in the INTEGRAL Admin application. The top navigation bar includes links for Session Info, Help, Home, and Logout. On the left, there's a sidebar with sections for 'Extra Info' and 'Functions'. The main panel contains fields for 'Procedure Code' (with a search icon), 'Procedure Class' (with a search icon), 'Description' (in a large text area), and 'Long Description' (in a multi-line text area). At the bottom, there are buttons for 'Exit', 'Previous', 'Refresh', and 'Continue'.

Notes and comments:

- All procedure and drug codes are user defined.
- Select the appropriate procedure class for the new procedure (setup in TR9A2).
- Enter the relevant description

11.1.1 .

A journal may also be required to adjust the RI claim recovery amount. The recovery is set at the time of claim authorisation. See Appendix A, GL accounting movements for T965 RI recovery for details required for journal.

Consider if a journal is required for other claims postings at the time of claim authorisation See Appendix A, GL accounting movements at the time of claims authorisation (admittance).

9.7.3 Claim against the wrong member.

If a death claim has been setup against the wrong member we will need to do the following:

- Apply the appropriate payment correction depending on the status of the claim payment.
 - o Remove payment if not yet processed see section **Error! Reference source not found. Error! Reference source not found.**
 - o Cancel payment once funds have been returned if payment is processed see **Error! Reference source not found. Error! Reference source not found.**
 - o If the claim has not yet been authorised no payment will have been paid so you can just withdraw this claim
- A journal may also be required to adjust the RI claim recovery amount if the claim has been

authorised. The recovery is set at the time of claim authorisation. See Appendix A, GL accounting movements for T965 RI recovery for details required for journal.

- Consider if a journal is required for other claims postings at the time of claim authorisation See Appendix A, GL accounting movements at the time of claims authorisation (admittance).
- Amend the client status on the member whose date of death has been set in error See **Error! Reference source not found. Error! Reference source not found.** section.
- Reinstate the member terminated in error.
- Terminate the correct member
- Register the claim against the correct member

10.0 Receipts

All money received into the company is entered as a cash receipt.

10.1 Cash Processing

From the System Master Menu select <Receivable and Payables> option, and select the <Receipts> option. You will be brought to the Cash Receipt submenu.

The screenshot shows the INTEGRAL Admin software interface. The left sidebar is titled 'Main Menu' and lists various administrative functions. The main window is titled 'Cash Receipt Submenu'. It contains two main sections: 'Input' and 'Actions'. The 'Input' section includes fields for 'Bank Code' (a dropdown menu), 'Policy Number' (a search bar), and 'Receipt Number' (a search bar). The 'Actions' section contains several radio button options for different receipt types and actions. At the bottom right, there are buttons for 'Exit', 'Refresh', and 'Continue'.

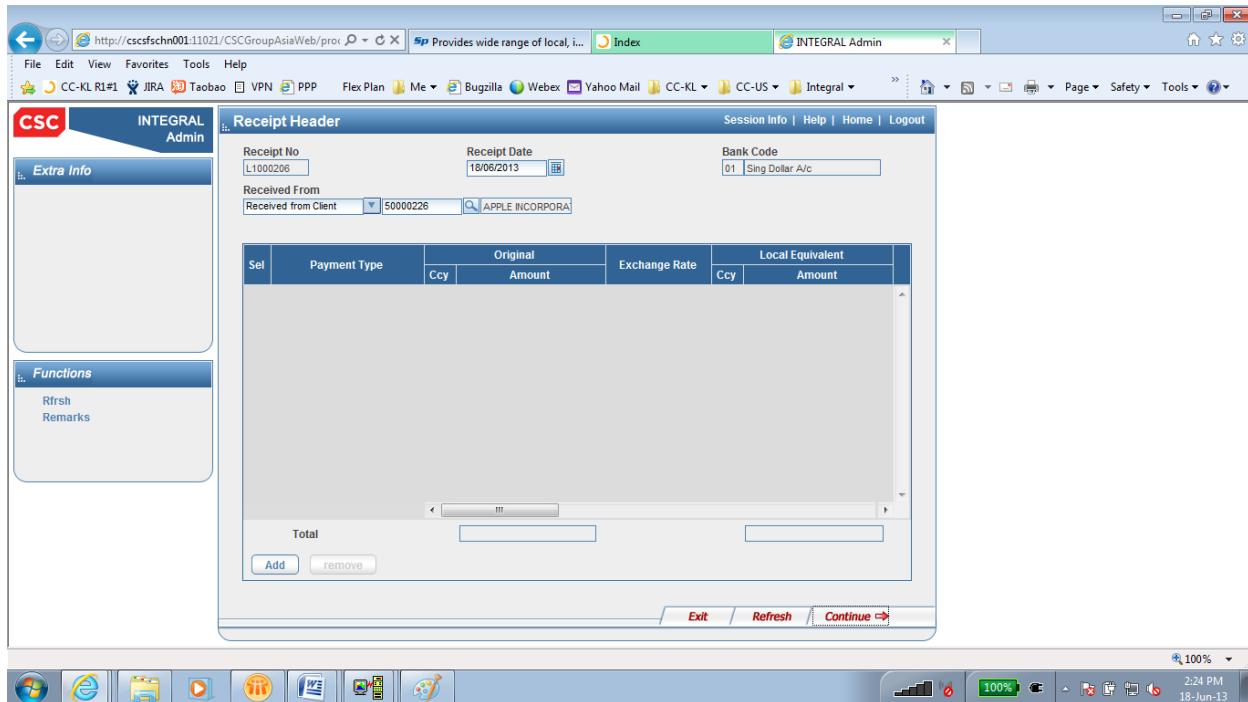
There are options here to create receipt for Cash Not Banked or Cash Banked.

The bank code is mandatory and the user can use the drop-down list to select bank code.

When creating a new receipt, the receipt number will be automatically generated on receipt creation.

10.2 Create Receipts

On selection of <Cash Not Banked> or <Cash Banked> you will be brought to the Receipt Header screen:



Click on <Add> to add in the Receipt Header details.

Payment Type	Select
Original Amount	SGD
Cheque No	
Cheque Date	
Bank Details	Select
Confirm	

Notes and comments:

- The receipt effective date will default as today. This can be overridden to an earlier date if required.
- The payor client number should be entered. Use the client scroll button (if number is not known) to search clients.
- Multiple payments can be receipted at the same time. For each payment enter:

- the payment type: e.g. cash, cheque (click on scroll button for a complete list);
- the original amount (if you click <Refresh> the local equivalent amount will be defaulted);
- If the payment type is “cheque” then the cheque details should be recorded: cheque number, cheque type, cheque date, bank account and account number.

Press <Click> to proceed. You will be brought to the Cash Dissection screen.

Select	Subaccount Code	Type	Dissection Key	Currency	Original	Exchange Rate	L Currency
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	35000225	<input type="text"/>	<input type="text"/>	<input type="text"/>	SGD

Notes and comments

- Cash can be receipted against numerous subsidiary ledgers, client, agent or contract for example. The subsidiary ledger has types and codes that are table driven. Each combination determines the dissection key validation. (i.e. client number, agent number, policy number). Examples are
 - FL S is used for policy-specific cash received from the owner: policy number is the dissection key
 - FL SB is used for policy-specific cash received from a subsidiary: Policy Number and Subsidiary number are the dissection key
 - CT SG is used for cash received from a company and the policy is not known. It will go into company suspense and can be applied to the policy on set-up. Client number is the dissection key
 - CL S is used for money received from a client which cannot be matched to a policy at the time of receipt. For example if the policy has not been created at the time of receipt

For a complete list of sub-account codes and types available, see Appendix A.

- Enter the original amount to be allocated to each dissection. Click <Refresh> to update the Local Amount.

- The receipt should balance. <Header> option will check details as you enter.
 - If you need to return to the header to make amendments, click on <Header>
- On creation of a receipt for a policy's float suspense - FL S or FL SB, the system will check to see if there are any outstanding bills. If there are, it will attempt to settle them, starting with the oldest. Bills will only be settled if the full amount has been received.

10.3 Cash receipt cancellation

If a receipt has been entered in error, or a cheque bounces, it can be cancelled using <Receipt Cancellation>.

Enter the receipt number that you wish to cancel. The Receipt header screen will be automatically populated with the original receipt details for a contra amount. All fields will be protected.

Click <Continue> to confirm and the Receipt Dissection screen will be displayed with the original receipt details for the contra amount. All fields will be protected.

Click <Continue> to confirm and you will be returned to the submenu, the receipt will have been reversed, and the correct reversal financial entries will have been made.

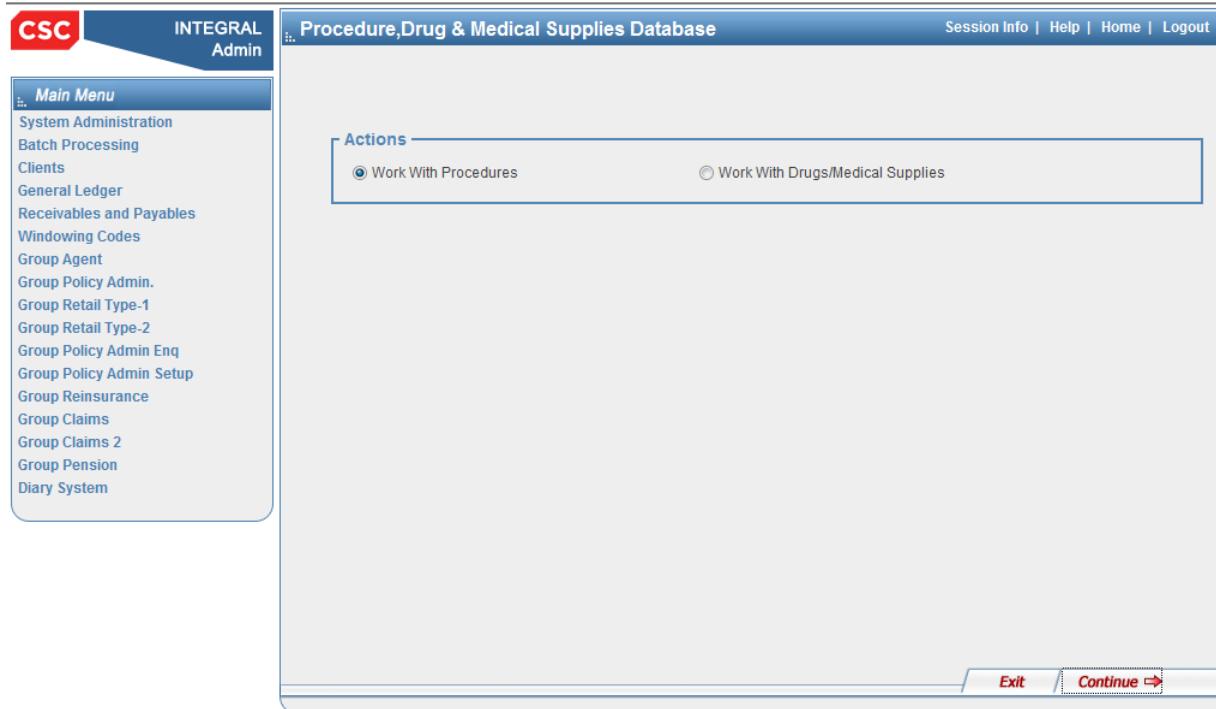
If the receipt was used to settle any bills, those bills will be reset to outstanding.

11.0 Procedures, Drugs & Medic

This section will explain on the creation of the procedure code and drug codes used in the Group Claims 2 module.

In Integral Group Admin system, medical claims are entered against procedures and drug codes and the system will automatically map the procedure code to the benefit code(s) in a process known as benefit mapping.

To create a Procedure code or a Drug code, select <Group Claim 2> and select <Procedure, Drugs & Medic>option.



11.1 Procedures

Select the <Work with Procedures> option and click <Continue> to bring you to the Work with Procedures screen.

CSC INTEGRAL Admin

Work With Procedures

Session Info | Help | Home | Logout

Locate By Procedure Code

Search By Description

More...

Ind	Select	Procedure Code	Long Description	Short Description	
	<input type="checkbox"/>	*****	Catch All - Procedure code	Catch All	A0E
	<input type="checkbox"/>	A01000	Removal whole/> half stomach	Rem Stomch	A0E
	<input type="checkbox"/>	A06000	Gastro-jejunocolostomy	Gastro	A0E

Functions

Add new procedure

Modify **Delete** **Surg Catg.** **Fee SchMth**

Exit **Previous** **Refresh** **Continue ➔**

Click on the function <Add new procedure> to create a new procedure code.

CSC INTEGRAL Admin

Work With Procedure - New

Session Info | Help | Home | Logout

Procedure Code

Procedure Class

Description

Short Description

Long Description

Functions

Exit **Previous** **Refresh** **Continue ➔**

Notes and comments:

- ❑ All procedure and drug codes are user defined.
- ❑ Select the appropriate procedure class for the new procedure (setup in TR9A2).
- ❑ Enter the relevant description

11.1.1 Fee Schedule method for a procedure

To add a fee schedule, select the procedure code and click on <FeeSchMth> in the Work with Procedures screen.

The screenshot shows the 'Fee Schedule Method For A Procedure' screen. At the top, there is a search bar labeled 'Procedure Code' containing 'A9999'. Below the search bar is a table with five columns: 'Select', 'Network Level', 'Short Description', 'Fee Schedule Method', and 'Short Description'. There is one row in the table. At the bottom of the table are 'Modify' and 'Delete' buttons. The status bar at the bottom right shows '100%' and the date '25-Jun-13'.

Click on <Add> function to create a new fee schedule method.

The screenshot shows the 'Assign Fee Schd Mthd To A Procedure' screen. It has three main input fields: 'Procedure Code' (A9999), 'Network Level' (Inside the network), and 'Fee Schedule Method' (dropdown menu showing 'Select', '01-Fee schedule database', and '02-Table TR9H9'). At the bottom are 'Exit', 'Previous', 'Refresh', and 'Continue' buttons.

Notes and comments:

- ❑ Network level is set-up in TR9C7.
- ❑ Fee schedule is set-up in TR9HH.
- ❑ The fee schedule must be defined for every procedure code before they can be used in claims.
- ❑ The fee schedule method tells the system the method and the amount to be reimbursed to a provider for a procedure.
- ❑ 2 fee schedule methods are supported in INTEGRAL: –
 - Method 01 – Fee schedule database
 - Method 02 – Set up in TR9H9

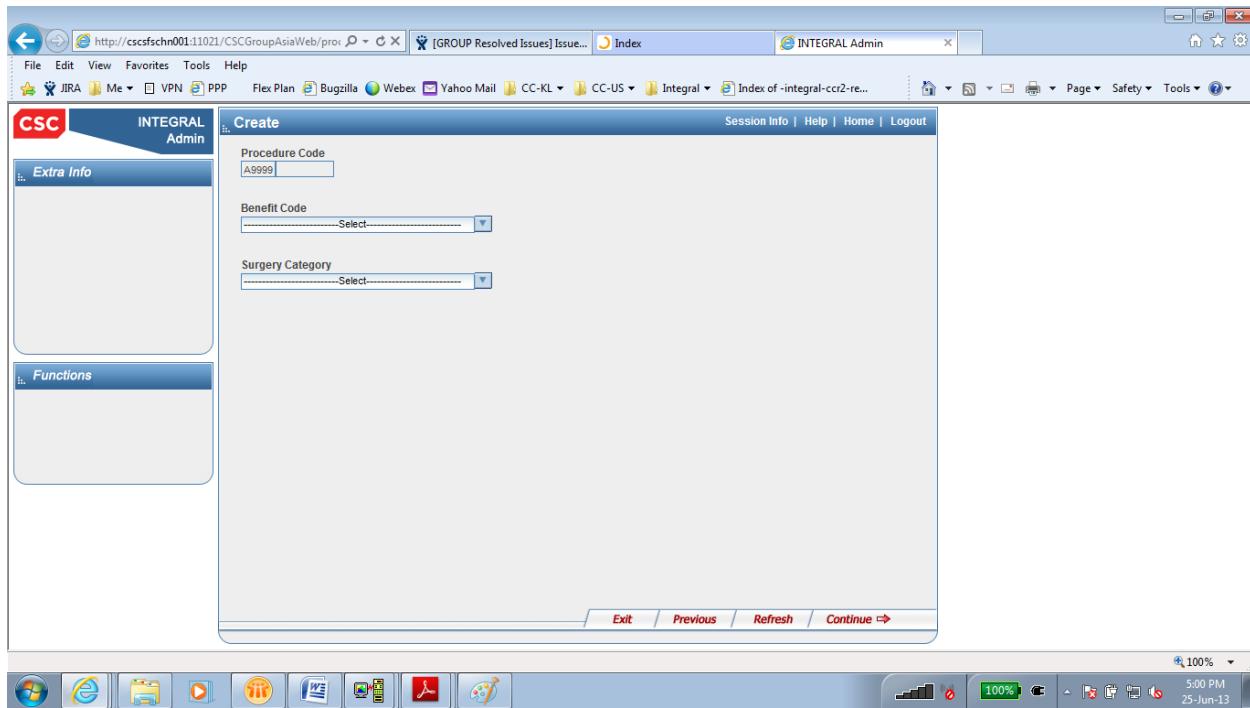
11.1.2 Link Procedure code to benefits and surgery categories

To add a fee schedule, select the procedure code and click on <Surg Catg> in the Work with Procedures screen.

Link Procedure Code to Surgery Category screen

The screenshot shows the INTEGRAL Admin software interface. On the left, there's a sidebar with 'CSC' logo, 'INTEGRAL Admin' title, 'Extra Info' section, and 'Functions' section with 'Add New Benefit' option. The main area has a title bar 'Link Procedure Code To Surgery Category' with 'Session Info | Help | Home | Logout'. Below it is a search bar 'Procedure Code' with 'A9999' entered. A large table grid displays columns: 'Select', 'Benefit Code', 'Short Description', and 'Surgery Category'. At the bottom of the table are 'Modify' and 'Delete' buttons. At the very bottom of the screen are navigation buttons: 'Exit', 'Previous', 'Refresh', and 'Continue' with a right-pointing arrow.

Click on <Add> function to create a new fee schedule method.



Notes and comments:

- Benefit codes are set up in T9798.
- Surgical Category are set up in T9808.
- Procedure code with fee schedule method set as '02' should set up the surgical method as well.

11.2 Drugs & Medical Supplies

Select the <Work with Drugs/Medical Supplies> option and click <Continue> to bring you to the Work with Drugs and Supplies screen.

This is the control screen to add, modify or delete drug codes. We can use the following options:-

Option 1 – Create as many drug codes as necessary and for those drugs which are defined in the database, enter the claims directly against the drug code.

Option 2 – For those drugs that are not defined in the drug database (could be none), define a generic procedure called 'DRUG' and enter the claim against this procedure code.

A combination of the 2 options can be used together i.e. use option 1 for some drugs and option 2 for the remaining drugs.

CSC INTEGRAL Admin

Work With Drugs And Supplies

Session Info | Help | Home | Logout

Locate By
Drug Code Name

More...

Ind	Select	Drug Code	Drug Description	Manufacturer C
	<input type="checkbox"/>	BIOGE	Biogesic	50000281

Modify **Delete** **Display**

Filter By
Manufacturer

Exit **Continue ➔**

Click on <Add New Drug> function to create a new Drug code.

Drug Code - Details

CSC INTEGRAL Admin

New Code

Session Info | Help | Home | Logout

Drug Code Manufacturer

Drug/Medical Supply Indicator Unit of Measure

Standard Quantity Dispensed per Prescription Drug Class

Dispensing Type Recommended Dosage times per

Cautionary Message

Alternate Reference

Exit **Previous** **Refresh** **Continue ➔**

Notes and comments:

- Drug codes are user-defined.
- Manufacturer must be created as a client.
- Drug class are set up in TR9AV
- Unit of measure are set up in TR9AX
- Dispensing type are set up in TR9C9
- Dosage frequency are set up in TR9AY
- Drugs and medical supplies are entered here and indicated by the Drug/Medical Supply indicator.

12.0 Provider Maintenance

To create a Provider, select <Group Claim 2> followed by <Provider Maintenance> option.

The screenshot shows the 'Provider Maintenance Submenu' window. At the top right are links for 'Session Info', 'Help', 'Home', and 'Logout'. On the left is a vertical 'Main Menu' with options like System Administration, Batch Processing, Clients, General Ledger, Receivables and Payables, Windowing Codes, Group Agent, Group Policy Admin, Group Retail Type-1, Group Retail Type-2, Group Policy Admin Enq, Group Policy Admin Setup, Group Reinsurance, Group Claims, Group Claims 2, Group Pension, and Diary System. The main area has sections for 'Input' (Client Number search field) and 'Actions' (radio buttons for Add New Provider Organisation, Add New Provider, Modify Provider Organisation / Provider, Inquire on Provider Organisation / Provider Details, Delete Provider Organisation / Provider, and Link Providers to a Provider Organisation). At the bottom right are 'Exit' and 'Continue' buttons.

12.1 Add new Provider Organisation

The screenshot shows the 'New' provider organisation setup screen. The left sidebar has 'Extra Info' and 'Functions' sections. The main form includes fields for 'Provider Organisation' (set to 'LIANG CLINIC'), 'Medical Provider Category' (dropdown), 'Area Code' (dropdown), 'Provider Group' (dropdown), 'Default Fee Schedule' (dropdown), and 'Alternate Reference Number' (text input). Under 'Office Hours', there's a table for setting daily office times from Monday to Friday. The table has columns for 'Days / Shifts', 'Hours', 'Minutes', and two 'to' columns. For each day, the first 'to' column is at 00:00 and the second is at 00:00, indicating continuous operation. At the bottom right are 'Exit', 'Previous', 'Refresh', and 'Continue' buttons.

Days / Shifts	Hours	Minutes		Hours	Minutes	Hours	Minutes	
Mon	00	00	to	00	00	00	00	to
Tue	00	00	to	00	00	00	00	to
Wed	00	00	to	00	00	00	00	to
Thu	00	00	to	00	00	00	00	to
Fri	00	00	to	00	00	00	00	to

Notes and comments:

- A provider organisation must be created as a Corporate client.
- The corporate client special indicator must be set to '01' – Provider organisation by the system when the client is created as a provider organisation.
- Medical Provider are set-up in T9692. User defined field to indicate the category of the provider organisation. Examples are Government Hospitals, Private Hospitals, Clinics, X-ray labs etc.
- Alternate Reference Number is a free text field to enter any other identification number.
- Area code are set-up in T9823. Optional entry to assign the area code to which the provider organisation belongs. If a policy is subject to area code concept and processing, the system will expect an area code at the time of claim processing.
- Provider Group are set up in TR9C8. This is user defined field to group the provider organisations. A simple grouping could be inside network and outside network.
- Default fee-schedule is an optional input. This field is not used in benefit mapping or during claims processing. This field is used when copying a provider organisation record in a provider network (Copy option).
- Office hours is used in benefit mapping and is an optional input. The work hour slab is calculated using the following information:-
 - Work hour rule defined in network detailed database for that provider organisation
 - Work hour slab are set up in TR9AU for the work hour rule
 - Time of service entered in claim screen
 - Office hours defined in provider organisation database

System will put a hold code of '72' if there is a mis-match and inconsistency between claim data (time of service) and office hours defined in provider organisation database.

12.2 Add new Provider

In INTEGRAL GROUP, it is optional to enter the details of provider individual. Only in situations when the provider fees depends on the provider capacity of the individual provider (example being provider fees different for junior and senior doctors for the same service in the same provider organisation), it becomes mandatory to enter the details of the individual providers.

Even if provider fees does not depend on individual providers, it will be good practise to capture the details of the individual providers who performed the specific services for the following reasons:-

- Claims statistics at providers individual level
- Accountability for consistent pricing and treatment patterns at individual providers level
- Matching patients needs with the skill set of individual providers (who lived close to patient) for the purpose of referrals

- Additional checking for hold codes 73 through 79. This will result in better claim cost control and help to reduce instances of claim abuse.

The screenshot shows the 'Provider Maintenance' screen of the CSC INTEGRAL Admin system. The left sidebar has 'Extra Info' and 'Functions' sections. The main area contains fields for provider information like name and ID, medical provider category, license details, specialities, and patient demographic filters. At the bottom are standard navigation links.

Notes and comments:

- A provider individual must be a personal client.
- The personal client special indicator must be set to '02' – Provider individual by the system when the client is created as a provider individual. The special indicators are stored in FSU Company table TR391.
- Medical provider are set up in T9692. This is a user defined field to indicate the category of the individual provider. This field is only for information and no processing implication.
- Provider status are set up in TR90I. This field is being updated by users and will be used during claim adjudication and the system puts the following hold codes:-
 - 75 – Provider fraud suspect
 - 76 – Provider suspended
- Licence status are set up in TR90J. This is an optional input. This field is being updated by users and will be used during claim adjudication and the system puts the following hold codes:-
 - 75 – Provider licence revoked
 - 76 – Provider licence suspended
- Speciality-1 and Speciality-2 are set-up in TR9A8. User defined and optional input.

- Alternate reference number is a free text field to hold any other identification number for the provider.
- Patients sex which the provider will see. This field is checked during claim adjudication and the system will a hold code of 73 –Provider will not see patients of this sex
- Beginning and ending age which the provider will see. . This field is checked during claim adjudication and the system will a hold code of 74 –Provider will not see patients of this age
- Educational qualification is an optional input.

12.3 Link Providers to a Provider organization

The screenshot shows the 'INTEGRAL Admin' application interface. On the left, there's a sidebar with 'CSC' and 'INTEGRAL Admin' branding, followed by 'Extra Info' and 'Functions' sections. The 'Functions' section contains a link to 'Add Provider'. The main content area is titled 'Providers under a Provider organisation'. It displays a table with one row of data. The table columns are: Select (checkbox), Provider Organisation (50000245, Changi Hospital), Provider Code (50000230), Provider Description (Anderson Julian), Start Date (01/01/2010), End Date (NA), and Provider Capacity (NA). At the bottom of the table are buttons for 'More...', 'Modify', 'Delete', and 'Display'. Below the table are navigation buttons: 'Exit', 'Previous', and 'Continue'.

Select	Provider Organisation	Provider Code	Provider Description	Start Date	End Date	Provider Capacity
<input type="checkbox"/>	50000245 Changi Hospital	50000230	Anderson Julian	01/01/2010	NA	NA

Click on <Add Provider> if you need to add a provider to the provider organization.

This screen is used to attach individual providers to a provider organization. The relationship between individual providers to provider organization is many to many. One provider organization can have many individual providers under it and the same individual provider can be attached to more than one provider organization.

The screenshot shows the INTEGRAL Admin software interface. The top header includes the CSC logo, the title 'INTEGRAL Admin', and a 'Session Info | Help | Home | Logout' menu. On the left, there's a sidebar with two tabs: 'Extra Info' (selected) and 'Functions'. The main content area contains several input fields: 'Provider' with a search icon, 'Start Date' with a calendar icon, 'End Date' with a calendar icon, and 'Provider Capacity' with a search icon. At the bottom, there's a navigation bar with buttons for 'Exit', 'Previous', 'Refresh', and 'Continue'.

Notes and comments:

- Provider is selected from the client database (only personal client).
- Provider capacity are stored in table TR9A0. This is used if the provider fees depend on the individual provider who performs the service.

12.3 Procedures List

List of procedures is entered by selecting <Proc List> under Functions box. This is an optional input.

The screen captures the list of procedures classes which an individual provider can service. If this data is entered and in the claim screen the individual provider data is entered, the system verifies the procedure class corresponding to the procedure code is in this list.

Procedure class are set-up in table TR9A2.

Screenshot

13.0 Provider Fee Schedule

Select <Group Claims 2> on main menu followed by <Procedure Fee Schedule> option.

Procedure Fee Schedule submenu

Procedure Fee Schedule

Input

Fee Schedule id

Clone From

Actions

Work with Provider Fee Schedule Clone Fee Schedule

Session Info | Help | Home | Logout

Main Menu

- System Administration
- Batch Processing
- Clients
- General Ledger
- Receivables and Payables
- Windowing Codes
- Group Agent
- Group Policy Admin.
- Group Retail Type-1
- Group Retail Type-2
- Group Policy Admin Enq
- Group Policy Admin Setup
- Group Reinsurance
- Group Claims
- Group Claims 2
- Group Pension
- Diary System

Session Info | Help | Home | Logout

Exit **Continue ➔**

'Fee Schedule id' must be set-up in table TR9A9. Select the appropriate fee schedule from the search page and click <Continue> to return to Procedure Fee Schedule submenu.

Table Item Search

In Table
Provider Fee Schedule-id | Provider Fee Schedule | TR9A9

Search Starting

Description **Item** **Short**

Common Fee schedule - Outside	OUTNET	Outside
Fee schedule-Mount Elizabeth	MOUNTE	Mount-E
KPJ Inside Schedule 1	KPJIN1	KPJIN Sch1
KPJ Outside Schedule 1	KPJOT1	KPJOUT 1
Major Medical-Inside Network	MAJMED	MAJMED
Raffles Medical-Inside Network	RMGINS	RMGINS
Shenton Medical-Inside Network	SHENME	SHENME
Test multiple provider capacit	TESTPC	PC

Session Info | Help | Home | Logout

Session Info | Help | Home | Logout

Exit **Refresh** **Continue ➔**

13.1 Work with Provider Fee Schedule

To enter the details of a provider fee schedule, click on the option <Work with Provider Fee Schedule>

The screenshot shows the INTEGRAL Admin software interface. At the top, there's a header bar with the CSC logo, INTEGRAL Admin, Session Info, Help, Home, and Logout links. On the left, there's a sidebar with sections for Extra Info (containing KPJIN1) and Functions (with Add New). The main area is titled 'Work with Provider Fee Schedule'. It contains several input fields and dropdown menus: Fee Schedule (set to KPJIN1), Discount Routine, Standard Schedule (dropdown menu), Default Values, Member Type (dropdown menu), Work hour Slab (dropdown menu), Network Level (dropdown menu), Start Date (date picker), Provider Capacity (dropdown menu), Fee Basis (dropdown menu), Amount (text input), Type of Discount (dropdown menu), Locate (button), Service Code (text input with search icon), and a 'More...' button. Below these is a table listing drug codes and descriptions:

Select	Drug Code	Drug Description	Member Type
<input type="checkbox"/>	A01000	Removal whole/> half stomach	NA
<input type="checkbox"/>	A100	Hospital Room & Board	NA

At the bottom of the screen are buttons for Modify, Delete, Copy, Cpy All Srv, Exit, and Continue.

User can create as many fee schedule as necessary. The same fee schedule can be shared among a group of provider organizations. The user can also create a standard fee schedule and create other fee schedules with fee amounts expressed relative to the standard fee schedule. The advantage of this approach when the fee amounts in standard fee schedule changes, the values in other fee schedules are automatically re-computed based on the new values in standard fee schedule.

Notes and comments:

- ❑ The fee schedule consists of header and detailed information.
- ❑ The header consists of discount routine and standard fee schedule.
- ❑ The detailed is the data corresponding to fee schedule method '01' in TR9HH.
- ❑ The default values are to facilitate easy and faster data entry. The default values are not stored in the database.
- ❑ The fee basis (and hence the fee amount) depends on the following;
 - Service code (procedure code or drug code)
 - Member type
 - Work hour slab
 - Network level
 - Provider capacity
 - Date
 - Room Type

Service code

If the fee basis depends on a specific service code (procedure or drug), enter the service code. If the fee basis is the same for a group of service codes or service code independent, enter ‘*****’. When the system looks for a match, it first looks for the exact service code entered in claim screen. If no match is found, the system attempts a match by ‘*****’. A good example of such a fee schedule, for all services performed by outside network providers, there may not be any provider contract and the user can create a fee schedule with just one service code ‘*****’ and fee basis – ‘INCU’ which is same as incurred.

Member type

This is defined in new product/plan screen SR9B1 and depends on policy/product/plan. The reason for having member type as one of the variables for fee basis is the fee may be different for government staff & others. If the fee basis does not depend on member type, the user can create a dummy value such as ‘N.A.’.

Work hour slab

For the same service/provider organisation, the fees may be different for day time and night time. The work hour slab is calculated using the following information:

- Work hour rule defined in network detailed database for that provider organisation
- Work hour slab entered in TR9AU for the work hour rule
- Time of service entered in claim screen
- Office hours defined in provider organisation database

Network level

The fee basis (and hence the fee amount) may be different depending on whether a provider organisation is inside or outside the network. Hence this is a variable that determines the fee basis.

Provider capacity

In situations provider fees may depend on the provider capacity of the individual provider (an example being provider fees different for junior and senior doctors for the same service in the same provider organisation). Hence this is a variable that determines the fee basis.

Provider capacity

In situations provider fees may depend on the provider capacity of the individual provider

Start date & end date

Self explanatory

Fee Basis

All valid values of fee basis are defined in system controlled table TR90K:

- \$/DM -Minimum (incurred, \$/day * no-of-days)
- \$/DY -Fixed amount per day
- DISC -Discounted charge
- FLAT -Flat fee (does not depend on incurred)
- INCU -Same as incurred
- INMX – Same as incurred with a fixed maximum amount
- NOPC – No provider contract
- ZERO -No amount payable to provider

Pre-paid

If the service is on fee-for-service basis enter 'N'.

If the service is on capitation enter 'Y'. For capitation, fee basis should be 'ZERO'.

Amount

For fee basis \$/DM, \$/DY, FLAT, INMX enter the amount here.

Type of discount

If Fee basis = 'DISC', one of the following values should be entered here.

- AMT -Fixed amount (with respect to the standard fee schedule)
- PER -Fixed percentage
- USER – User defined routine

Discount percentage

If Fee basis = 'DISC' and discount type = 'PER', enter the discount percentage here.

Discount percentage on

If Fee basis = 'DISC' and discount type = 'PER', enter one of the following values here:

- INC -Incurred
- STD -Standard charge (as defined in standard fee schedule)

Discount amount

If Fee basis = 'DISC' and discount type = 'AMT', enter the discount amount here.

14.0 Provider Network

To enter the details of a provider network, click on the <Group Claims 2> followed by the option <Provider Network>. Click <Continue> to show the list of Provider Networks.

Work With Provider Networks menu

The screenshot shows a software interface titled "Work With Provider Networks". The top navigation bar includes links for "Session Info", "Help", "Home", and "Logout". On the left, there's a sidebar with "Extra Info" and "Functions" sections. The "Functions" section contains a link "Add new prov. netw.". The main area displays a table of provider networks with columns: Select, Provider Network Id, Description, Fee Schedule, Payee, Payment Method, Place of Service, Network Level, and a blank column. The table lists five networks:

Select	Provider Network Id	Description	Fee Schedule	Payee	Payment Method	Place of Service	Network Level	
<input type="checkbox"/>	INSKPJ	KPJ - Inside Network	KPJIN1	PO	A			
<input type="checkbox"/>	KPJ	KPJ - Network	TESTPC	PO	0			
<input type="checkbox"/>	MAJMED	Major Medical-Inside Network	SHENME	PO	0			
<input type="checkbox"/>	MTELIZ	Mount Elizabeth-Inside Network	MAJMED	PO	0			
<input type="checkbox"/>	SHENME	Shenton Medical-Inside Network	SHENME	PO	0	NA	IN	

At the bottom, there are buttons for "Modify", "Delete", and "Netw. Dtl.". A footer bar includes "Exit", "Previous", "Refresh", and "Continue" buttons.

The Provider network consists of header information and detailed information. The header information is entered using option < Add new prov.netw.> while the detailed information is entered using option <Netw Dtl> .

Click on <Add new prov.netw.> to add a new provider network.

Add new Provider Network screen

The screenshot shows the 'Work With Provider Network - New' interface. The top navigation bar includes the CSC logo, INTEGRAL Admin, and links for Session Info, Help, Home, and Logout. On the left, there are two sections: 'Extra Info' and 'Functions'. The main form area contains several dropdown menus and input fields. At the bottom, there are buttons for Exit, Previous, Refresh, and Continue.

The header screen consists of Fee schedule, Payee and payment method or requisition type. At the moment, the only value supported for payee is 'PO' (which is provider organisation).

The default values for Place of service, Network level, Provider capacity, Work hours rule is only to facilitate easy and faster data entry. The default values are not stored in the database.

Notes and comments:

- Provider network are set-up in table TR9A4
- Fee schedule are set-up in table TR9A9
- Payee are set-up in table TR9C3
- Payment method are set-up in T3672
- Default Place of service are set-up in table TR9AD
- Default network level are set-up in table TR9C7
- Default provider capacity are set-up in table TR9A0
- Default Working hours rule are set-up in table TR9AU

The detailed is the data corresponding to the provider organisation under the network provider.

CSC INTEGRAL Admin

Add Provider Organisations To a Network

Session Info | Help | Home | Logout

Provider Network
INSKPJ KPJ - Inside Network

Locate
Name Id

More...

Select	Provider Organisation	Claim Type	Place of Service	Start Date	End Date	Fee Schedule Id	
<input type="checkbox"/>	50000244 Singapore General Hospital	NM	NA	01/01/1990			
<input type="checkbox"/>	50000245 Changi Hospital	NM	NA	01/01/1990			
<input type="checkbox"/>	50000245 Changi Hospital	NM	NA	01/01/1990			

Modify Delete Copy Copy all PO

Exit Previous Refresh Continue ➔

Click on <Add new prov.org.> option to add provider organisation to the network provider.

CSC INTEGRAL Admin

Provider Org. Of a Network - New

Session Info | Help | Home | Logout

Provider Organisation

Claim Type

Place of Service

Start Date

End Date

Fee Schedule

Network Level

Provider Capacity

Working Hours Rule

Payment Method

Payee

Exit Previous Refresh Continue ➔

Notes and comments:

The fee schedule, network level, provider capacity and work hours rule depends on following:

- Provider organisation
- Claim type
- Place of service
- Date

Provider organisation

This is entered in claim screen and there is only one value for a claim. Provider organisation is windowable to Client database (corporate clients only).

Claim type

This is entered in claim screen and there is only one value for a claim. The claim type are set-up in table TR9A1.

Place of service

This is entered in claim screen one for every service code. The place of service are set-up in table TR9AD.

Start Date & end date

Self explanatory.

Fee schedule, Network level & Work hour rule

The combination of above four values should uniquely refer to a provider fee schedule, network level and work hours rule. If there is no value of Fee schedule is entered against a provider organisation, the system assumes the default provider schedule at network level will apply.

Fee schedule is in table TR9A9, Network level in table TR9C7 and Work hour rule in table TR9AU.

Provider capacity (TR9AD)

If there are multiple values of the provider capacity for the same provider organisation, claim type, place of service and date, the system resolves the provider capacity as follows: If there is gate keeping , check if the provider organisation is the primary care physician (gate keeper) . Use the provider capacity of gate keeper in TR9A7 to resolve the provider capacity.

If the provider capacity still cannot be resolved, check the provider capacity of the individual provider from the individual provider database.

Payment method

If no value is entered, the default value at network header will be assumed. All valid values are in T3672.

Payee

If no value is entered, the default value payee at network header will be assumed.

15.0 Benefit Relationships

To enter the relationship between a benefit and its procedure class, click on the <Group Claims 2> followed by the option <Benefit Relationships>. Click <Continue> to show the list of Benefits.

Benefit Relationships menu

The screenshot shows a web-based application interface for 'INTEGRAL Admin'. The top navigation bar includes links for 'File', 'Edit', 'View', 'Favorites', 'Tools', and 'Help'. Below the main menu, there is a toolbar with various icons. The left sidebar contains a 'Main Menu' with several options: System Administration, Batch Processing, Clients, General Ledger, Receivables and Payables, Windowing Codes, Group Agent, Group Policy Admin., Group Retail Type-1, Group Retail Type-2, Group Policy Admin Enq, Group Policy Admin Setup, Group Reinsurance, Group Claims, Group Claims 2, Group Pension, and Diary System. The main content area is titled 'Benef Relationships' and contains an 'Actions' section with a radio button labeled 'Work With Benefit Relationships'. At the bottom of the page are 'Exit' and 'Continue' buttons.

The screenshot shows the 'Work with Benefit Relationships' page. The left sidebar has sections for 'Extra Info' and 'Functions', with 'Add Benefit' being the selected function. The main content area is titled 'Work with Benefit Relationships' and features a search bar with fields for 'Locate By' and 'Benefit Code'. Below the search bar is a table listing benefit relationships. The table has columns for 'Select', 'Benefit Code', 'Description', 'Procedure Class', 'Drug Class', and 'Diagnosis Class'. The data in the table is as follows:

Select	Benefit Code	Description	Procedure Class	Drug Class	Diagnosis Class
<input type="checkbox"/>	A100	HRB	R&B		***
<input type="checkbox"/>	A101	ICU	A01		***
<input type="checkbox"/>	A104	Hosp-O'sea	A04		***
<input type="checkbox"/>	A105	Surgery	A05		***
<input type="checkbox"/>	A120	MS FEES	EMS		PRG
<input type="checkbox"/>	A121	Ambulance	EMS		PRG

At the bottom of the page are 'Modify' and 'Delete' buttons, along with 'Exit' and 'Continue' buttons.

Notes and comments:

- Procedure class is set-up in table TR9A2
- Drug class is set-up in table TR9AV
- Diagnosis class is set-up in TR9A3

Benefit relationship is used to relate a benefit to all its procedure classes and diagnosis classes. This relationship is important because at claims stage the system can check if procedures and diagnosis are linked to a benefit under the contract. If the system cannot find a benefit linked to the procedures and diagnosis of the claim, the system will put the hold code 63 – No mapping benefit.

One benefit can be linked to many procedure class and diagnosis class combination. For example consider a benefit called Maternity. This can be related to two diagnosis classes called pregnancy and child birth. This can be linked to three procedure classes called Abortion, Normal & Caesarean. Hence the valid combinations would be:

Benefit	Diagnosis Class	Procedure Class
Maternity	Pregnancy	Abortion
Maternity	Childbirth	Normal
Maternity	Childbirth	Caesarean

By setting up the above relationship, the user can ensure that the above three combinations are the only combinations for which the system will map the procedure/diagnosis code to maternity benefit.

Every benefit should have at least one diagnosis class and procedure class defined against it.

Benefit relationships could be an easy and convenient mechanism to exclude certain procedures to be covered under a benefit. For example, if cosmetic surgery is not covered under the surgery benefit, the user can set-up two procedure classes - Normal surgeries and cosmetic surgeries. Link all those cosmetic surgery procedures codes to cosmetic procedure class. Then set-up the benefit relationship as follows:

Benefit	Diagnosis Class	Procedure Class
Surgery	Surgery	Normal Surgery

For certain benefits, all the diagnosis classes may be applicable. For example, for room & board benefit, there will be many diagnosis classes that can lead to hospitalisation. Hence the system supports a wild card generic diagnosis class ‘***’. If the diagnosis class against a benefit is defined as ‘***’, the system will map all diagnosis codes to that benefit.

A given procedure class/ diagnosis class combination can map to more than one benefit. For example, consider a surgical procedure called Removal of malignant thyroid gland. Assume procedure class and diagnosis class for this claim is ‘Surgery’. Now this procedure may be mapped to the following three benefits within the policy:

- Surgery
- Anaesthesia
- Operating Theatre

Another example could be if an insured dies during the course of hospitalisation, an amount may be payable under the following two benefits:

- Funeral expenses
- Lump sum death benefit amount

16.0 Claims (Medical)

To create a medical claim, click on the <Group Claims 2> followed by the option <Claims Registration> to bring you to the Claims submenu.

The screenshot shows the CSC INTEGRAL Admin software interface. The top navigation bar includes 'Session Info | Help | Home | Logout'. The left sidebar is the 'Main Menu' with various administrative options. The central area is the 'Claims - Sub Menu'. It has two main sections: 'Input' and 'Actions'. The 'Input' section contains fields for member identification (Client Number, Name, RI Risk Class, Input Currency), ID number, policy number, date of visit, employee number, product code, diagnosis code, and claim number. The 'Actions' section lists several options with radio buttons: Create New Claim (selected), Clear Reserves, Display Claim, Create Remaining Bills, Work With Regular Claims, Enquire Reserves, Modify Claim, Modify Incurred Date, Create New Pre-authorization, Enquire Regular Claims, Create New Claim Occurrence, Modify Diagnosis Code, Work With Reserves, and Authorize Pre-authorization. At the bottom right are buttons for 'Exit', 'Refresh', and 'Continue'.

Notes and comments:

- Product codes are set-up in table T9797
- RI risk classes are set-up in table TR9D0
- Diagnosis codes are set-up in table T9697
- Input currency is set-up in table T3629

16.1 Create new claim

The member/dependent can be identified by FSU client number or id-number (NRIC) or employee number. If the chosen member/dependent has more than one policy, the system will list all the policies under the member/dependent of which one has to be chosen.

Name, date of birth, age, sex and Policy number and employer name are displayed for information only.

Product code, date of visit and diagnosis code are compulsory input. If the product has re-insurance and has more than one RI risk class, then the user has to choose the RI risk class. If the claim currency is the same as policy currency, then the user need not enter any input currency. If the claim currency is different from policy currency, then the user has to enter the input currency and the exchange rate from input currency to policy currency.

16.2 Create new claim occurrence

The claim-id in INTEGRAL GROUP system is 8 digits claim number + 2 digits occurrence number. A claim is entered against a policy/product/insured-life (member or dependent). The claim occurrence number is meant to be used under the following situations:

1. Multiple bills for the same policy/product/insured-life for the same disability at different points of time (example out-patient treatment that leads to hospitalisation or post hospitalisation follow-up treatment or simply separate bills from hospital, surgeon and specialist doctor). For all the bills, the date of visit will be the same which is the date of hospitalisation of the original claim (occurrence number '00').
2. Re-hospitalisation for the same policy/product/insured-life for the same disability within the separation period. The re-hospitalisation can be to the same hospital or a different hospital. For this situation, the date of visit will be different from the original claim.

When the insurer receives a hospital bill for reimbursement, it may not be easy for the users to decide whether this bill should be entered as a new claim or a claim occurrence. Hence the following solution is proposed:

Whenever a bill is received, the users will always enter it as a new claim. The system should have the necessary logic to prompt the user to check whether the bill should be entered as a claim occurrence of an existing claim instead of a new claim. This prompt will be based on the following logic:

- If there is any other claim occurrence against the same policy/product/insured-life having the same date of visit as the current claim, prompt {ignore diagnosis code, provider organisation and date of discharge while looking for a possible match}. This logic will cover situation 1.
- For each previous claim occurrence against the same policy/product/insured-life, let A = Date of discharge + Separation period {ignore diagnosis code and provider organisation while looking for a possible match}. If date of visit of current claim is <= A, prompt. This logic will cover situation 2.

The final decision as to whether a bill is new claim or claim occurrence lies with the user. This means the users can ignore the prompt by the system.

16.3 Modify & Display claim

The claim number + occurrence number should be entered. No other field need to be entered.

16.4 Work with Reserves, Clear Reserves & Enquire Reserves

The claim number (without the occurrence number) should be entered. No other field need to be entered.

16.5 Claims Header

The screenshot shows the CSC INTEGRAL Admin software interface. On the left, there's a sidebar with 'Extra Info' and 'Functions' sections. The main area is titled 'Claim Header' and contains various input fields for claim details. At the bottom right of the main area, there are buttons for 'Exit', 'Refresh', and 'Continue'.

Claim Header			Session Info Help Home Logout	
Claim Number 55000017 00	Date of Visit 01/05/2012	Member 00001 00 Chua Charles Mr	Currency Singapore Dollars	Status CP Claim Pending
Policy 35000110 APPLE INC	Product GHC1	Member Period 01/01/2012 to 31/12/2012	Plan 001	Reversal Link
Diagnosis X-010 HEADACHE	Regular Claim <input type="checkbox"/>		Cause Code Illness	
Policy Period 01/01/2012 to 31/12/2012	Time of Visit 8	Claim Type Normal	Referred By	
Gate Keeper	Who Paid Claimant	Credit Card No	Payment Method -Select-	Cashless N
Provider Organisation 50000245 <input type="button" value="Search"/> Changi Hospital	Date Medical Condition First Known	Date of Discharge	Take-up Claim N	First Report Date 10/05/2012
Death Claim <input type="checkbox"/>	Old Claim No			
Client Claim Reference No	Claim Amount Paid			
Claim Form Received on				

Notes and comments:

- Provider organisation can be selected from client database
- Referred by is selected from client database
- Claim types are set-up in table TR9A1
- Payment methods are set-up in table T3672
- Who paid code is set-up in table TR900

Provider organisation

This is provider organisation visited by claimant. This can be a hospital or clinic or lab or X-ray centre. The value should exist in provider organisation database.

Referred by

If the visit was referred by another doctor or clinic, client number of the referrer.

Claim type

Claim type is a mechanism to set different claim processing rules for different types of claims. Examples of claim type are emergency, non-emergency, ex-gratia etc., Claim type is used in the following places in the system:

Benefit limits -SR9B4

Benefit mapping -SR9B5

Add provider organisation to a network -SR9BM

This field is compulsory input and is defaulted from TR9C6.

Time of visit

This is used to calculate the work hour slab. This field is compulsory input and is defaulted from TR9C6.

Client claim reference number

This field is the claim reference number of the policy owner. Optional input. This is useful to print in client correspondence such as claim statement.

Death claim indicator

Valid values Y or N. If value = 'Y', date of death in client database is updated.

Claim amount paid

This field is to be entered, if an amount was paid to the provider. This field will decide the entries in the claim payee screen SR9CE.

Payment method

If an amount has been paid to the provider, this field indicates the payment method.

Credit card number

If an amount has been paid to the provider by credit card number, this field indicates the credit card number.

Who paid

If an amount has been paid to the provider, this field indicates who paid.

Valid values are:

- C - Claimant
- H - HMO/insurer
- T - Third party

This field will decide the entries in the claim payee screen SR9CE

Date medical condition first known

Self explanatory. If a value is entered, this field is used to find out preexisting condition.

First report date

Date claim was first reported. This field can be before the date of visit.

Claim form received on

Date claim form was received.

Date of discharge

Optional input. Date insured life was discharged from place of service.

16.5.1 Third party claim processor

Click on the option <3rd Party> n the Extra info Box to enter details of the Third Party Claim Processor.

Third Party Claim Processor

Claim Processed By

Reference Number

Session Info | Help | Home | Logout

If a claim is processed by a third party claim processor, this screen captures the relevant details. In INTEGRAL GROUP, a third party claim processor has to be setup in the TPA module and is a client with a special indicator set as 'Third party processor'. The reference number is the number (if any) assigned by third party claim processor.

16.5.2 Follow Up

Click on the option <3rd Party> n the Extra info Box to enter details of the Third Party Claim Processor.

Follow-ups

Policy

35000110

Policy Owner

50000226 APPLE INC

Member

00001 00 Chua, Charles

Select	Code	Status	Reminder Date	Completion Date	
<input type="checkbox"/>	Clinical Abstract Form	Follow-Up Outs			
<input type="checkbox"/>	AWAITING DOCTORS	Follow-Up Outs			
<input type="checkbox"/>	-----Select-----	-Select-			

Add Remove

Notes and comments:

- Follow-up code windowable to T9776
- Follow-up Status windowable to T9777

This screen is used to indicate any follow-up requirement that may be needed in connection with the claim such as doctor's report, proof of age etc.

Valid values of follow-up status are:

- O – Outstanding
- R -Received
- W – Waived

The system will not allow a claim to be authorised if it has a follow-up with status = outstanding (hold code = 55).

16.5.3 Provider case notes

Click on the option <Case Note> n the Extra info Box to enter any provider case notes. This is purely for information.

The screenshot shows a web-based application window titled "Provider Case Notes". At the top right, there is a menu bar with links: "Session Info | Help | Home | Logout". Below the title, there is a section titled "Provider Case Notes" containing six empty text input fields arranged vertically. A "More..." button is located at the top right of this section. The entire interface is enclosed in a light gray frame.

16.5.4 Symptoms

Click on the option <Symptoms> in the Extra info Box to describe the symptoms of the patient.

The screenshot shows a software interface titled "Symptoms". At the top right are links for "Session Info", "Help", "Home", and "Logout". Below the title is a large text area with a header "Symptoms" and six empty horizontal text input fields. A "More..." button is located in the top right corner of this area. The entire window has a light gray background.

16.5.5 Additional claim data

Click on the option <More Data> in the Extra info Box to enter more information on the claim.

The screenshot shows a software interface titled "Additional Claim Data". At the top right are links for "Session Info", "Help", "Home", and "Logout". The form contains several input fields: "Claim Number" (text box with value "55000017 00"), "Medical Leave From" (date range input with start and end date pickers), "3rd Party Recovery Pending" (checkbox), "Pending From" (button with search icon), "TPA Reference Number" (text box), "Inward Number" (text box), "ICD-10 Level-1" dropdown menus (labeled "Select"). The entire window has a light gray background.

Medical leave is the period claimant is on medical leave.

Third party recovery to indicate is the any third party recovery pending.

Pending from is selected from client database and should be entered is Third party recovery checkpoint is selected.

16.6 Claim Details

After Claim Header, the system will display the Claim Details screen. This entire screen is display only (all fields are protected input).

Click on <Add> to add a new claim detail or select an existing claim detail and click on <Modify>, <Delete>, <Display> or <Worksheet> option.

CSC INTEGRAL Admin

Claim Details Session Info | Help | Home | Logout

Extra Info

- Advance Payment
- Claim Reserve
- Prior Accumulation

Functions

- Major Medical
- Add

Claim Number	Date Visit	Currency
55000017 00	01/05/2012	Singapore Dollars
Status	CP Claim Pending	Policy
Provider Organisation	Member	35000110 APPLE INC
50000245 Changi Hospital	00001 00 Chua Charles Mr	Product
Plan	Diagnosis Code	GHC1
001	X-010 HEADACHE	

More...

Active Ind	Select	Date From	Date To	Service Code	Item Code	Inurred	
	<input checked="" type="radio"/>	01/05/2012	09/05/2012	A100	Hosp R&B		

Modify Delete Display Worksheet

Total: 1260.00 Member Co-payment %: 20 Member/HMO Share: 342.00 1008.00

Exit Refresh Continue ➔

16.6.1 Claim details update

CSC INTEGRAL Admin

Claim Details- Create

Session Info | Help | Home | Logout

Date From <input type="text"/> to <input type="text"/>	Service Code <input type="text"/>	Incurred <input type="text"/>
Diagnosis Code <input type="text"/>	External Room Type -----Select-----	Place of Service Not applicable
Invoice Number <input type="text"/>	Payable to Provider <input type="text"/>	
Provider <input type="text"/>	Number of Units <input type="text"/> 1	
Number of Days <input type="text"/>	Benefit Limit Basis <input type="text"/>	
Benefit Limit Not applicable	HMO - Major Medical <input type="text"/>	HMO Share <input type="text"/>
Amount Dissallowed <input type="text"/>	TPA Difference <input type="text"/>	
HMO - H&S <input type="text"/>		
Member Share <input type="text"/>		

Exit / Refresh / Continue ➔

Notes and comments:

- Service code are selected from (Procedure + Drug) database
- Provider is selected from client database (Role = PR)
- POS (Place of service) are set-up in table TR9AD

This screen is used to add a service code (procedure or drug) and its details.

Date from

Start date of service. This is a compulsory input. Presently there is no validation between start date and date of visit entered in sub-menu.

Date to

End date of service. If no value is entered, this date is assumed to be start date.

Service code

This is a mandatory input for Procedure or drug code.

Incurred

Amount charged by provider.

Provider

If the fees depend on individual provider (within the provider organisation) who did the service, this

is compulsory input else it is optional input. If the system expects a value and no value is entered, the system will prompt.

Payable to provider

This is automatically calculated by the system based on the fee schedule method, provider fee schedule and the fee basis. Allowed to over-write if the user profile has authority and subject to % tolerance limits specified in user profile.

Room Type

This is mandatory and can be selected from TRxxx.

Invoice Number

This is mandatory and is a free text field to enter the invoice number.

Place of service

Compulsory input and defaulted from TR9C6. This is one of the variables that determines the fee schedule in network detailed database – screen SR9BM.

Number of days

This is automatically calculated by the system based on the formula entered in T9804 (inclusive or exclusive of end date). Users are allowed to over-write by +/- 1 day.

Number of units

This is used when the fee basis is FLAT. The payable to provider is multiplied by Number of units.

Benefit Limit

The first non-zero benefit limit is displayed for information.

Benefit Limit basis

This is the basis corresponding to that benefit limit. This is displayed from TR9A6.

Member share

This is automatically calculated by the system based payable to provider, benefit limits and member liabilities. Allowed to over-write if the user profile has authority and subject to % tolerance limits specified in user profile.

HMO share

This is automatically calculated by the system based on provider share and member share. Allowed to over-write if the user profile has authority and subject to % tolerance limits specified in user profile.

16.6.2 Claim worksheet

Select the claim detail and click on <Worksheet> option to view the details of the benefit mapping for the specified claim detail.

Claim worksheet			Session Info Help Home Logout																																
Claim Number 55000017 00	Date of Visit 01/05/2012	Currency SGD																																	
Member 00001 00 Chua Charles	Policy 35000110 APPLE INC	Status CP																																	
Provider Organization 50000245 Changi Hospital	Gate Keeper	Member Period 01/01/2012 to 31/12/2012																																	
Product GHC1	Claim Type NM Normal																																		
<table border="1"> <tr> <td>Details 1</td> <td>Details 2</td> <td>Details 3</td> <td colspan="3"></td> </tr> <tr> <td>Plan 001 Gold Plan</td> <td>Area Code</td> <td colspan="3">Diagnosis X-010 HEADACHE</td> </tr> <tr> <td>Service Code A100 Hospital Room & Board</td> <td>Benefit A100 Hosp Room & Board</td> <td colspan="3">Network INSKPJ KPJ - Inside Network</td> </tr> <tr> <td>Fee Schedule KPJIN1 KPJ Inside Schedule 1</td> <td>Fee Basis \$/DY Fixed amount per day</td> <td colspan="3">Pre-Paid N</td> </tr> <tr> <td>Referrals 1</td> <td>Fee Schedule Method 01</td> <td colspan="3"></td> </tr> </table>						Details 1	Details 2	Details 3				Plan 001 Gold Plan	Area Code	Diagnosis X-010 HEADACHE			Service Code A100 Hospital Room & Board	Benefit A100 Hosp Room & Board	Network INSKPJ KPJ - Inside Network			Fee Schedule KPJIN1 KPJ Inside Schedule 1	Fee Basis \$/DY Fixed amount per day	Pre-Paid N			Referrals 1	Fee Schedule Method 01							
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HR Slab NA Not applicable	Provider Capitation NA Not applicable	Pre Authorization N Not applicable																																	
<table border="1"> <tr> <td>Details 1</td> <td>Details 2</td> <td>Details 3</td> <td colspan="3"></td> </tr> <tr> <td>Plan Limits 5000 A/PY</td> <td></td> <td></td> <td colspan="3"></td> </tr> <tr> <td>Benefit Limits 140 A/D</td> <td></td> <td></td> <td colspan="3"></td> </tr> <tr> <td>Plan/Benefit Deductible</td> <td></td> <td></td> <td colspan="3"></td> </tr> <tr> <td>Plan/Benefit Member Co-Payment 20 %</td> <td></td> <td>%</td> <td colspan="3"></td> </tr> </table>						Details 1	Details 2	Details 3				Plan Limits 5000 A/PY						Benefit Limits 140 A/D						Plan/Benefit Deductible						Plan/Benefit Member Co-Payment 20 %		%			
Details 1	Details 2	Details 3																																	
Plan Limits 5000 A/PY																																			
Benefit Limits 140 A/D																																			
Plan/Benefit Deductible																																			
Plan/Benefit Member Co-Payment 20 %		%																																	

This screen is display only and all the fields are protected input. This is the outcome of benefit mapping and is useful to find out how the system calculated the amount payable to provider, HMO share and member share.

16.6.3 Claim advance payment

To make a Advance Payment, click on <Advance Payment> in Claim Details screen.

The screenshot shows the 'Claim Advance Payment' screen. At the top, there is a header bar with the CSC logo, INTEGRAL Admin, Session Info, Help, Home, and Logout links. Below the header is a section titled 'Total Amount Payable' with a value of '1008.00'. A large grid table is displayed, with columns labeled 'Active Ind', 'Select', 'Payee Number', 'Name/Address', 'Batch', and 'Bank Code'. Below the grid are buttons for 'Modify', 'Delete', and 'Display'. At the bottom of the screen are buttons for Exit, Previous, Refresh, and Continue.

Click on <New Advance Payment> to create a new payment.

The screenshot shows the 'Advance Payment Details Create' screen. At the top, there is a header bar with the CSC logo, INTEGRAL Admin, Session Info, Help, Home, and Logout links. The main area contains several input fields: 'Total Amount Payable' (1008.00), 'Payee' (with a search icon), 'Batch Request Indicator' (set to 'Batch'), 'Bank Code' (01), 'Requisition Type' (1), 'Amount' (empty), 'Take-up' (checkbox), and 'Requisition Number' (two empty fields). At the bottom right are buttons for Exit, Previous, Refresh, and Continue.

Notes and comments:

- Payee code is selected from client database.
- Bank code is set-up in table T3688
- Requisition type is set-up in table T3672

The system allows any number of advance payments to be made on a claim. Advance payments are typically required in the following situations:

- Request for a detailed medical report from the hospital
- Settlement of money in full to the hospital within the credit period pending decision on the final outcome of claim

The system does not make any check on the amount being paid in advance.

16.6.4 Claim Reserves

CSC INTEGRAL Admin

Claim Reserves

Session Info | Help | Home | Logout

Claim Number 55000017	Policy Number 35000110 APPLE INC	Product GHC1 Group Health - Hospital Care
Currency SGD	Policy Period 01/01/2012 to 31/12/2012	Member Period 01/01/2012 to 31/12/2012
Diagnosis X-010 HEADACHE	Number of Occurrences 1	Date of Visit of First Occurrence 10/05/2012

Outstanding Reserve Amount

Current	New	Reserve Code/Type
---------	-----	-------------------

More...

Outstanding Reserves	Reserved By	Date Reserved	Cumulative Amount P

Exit / Previous / Continue ➔

Notes and comments:

- Reserve code windowable to TR9DQ

The setting up of claim reserves is controlled by the claim reserve flag in product table TR911. The claim reserve flag has the following three values (TR9DK):

- 1 – Always reserve
- 2 -Never reserve
- 3 -Optional reserving

The system displays the complete history of all the previous reserves transaction on this claim. The cumulative amount paid is also displayed for information. The user can enter the new outstanding reserve amount and an optional reserve code.

When the user exits from this screen, a pop-up window to confirm the reserves will be shown. Upon confirmation, the necessary financial transaction record will be automatically generated.

When the final payment is made on a claim (claim payment batch job followed by payment authorisation or media run), the system automatically offsets the outstanding reserve amount by the amount paid and also creates a record in claim reserve file.

If claim reserve flag = '1', the system does not allow a claim to be approved unless there is sufficient reserves (hold code = 56).

16.6.5 RI Claim Reserves

Screen

When a reserve is entered against a claim, the system automatically does a RI reserve recovery from all the affected re-insurers and the amount of RI reserve recovery is displayed in this screen. When a final payment is made, the system also offsets the RI reserve recovery. However for advance payment, the system does not offset RI reserve recovery.

16.6.6 Prior accumulation

The screenshot shows the INTEGRAL Admin software interface. The top navigation bar includes 'Session Info | Help | Home | Logout'. On the left, there's a sidebar with 'CSC' logo, 'INTEGRAL Admin' title, 'Extra Info' section, and 'Functions' section. The main content area has a title 'Ben. Limits, Mbr. Liabilities & Prior Acc.' and a subtitle 'Policy Period'. It displays plan information (Plan: 001 Gold Plan, Product: GHC1), policy period (01/01/2012 to 31/12/2012), and claim type (NM/NM). It also shows member period (01/01/2012 to 31/12/2012) and plan annual aggregate deductible. Below this is a table titled 'Prior Accumulation & Member Liabilities' with columns: Benefit, Description, Net Level, Year, Month, and Maximum Amount Used Till Date. At the bottom, there are buttons for 'Exit', 'Previous', and 'Continue'.

This screen is display only and all the fields are protected input. It gives the life time, yearly and monthly limits for both amount & visits for each benefit/network level combination. If the benefit code is blank, it is taken as plan level.

16.6.7 Claim Hold codes

CSC INTEGRAL Admin

Extra Info

Functions

Claim Hold Codes

Provider Organization 50000245 Changi Hospital		Gate Keeper	Member Period 01/01/2012 to 31/12/2012	
Product GHC1		Claim Type NM NM	Plan 001 Gold Plan	Fee Schedule Shenton Medical-Inside Network
Diagnosis X-010 HEADACHE		Network INSKPJ KPJ - Inside Network		

Ind	Select	Hold	Description	Authorization	Ser
	<input type="checkbox"/>	55	Follow-ups outstanding	N	

[More...](#)

[Exit](#) / [Previous](#) / [Continue ➔](#)

This screen is display only and all the fields are protected input. The system automatically puts the hold codes during claim adjudication. There are two types of hold codes: those at claim level and those at claim/service code level.

The list of all the hold codes are in table Txxxx attached in the appendix.

The hold codes at claim level are:

01, 03, 04, 05, 06, 07, 08, 09, 11, 12, 13, 14, 21, 22, 53, 55, 71 & 72.

All the remaining hold codes are at claim/service code level.

16.7 Claim Payee details

CSC INTEGRAL Admin

Claim Payee Details

Claim Number 55000017 00	Date of Visit 01/05/2012	Currency SGD
Member 00001 00 Chua Charles Mr	Policy 35000110 APPLE INC	Provider Organization 50000245 Changi Hospital
Current Status CP Claim pending	New Status -----Select-----	Reason -----Select-----
Amount Payable 1008.00	Less Advance <input type="text"/>	Clear Reserves <input type="checkbox"/>
Nett 1008.00	Less Premium <input type="text"/>	

More...

Ind	Select	Payee ID	Payee Name	Batch Request	Bank
	<input type="checkbox"/>	50000231	Chua Charles Mr	B	01

Functions

- Add

Modify Delete Display E

Total Payable
6250.00

Exit Refresh Continue ➔

Notes and comments:

- Payee is selected from client database
- Bank code is set-up in table T3688
- Requisition type is set-up in table T3672

The list of all the claim payees and the amount payable/recoverable against each of them is entered here. The system makes the validation on claim payees as per user defined rules in T9817. The system automatically maps this screen to the advance amount paid for each payee.

When the batch claim payment job is run, the system consolidates all payments against a payee and generates a multi dissection payment requisition. The consolidation is done at the following level:

Branch/Payee/Currency/Provider group/Major class/Requisition type/Bank code

The system also updates the claim data with the payment requisition number. When this payment requisition is authorised, the system updates the claim data with the cheque number.

The system validates that the total amount approved against a claim is equal to sum of (advance + actual) payment of all payees in that claim.

16.7.1 Reinsurance Claim recovery

CSC INTEGRAL Admin

Reinsurance Claim Recovery

Session Info | Help | Home | Logout

Claim Number 55000017 00	Claim Status CP Claim pending	Incurred Date 01/05/2012
Policy No 35000110 APPLE INC	Client No 50000231 Chua Charles Mr	Installment No 00
Member No 00001 00	ID 	Ceding Basis Prem Basis
Product GHC1 (Group Health - Hospital Care)	Plan 001 Gold Plan	Risk Class ???????????

Recovery Details Other Details

More...

Reassurer	Arrang	RI Claim Recovery	Over Written Amount

Exit Previous Refresh Continue ➔

This is the automatic RI recovery from both proportional and non-proportional treaties from all the reinsurers (retro-participant level).

16.7.2 Other claim payments

CSC INTEGRAL Admin

Other Claim Payments

Session Info | Help | Home | Logout

Claim Number 55000017 00	Date of Visit 01/05/2012	Status CP
Member 00001 00 Chua Charles Mr	Provider Organisation 50000245 Changi Hospital	
Policy 35000110 APPLE INC	Processed By 	

More...

Active Ind	Select	Sub-Account Code	Sub-Account Type	Fee Type	Batc

Modify Delete Display

Exit Previous Refresh Continue ➔

Notes and comments:

- SACS code is set-up in table T3616
- SACS type is set-up in table T3695
- Fee type is set-up in table TR958
- Payee is selected from the client database
- Bank code is set-up in table T3688
- Requisition type is set-up in T3672
- Currency code is set-up in table T3629

This screen is used to make non claim payments related to the claim such as third party fees, Taxes (GST), surveyor fees, auditor fees etc. Each type of payment is identified by a SACS code (sub account code) and a SACS type (sub account type). When the SACS code = 'GC' and SACS type = 'FE', the user is prompted to enter fee type and the amount is automatically calculated by the system based on table TR957 (the key for this table is product code + currency + fee type). The other claim payments are also consolidated during claim payment batch job and the system generates one payment requisition for all payments related to the same branch/requisition type/bank code/payee/currency/SACS code/SACS type.