INTEGRAL GROUP

Base System Guide

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1. INTEGRAL GROUP

Introduction

The purpose of this document is to give an overall introduction to the CSC Integral Group base system and to briefly explain the functionality and subsystems. It has been designed so those individuals that are newly introduced to the system can refer to this document as background information. Together with the Integral Financial Services Umbrella (FSU) Base Guide, this document is the base training material and reference guide for General Insurance Company's staff after the completion of the initial structured training.

This document is a condensed version of the system manuals. Should any individual require additional information then it is suggested that a study be made of the particular subsystem manual(s). These manuals will include the program descriptions together with the actual program format itself, a clerical guide and in the majority of instances an explanation of the system module, description and examples of required system tables.

1.1 System Structure

The system has been designed so that it is Client Driven and Parameter driven. (If any of these terms is unfamiliar they will be explained later in greater detail.) In addition to this the system may accommodate the requirements of a composite Life and General Insurance Office. This is achieved by a modular design of the system and the result of this approach is Integral FSU Application and either or a combination of Integral Life, Integral Group and Integral P&C.

1.2 INTEGRAL FSU

INTEGRAL FSU (Financial Services Umbrella) contains the Client Database, General Ledger, Receipts, Media Payments, (Direct Debit and Credit Automatic Cheque Production), Group Billing and Standard Letters.

One of the main differences between this system and computer system of the past is that it is Client Driven rather than contract. This means that everyone that has any dealing with the General Insurance Office is registered as a Client. All the policyholders, beneficiaries, payees will all be registered as a Client in the Client Database. In addition to the normal policy dealings all suppliers of stationery, utilities and normal accounting style transactions will be also required to be clients of the system. The amount of information collected on these clients is of a basic nature, name, address, contact numbers, email, etc. However, in the case of insured you will require extra information like the date of birth. Clients can be a Corporate or an Individual.

So as to distinguish between clients and their dealings with the company the system records Client Roles. These roles can be Client or it could be an Agent, Beneficiary, Payee, etc. The advantage of having a Client based system is that your marketing functions can be centralised, notices and direct debit bills can be collated, etc.

As mentioned above, FSU in addition to the Clients Database holds the General Ledger and Payment System. This enables a composite office to have two, or more if developed, applications using the same General Ledger and Payment System.

1.3 INTEGRAL GROUP Application

The application is the lowest level within the system and will hold all the rules relating to the contracts, such as Product Definition, Method of Payment Change Rules, Commission Calculations and Commission Payment Release Patterns, Surrender Values, Loan interest rates and so on.

In the base system all the rules are held on tables and hence the term table driven. The reason for these tables is so that a flexible approach can be made maintaining contracts and any changes to contract rules can be accommodated by amending tables rather than hard coded programs. The obvious advantage of this system is that changes can be accommodated easily and new products can be designed and set up in a very short period of time, assuming no new programming features are required.

On-line is an expression describing a transaction completing as you commit the change by pressing the enter key fully updating the database immediately. Such things as Sum Insured change can be completed and you can review the results immediately rather than waiting for overnight processing of a batch system. However, there are some transactions that whilst complete in the same day as input there could be a delay prior to reviewing the results, normally only a couple of minutes. The reason for this situation is that transactions, such as, policy issue will need to write a large number of records, accounting, policy history and more and if this was in “on-line” it would hold the record on the screen and inhibit the clerk's efficiency. To assist this, the transaction will go into a background queue freeing up the screen for further input.

Therefore, the system has different methods of processing, On-Line Real Time, online Batch processing and the common scheduled batch processing for things like General Ledger Update.

1.4 Tables

The system makes extensive use of codes and information are held on tables to define the rules and processes required for each type of application and product. A table may hold valid codes with additional information, or may have extra data screen containing further information for each of the code entries.

Some extra data screen tables are dated tables, that is, a “from” and a “to” date can be entered and the information contained on that particular table is valid for that date range. Dated tables cater for alterations to contract rules that apply to specific date range such as legally imposed changes or changes to premium or commission rates.

Some common functions require processing that is specific to a particular product type. In such circumstances, tables are used to point to processing subroutines, for example, renewal and claim processing. These subroutines in turn may also reference other tables during processing. The subroutines delivered with the base system are method based and can be customised and created according to the product's requirements, for example commission calculation methods, premium calculation methods or rounding routines, etc. Since programs access tables to obtain the required subroutines, there is no need for hard coding of these subroutines and subsequent compilation of programs. This approach provides flexibility, since table entries and subroutines can be tailored to individual requirements.

Each code item on a table has a constant format and this format is referred to throughout the system and all documentation contained in the set of Integral FSU and Integral GROUP manuals as the key. In some tables, the item key may consist of asterisks where the key, or part of that key, applies to all cases.

Some table fields exist because an area of processing has been recognised, but little or no functionality has been added to the base system. This is due to the fact that there are so many differing insurance processes and practices that CSC provide the minimum and expect clients to customise these areas.

1.5 Policy Structure

Policy information of an insurance product is structured into three main level of processing in Integral GROUP. This is usually established upfront prior to any processing of the nominated product and appropriate tables need to be set up for validations, system default data, processing and calculation rules, earning, etc.

This structure allows for a wide range of policy types or “product packaging” to be supported by Integral GROUP. They can range from a policy type with simple single-product to complex multi-products policy structure.

1.6 Policy Header

At the top of the policy structure is the policy header. It stores standard information which is common to all policies, such as:

- Policy type and number
- Policy period – inception and expiry dates
- Servicing agent
- Policy owner name and number
- Billing currency, billing type

- Renewal information

Supplementary information may be attached in the policy levels. At the policy header, information such as Owner Long Name, Payor Details, Despatch Address, Direct Debit Details, Follow-Ups, Eligibility Details, General page and Extra Text can be added.

Policy types are also associated with a Company Major Class, Head Office Major Class and Government Major Class. This allows the system to make appropriate grouping in various reports so that financial information can be provided in convenient forms to the various external parties.

1.7 Product / Plan Details

On the next level down is the Product/Plan details. User-defined details are maintained to reflect the information requirements for each type of product. There may be one or many separate products forming the policy. The products allowed for each Policy type can be defined at Policy Type table. The association of product types to policy types is controlled through Table T9799. The system will use this table to verify that correct products are attached only to the permissible policy types.

Within each product, there must be a plan defined. It can be more than 1 plan in a product. Within each plan the limits can be defined, selection of premium method is done and the attachment of benefit templates to a plan.

Generally, insurance companies have different Products marketed thought different channels. These Products can be similar but bears a different Product name or has different benefits that are specially customized for their Broker or channel. In the Integral GROUP system, it is built to enable the different Product types to be configured and should cover most needs for the Insurance Company.

When there is a need for new requirements, programmers can produce a new Product type at any time and add them to Integral GROUP or make changes to the existing Product screens. This will require a discovery phase to study the requirements and the appropriate customization required.

1.8 Members / Headcount Details

On the next level down are the Members to be attached to a plan in the policy. This member will adopt all the values and benefits of the plan.

If the Member details are not found in existing database, it must be created as a client and attached to a plan. The Date of Birth is essential for Members Details. Based on the selection of Coverage basis, the Member salary is required to be entered.

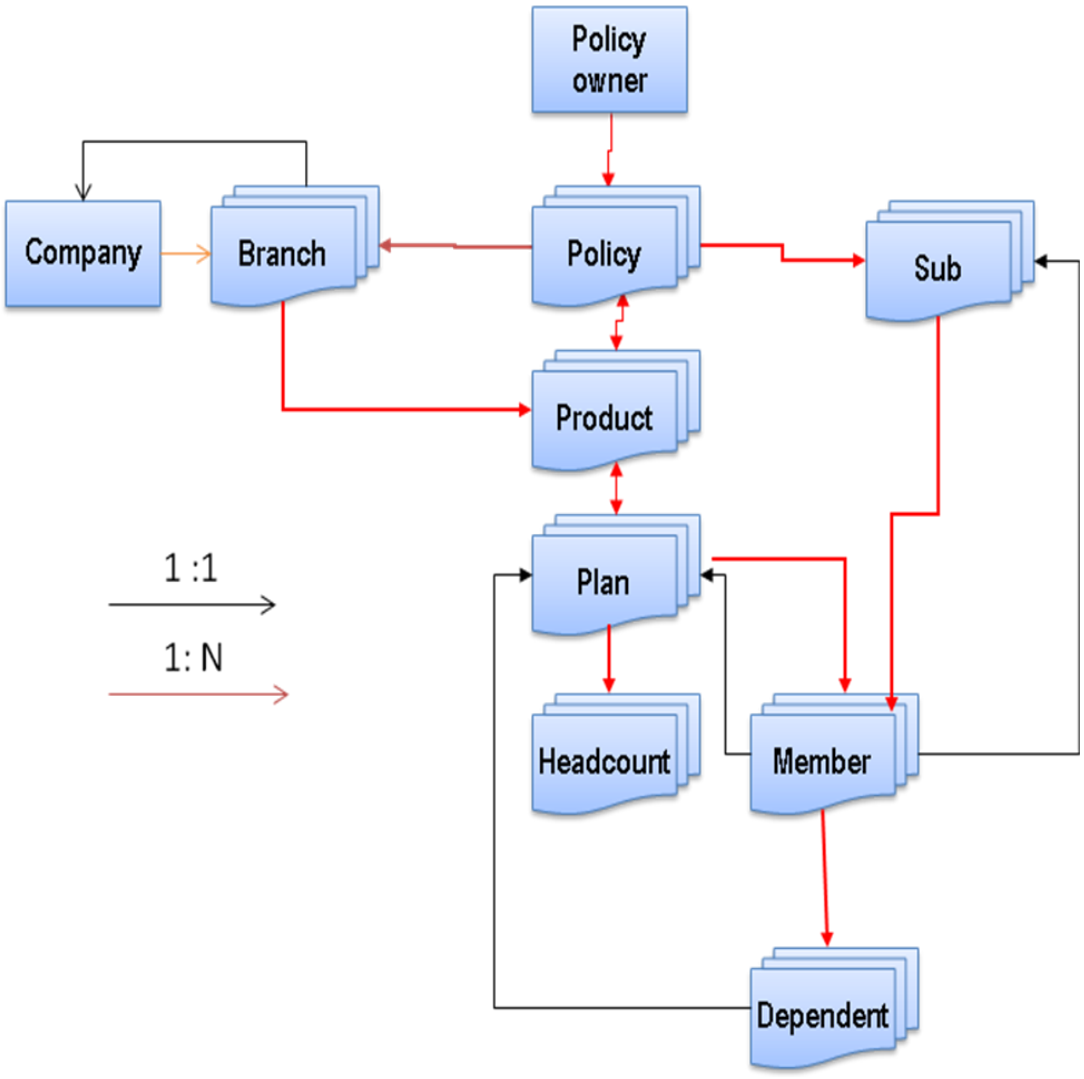
Dependents can be added to the member when the class of insurance covers dependents.

Beneficiary information can be added for each member or dependent.

When the members' details are not available, Integral GROUP offers a Headcount option when only members count, the members' average age and Sum Insured are required.

1.9 Policy Construction

With the above level structure mentioned, the following diagram shows the Group Policy Structure.



1.10 Products Supported

The base system supports the following products:-

Group / Individual Health (Indemnity / Managed care)

- Hospital & surgical
- Major Medical
- Maternity
- Dental
- Outpatient
- Hospital Income

Group Life

- Term Life
- TPD
- Crisis cover (Critical Illness / Dreaded diseases)

Group Accident

- Accidental Death
- Accidental Dismemberment
- Medical Expenses
- Temporary and Total Disablement
- Temporary and Partial Disablement

MRTA

- Death

Group Disability

- Disability Income
- Repatriation Benefit

Group Pension

- Defined benefit pooled
- Defined benefit individual
- Defined contribution individual
- Group Gratuity
- Group Pension / Superannuation
- Group saving linked / deposit insurance
- Leave encashment

2 Underwriting Concepts

Processing of underwriting transactions is menu–driven. For new business, quotation and take-up are all handled online, as are other normal business functions such as major alterations, minor alterations, policy termination and lapses. Considerable use is made of table-based variables, allowing user control over such matter as rates, limits, commission, etc. Policy schedules and billing statements are available online during trial run or in batch print after policy issue. The renewal cycle provides the means of controlling the renewal of policies with policy listing and generation of expiring notices.

2.2 Policy Numbering

Policy number is automatically allocated by the system given the policy types. The automatic number allocation capability allows the inclusion of alpha-numeric characters as a prefix to be concatenated as part of the numbering structure.

The Contract Type Table (T9799) contains the alpha prefix pre-set for Contract and Claims numbers. A maximum of 2 alpha-numeric characters is allowed.

The Auto Numbering Allocation Table (T3642) controls the range of numbers which may be allocated for a particular field and whether a check digit is to be added. The packet size is used in conjunction with the Top Up program to determine how many numbers are to be held for a particular field in the ANUM File.

2.3 Policy Status

The policy status code on the policy header determines:

1. If the policy is In Force
2. If the policy is undergoing renewal
3. If the policy is undergoing an on-line function

When the policy status code is of type 2 and 3 (refer to example below), then the policy is in the process of changing, as it is currently having a function performed upon it. Once the function is completed, the policy will revert to a status code of type 1. In this way, the system is able to check if it is valid to perform a particular function, given the current status of the policy.

Example of status codes

Policy in force status codes	IF	– Inforce
	CA	- Cancelled
	LA	- Lapsed
	QP	- Quotation

Pending Renewal status codes	PR	- Pending Renewal
Pending Status codes	PN	- Pending New Business
	PE	- Pending Endorsement
	CP	- Pending Cancellation
	XN	- New Business awaiting money-in
	XM	- Major Alteration awaiting money-in
	XI	- Billing instalment awaiting money-in
	XR	- Renewal instalment awaiting money-in

2.4 Dates

2.3.1 Commencement Date

This is the date from which the policy is in force. Each time the policy is renewed this date is changed to reflect the new term of insurance. Please note that the system also internally captures and maintains the first commencement date of the policy.

2.3.2 Original Commencement Date

This is the first inception date of the policy and will never change during the life of the policy. It is used to indicate when the policy first became effective.

2.3.3 Member Attachment Date

This is the effective date that a member was attached to a policy. It will never change through the life of a policy. During New Business, the attachment date can be the same as the effective date or a date that is later than the effective date. If a new member is added to a policy during a subsequent policy alteration transaction, then that member will have an attachment date equal to the effective date of the policy alteration. This date is used during claims to verify that the risk selected was in force at the time of the claim.

2.3.4 Effective Date

This date has a huge effect on the processing of the policy. It is entered whenever an underwriting transaction is performed and is subsequently used for rating of premiums, location of reinsurance treaties, claims proving, printing of policy schedule and so on.

2.5 Cash Marry

This feature ensures that policy premium has been received before the policy can have In-force status. Cash Marry is required to be set up at the Company Level in TR9PT and at Company/Branch level in T9804.

The feature applies for premium in the following payment mode:
a) Cash / Cheque / Demand Draft
b) Direct Debit / GIRO
c) Credit Card
d) Debit Card

e) Bank Guarantee
f) Agent Float
g) Cash Deposit

Regarding the Agent Float concept,
1. Agents are given an initial float amount at product level.
2. The system should allow agents to issue the policies against the float amount. If the float amount is insufficient then system should not allow issuance of policies.
3. When the premium amount is deposited by the agent, the system should allow registration of the amount through the receipt creation and replenish the float.

In case of Bank Guarantee, the system should allow issuance of policies against the Bank Guarantee and the premium is assumed paid as long as Bank Guarantee amount is equal to or more than the premium to be collected. When the premium amount is received, then it can be knocked off against the policy premium amount.

For Cash Deposit mode, Corporate Clients usually deposit cash in advance to use for premium against their policies.

Assumptions:
When the settlement mode is Agent Float or Bank Guarantee, the policy is assumed paid as they are covered and hence commission will be released immediately upon debtors posting.

For Refund Premium during Endorsements and Cancellations, the refund premium shall only be applied to Policy suspense.

During an underwriting transaction where premium is required to be collected for the policy, the system will check against table TR9VX on the option to be use. The options are Policy Suspense, Agent Credit and Bank Guarantee.

Upon policy issuance or receipt confirmation, the system will check whether there is enough Policy Suspense to cover the policy premium. If so, reduce / increase the Policy Suspense by the Premium amount and update the ACBL (Account Balance) file.

2.6 Underwriting and Claim Rules

Integral GROUP provides a facility to set up underwriting and claims rules in the user security profile. The security administrator can specify the following limitations on the users.

Maximum Premium Discount
Premium methods allowed to be used
Allowed to over-write claim payable amount (Claim 2)
Allowed to over-write GST type
Claim payable over-write tolerance limits: % minus and % plus.

Allowed to reverse claim payment

2.7 Claim Approval Limit

Integral GROUP provides a facility to set up the claim approval limits in the user security profile.

The details defined in Claim Approval Limit screen may be specified for all contract types or for selective product types. The product types displayed are defaulted from T9797 table.

The Claim Approval Limit can be set for different currencies.

The **Comparison Basis refers to the use of the following date** entered in the Claim screen. The valid values are O = Date of Loss, R = Date Reported and A = Date Approved.

System allows setting of two Claim Approval Limits and an effective date (This Date). The Claim **Limit Before** is used if the Comparison date is before the effective date entered and the Claim '**Limit On and After'** is used when the Comparison date is on or after the effective date.

The validation of the Claim Payee can be turned on or off in this option.

2.8 Coverage Basis

Integral GROUP has a number of options available for the calculation of the Sum Insured.

The Coverage Basis can be found in T9781 and they are as follows:-

01 No of Times Monthly Salary
02 No of Times Annual Salary
03 Fixed Sum Insured
04 Times Monthly Salary + Fixed Sum
05 Difference - Amount and years less now
06 Difference - Max age less now
07 Max (Annual Salary, Fixed SI)
08 Min (Coverage Basis 06, TR911MaxLmt)
09 Percentage of Sum Insured of member
10 Percentage of sum insured of base prod
11 Informed SI - Enter directly
12 Factor * Contribution amount
13 Health Sum Insured

The sum insured field is used to capture the limit of liability, or the limit of cover for interest insured. Note that the total sum insured is passed through the system and used during reinsurance cessions.

2.9 Premium Methods

Integral GROUP has a number of premium methods available for the calculation of the premium amount.

The Premium methods can be found in T9824 and they are as follows:-

01 Group Family Rate - Every Policy
02 Individual Table Rate
03 Individual Policy Rate
04 Premium Method based on Industry
05 Individual fm Rate - Every Policy
06 MRTA - Premium method
07 Individual Policy Rate
08 MRTA-Annual billing-premium method
09 MRTA-int. rate not part of key
10 Informed Premium
11 Individual / Family based on SI
12 Individual / Family based on SI
13 Retail Travel Individual/Float

For the premium method 04, 11, 12 and 13, Integral GROUP provides the module for the user to enter the premium rates.

2.10 Premium

2.10.1 Annual premium

The annual premium is the amount that would be charged if the policy is of 1 year duration. The annual premium is used during renewal and calculation of premiums during policy alterations. The annualized premium for each member can be viewed by using the option 'Annual Premium' in the Work with Member screen during New Business. The figures are protected and served as the reference for the underwriter.

2.10.2 Posted premium

The posted premium will be displayed in the policy enquiry screens under bills. This amount is calculated by system based on the coverage basis, premium method and any other variables e.g. the period of coverage.

2.11 Agent Commission

2.10.1 Commission

The default commission rate can be maintained in a table (TR9I4) for every product/policy type/account type combination. The default commission rate and the commission range can be entered.

When the product screen is visited during policy creation, this commission rate id displayed as default which the user can over-write within the range specified in above table.

There are two separate fields called first year commission percentage and renewal commission percentage and both these percentage can be entered at the time of new business. In this way the users need not remember to change the commission percentage at the time of renewal. The same requirement holds good for over-riding commission percentage as well. The year refers to the policy year and not the member year.

Integral GROUP supports a cap on the maximum commission amount payable in one policy year for one policy/product mix/contribution type. This is true for new business commission as well as renewal commission. It is applicable to insurance products as well as to investment products. However for pure insurance products, contribution type is ignored. The commission here refers to basic commission and does not include over riding commission.

The maximum commission amount payable depends on the following variables:

- Product mix (Insurance or Investment or both)
- Contribution type (Ignored for pure insurance)
- Source of business (agent type)
- New business / Renewal

The maximum New business / Renewal commission amount is the same for all policies having the same product mix and source of business. The maximum should be applied for each policy/product mix combination within one policy year. If a policy has subsidiaries, the maximum is at policy level (sum total of commission from all subsidiaries). The commission amount is the difference between commission payable and commission recoverable (claw back). Commission claw back happens when premium is refunded on a pro-rata basis due to member resignation.

The commission cap users will enter is a yearly cap. If the policy duration is less than a year or more than a year, the commission cap needs to be pro-rated.

The maximum amount defined is before service tax.

2.10.2 Over-riding commission

In addition to the basic commission, a policy can have an over-riding commission paid to a different person. The over-riding commission is expressed as a percentage of the gross premium less all discounts on premium. The over-riding commission percentage can be different for different policies. This percentage will be entered at policy/product level (what this means is the over-riding commission for a rider can be lower than the base product).

Integral GROUP has a facility to set-up the default over-riding commission percentage and a range (indicating the minimum and the maximum) for the over-riding commission percentage. When the over-riding commission percentage is entered, the system should validate that it is within this range. The person receiving the over-riding commission can be different for different policies. This person will be entered at the policy level.

For policies with several subsidiaries, the over-riding commission will apply to all the subsidiaries. The system will only support a maximum of two commissions on a policy.

Over-riding commission is optional. All policies need not have over-riding commission. Hence the over-riding commission fields are optional input. Over-riding commission is applicable to all types of bills (normal bill, adjustment bill & provisional bill).

2.10.3 Commission payments

A batch job G3AGTPAY is required to be submitted so as to auto generates the payment requisitions for commission payment when it is due. There is no fixed cycle and system allows the flexibility to pay commissions on Daily, Weekly, Fortnightly or Monthly or on fixed dates of a month

Integral GROUP maintains a commission record for every bill and every contribution batch. The system should release a commission record for payment only if all of the following conditions are satisfied.
- Premium / Contributions corresponding to the bill or contribution batch has been received in full
- Agent has a valid license at the time of commission payment
- All cheques associated with the receipts corresponding to the bill or contribution batch has been realized.

There are 3 new fields are in the Integral Group Agent screen - License number, License Expiry Date and Lines of business. The system validates that an agent whose license has expired cannot be servicing an in-force policy or be receiving commission. The batch job that creates the commission payment transactions for payment will check if the agent has a valid license on the date of receipt of premium. If the license has expired, the commission should be withheld and should not be passed for payment purpose.

3 Underwriting Terms

3.2 Overview

Integral GROUP's Underwriting module provides a complete environment for the administration of policies, allowing full control over a policy at all stages of its existence. It is fully integrated with other functions/modules in Integral GROUP such as Claims, General Ledger and Debtors, ensuring data integrity throughout the system

The New Business function enables the creation of new policy or conversion of a quotation into new business. The screen flow as you complete the data entry of each will provide guidance to the information required. Basically, the process will navigate through the policy header, risk creation, premium posting, and reinsurance cession. The new business can either be issued at the end of the data entry or left pending (saved) for further review or additional data input.

All products follow the same New Business process and system will prompt for the relevant additional data to be entered for specific products such as MRTA.

This following defines the terms commonly used in the Integral GROUP policy administration system.

3.3 Policy

A Policy is a contract between one group (the group can be an Employer group, Creditor-Debtor group, Professional group, Association, Union, Affinity group, etc.) and the insurance company.

A policy is identified by a system generated unique 8-character coder. A policy can be for one company or a holding company with several subsidiaries under it.

3.4 Policy Type

A Policy Type is an attribute of a policy that indicates the nature of products covered in the policy. Policy type can be Group Term Life, Group Health Policy, Investment Policy, etc.

Each policy can have only on policy type. Moreover, the policy can have any of the following product mix:

- 'INS' - Insurance products only
- 'INV' - Investment products only
- 'BOTH' - Both investment and insurance products

“Product mix” decides what type of products goes into a policy.

Integral GROUP allows the savings products and the insurance products to be defined in the same policy. The system also allow more than one investment product in the same policy.

3.5 Benefit

A benefit is used to identify the risks that are covered under a product. Thus, a benefit represents an event under which a claim is payable.

Examples of benefits are as follows:
Yearly Renewable Term Life Product:

- Death

Total and Permanent Disability Product:

- Death
- Total and Permanent Disability

Group Health and Surgical:

- Room and Board
- Intensive care unit
- Surgery
- Operating theatre expenses
- Anaesthesia
- Hospital Miscellaneous Services
- Consultation
- Physician visit
- Medicines
- Diagnostic X-rays

Gratuity / Pension / Superannuation Product:

- Normal retirement
- Early retirement
- Late retirement
- Death
- Disability
- Retrenchment
- Resignation
- Withdrawal (partial surrender)
- Permanent departure from country
- Leave Encashment

Each benefit is identified by a user defined 4-character code. A product can have any number benefits defined under it. The same benefit can be used in more than one product.

3.6 Product

A Product is used to identify what the insurance company sells. Examples of product are Yearly Renewable Term Life, Total and Permanent Disability, Loan/Mortgage protection, Critical Illness, Hospital and Surgical, Accidental Death, Gratuity, Pension/Superannuation, Annuity, etc. Each product is identified by a user defined 4-character code. Products include base product as well as riders. A product can be a type of investment or insurance.

A policy can have any number of products under it. Different policies can have different product list. The users can mix insurance products and investment products under the same policy.

3.7 Plan

A Plan represents a grouping of similar members under a common category. This grouping is important because the list of products rules as to who is covered, eligibility rules, benefit amount/sum insured etc., are defined for the plan as a whole. All members under the same plan will be subject to the plan rules.

Examples of plan:
Employer-Employee Group

- Directors
- Managers
- Supervisors
- Admin staff
- Workers

Each plan is identified by a system generated 3-digit number.

Plans should be based on the definition and requirements of each employer group. For this reason, the scope of a plan is only within a policy. This means that Plan 001 under one policy could mean Managers while Plan 001 under a different policy could mean Directors.

A plan can have any number of products under it. Also, the same product can be shared by more than one plan. Hence, the relationship between plans to product can be many to many. A plan can be administered on a named member basis or headcount basis.

3.8 Premium Class

A Premium Class is used to identify the lowest level at which a General Ledger entry can be posted. Each premium class is identified by a user defined 3 character code. A premium class should be defined for each policy type and product combination.

3.9 MRTA Product

One of the products offered in Integral GROUP is the Loan protection insurance which is a form of personal insurance designed to protect an individual against the borrowed loan amount from a bank in the event of death of the borrower. It serves both short-term (typically unsecured) and long term (secured, e.g., mortgage repayment) loans. It insures the life of the borrower for the amount equivalent to the outstanding balance of a specific loan.

The insurance company pays out the sum insured (outstanding loan amount) as at date of death in full on the death of a borrower. The insurance company receives all the premiums through the financial institution. The premium can be a single premium or yearly premium or monthly premium. For single premium, the premium rate typically depends on loan period, interest rate, age and sex.

The pricing of the insurance policy is done on an individual basis but the administration is done on a group basis under a single group policy covering all the borrowers. The policy is an open ended policy with no end date. The insurance cover for each member starts from the date of loan and the period of cover is for the entire loan period. This means each member of the group policy will have a different start date and end date depending on date of loan and the loan period. The sum insured at the time of member enrolment is the loan amount.

The sum insured can reduce once a month or once a year or at level sum at X years of flat + decreasing sum insured on a monthly or yearly basis. The MRTA schedule is stored and can be viewed at member level.

If the member is terminated the Member Status Code is also changed accordingly (FS, CI). If there is a death claim on member – the member status is automatically updated to ‘DE’ when the death claim is authorized. Member Status Codes are listed in the table TR9QR.

The Member Status Code and the In-force flag are displayed on the ‘Work with Member’ screen.

Cancel from inception refunds all the following financials for that member by transferring the money to member level subsidiary ledger GM/SM.

- Single Premium
- MRTA Fees (if any)
- Stamp duty (if any)
- Service Tax (if any)

Integral GROUP has a batch job to automatically reduce RI sum insured based on Loan schedule. The RI sum insured will be reduced monthly or yearly (depending on decreasing frequency defined in policy type table) for all MRTA policies at member level.

The following are the policy terms and processing specific for MRTA policy.

3.8.1 Joint Lives

For MRTA policy coverage can be for Single or Joint Lives and the option allowed must be set up in table TR9JJ.

The coverage cannot be extended to more than two people and the age difference between the first and second life should be less than or equal to user defined X no. of years. The term of loan under consideration should be above user defined X no of years.

The system can support any number of joint lives (up to a maximum of 99). Each joint life will have the same member number as the main life but a different dependent number The premium rate is retrieved using the average age of joint lives for premium computation. The average age is not the algebraic average and should be obtained from a user defined chart/table

The loan details are kept against the main life and no loan detail will be kept against the joint lives.

Claim can be against any life. The outstanding loan amount in insurance schedule is payable upon death of any one of the joint lives. The main life and the all joint lives should be automatically terminated. No refund of premium in the event of death claim

When one of the joint life or both the joint lives is a sub-standard risk, there is no difference to the logic for calculating the standard premium. System allows percentage loading to be applied against any one or the two joint lives. All extra premiums should be calculated as a single premium from the date of inception / cover commencement date.

3.8.2 Formula for MRTA Loan Schedule

The MRTA loan schedule depends on the following variables

- Loan term (in months)
- Loan Interest rate (in months)
- Loan amount
- Moratorium (in months)
- Sum insured decreasing frequency (monthly or yearly)
- Is interest payable during moratorium period?

3.8.3 MRTA Loan Schedule Formula – No Moratorium

Let interest rate = A % per annum
Let B = Loan duration in months
Let C = Loan amount

Calculate the following **(^ means to the power of)**
T1 (rounded to 6 decimal places) = ((1 + (A * 0.01)) ^ (1/12)) - 1
T2 (rounded to 6 decimal places) = 1 / (1 + T1)

T3 (rounded to 6 decimal places) = T2 ^ (B)
T4 (rounded to 6 decimal places) = (1 – T3) / T1
EMI (rounded to 2 decimal places) = C / T4

Loan outstanding at the beginning of month / year n (n = 1 to loan duration B)
An (A1, A2, A3…. An)
An = A(n-1) - (EMI – (T1 * A(n-1)))

Let us understand this by the following example:
A = 9 %
B= 24 months
C = 500,000
T1 = 0.007207
T2 = 0.992844
T3 = 0.841680
T4 = 21.966547
EMI = 22,761.88

Loan Schedule

500,000	480,841.78	461,545.48	442,110.10	422,534.64
A1	A2	A3	A4	A5

The system generates and stores the schedule against the policy/member. The Schedule will never change during the life length of the loan even if there are partial capital repayments or change of interest rates.

3.8.4 MRTA Loan Schedule Formula – Moratorium

This formula has interest paid during moratorium.

Let interest rate = A % per annum
Let B = Loan duration in months
Let C = Loan amount
Let D = Moratorium (duration in months)

Calculate the following **(^ means to the power of)**
T1 (rounded to 6 decimal places) = ((1 + (A * 0.01)) ^ (1/12)) - 1
T2 (rounded to 6 decimal places) = 1 / (1 + T1)
T3 (rounded to 6 decimal places) = T2 ^ (B – D)
T4 (rounded to 6 decimal places) = (1 – T3) / T1
EMI (rounded to 2 decimal places) = C / T4

Loan outstanding at the beginning of month / year n (n = 1 to loan duration B):
An (A1, A2, A3…. An)
If n <= (D +1)
An = C Else An = A (n-1) - (EMI – (T1 * A (n-1)))

3.10 Travel Product

Travel insurance covers the risks during travel. The risks may be caused due to accident or natural causes. Depending up on the type of travel the policyholder wish to undertake, the Insurance companies adds different types of benefits.

Extension of travel policy depends on Trip type and Visa Type.

- No extension is allowed for multi trip policies as multi trip policies are yearly policies.
- Extension of travel policies can be done only for Single trip policies.
- No extension is allowed for single trip policies if the visa type is immigrant.

The following are policy terms and processing specific to Travel policies.

3.9.1 Trip type

Trip type is of two types, Single trip or Multi trip. This field will be having the value Not applicable and will be protected from entry for non travel products.

3.9.2 Total/Min man days and Man days deduction

These values are used in the batch job. Refer to section 3.8.6.

3.9.3 Premium rate

Mandatory input if Total/Min man days are entered.

3.9.4 Travel Data at Member Level

The following value can be entered in the Travel Data page at Member level:

- Travel Type
- Travel Zone
- Purpose of Travel
- Travel Duration
- Visa Type
- Visa Number
- Visa Duration
- Three Nominations
- Student Travel
    - Type of course
    - Sponsor
    - University
    - Course duration
- Passport
- Travel to Date

3.9.5 Travel Premium Method - 13

Premium method 13 is applicable only for Travel Products. The premium may be expressed as absolute amount or per man day rate.

For Family floater there is only one premium for the entire family based on the number of adults and number of children in the family.

The following variables are used to decide the premium:

- Policy Type
- Product
- Trip Type (Single or Multi trip)
- Travel Zone (Countries of travel)
- Individual or Floater
- Age
- Travel duration (number of days of travel)
    - The Premium can be an absolute Premium or Premium per man day.
    - If the Premium is per man day – Travel duration is not applicable.
    - If the premium is an absolute amount, travel duration is applicable.

The premium for trip extension would be calculated in two ways.
Total trip period including initial period and extended period is less than or equal to 180 days. The premium would be charged calculating the difference in premium applicable for the total period less the initial policy period.

Example:

Age = 45 years
Initial trip period (Days of travel) = 21 days
Number of days extended = 75 days
Total trip period after extension = 96 days
Premium amount for initial trip = $ 710 of 21days
Premium amount for total trip of 96 days = $ 2,542
Premium amount for extended trip = $2,542 – $710

3.9.6 Billing Job for Open ended Travel man-days Policies

Group travel policies are also issued with man days. The premium rate for this policy is defined as per man day rate. The man-days are captured at policy/product level.

As and when a member undertakes a trip, he is added to the policy and his/her travel duration will reduce the balance man days available at policy/product level to the extent of that member's trip duration.

A Group policy may also be issued with open ended members i.e., where the end date of travel of a member is not known. Minimum retention days are kept at policy/product level. Minimum retention premium is minimum retention days multiply by per man day premium rate.

Whenever a member is added,
a) If the trip end date is already known, deduct the corresponding man days (equal to trip duration) from the balance available under the policy.
b) If the member is open-ended, i.e. trip-end date is not known; deduct man days as per value defined in product level.

End date for open ended members: For open ended members, trip duration is not known and system calculates the end date for open ended members. This is equal to member attachment date + Number of days defined for open ended policy at policy/product header level.

When a member is terminated prior to the actual manual end date, the unutilized number of man days should be credited back to the balance of Product level man days.

At the time of renewal the unutilized man days which are in excess of minimum retention days are to be carried forward.

3.11 Pension Product

In general, a pension is an arrangement to provide people with an income when they are no longer earning a regular income from employment usually under per-determined legal and/or contractual terms. A recipient of a retirement pension is known as a pensioner or retiree.

In this section, the business functions and terms relating to Group Pension product processing in Integral GROUP system are document here.

3.11.1 Defined Contribution Schemes

A Defined Contribution scheme is basically a deposit administration scheme where the investment returns credited to the fund are at the discretion of the company. Contribution level is defined. Contributions as well as bonus units will be credited to individual employee's account. At the end of each financial year statement showing opening balance, contributions received and bonus units credited during the year together with closing balance for each member will be furnished.

On withdrawal due to resignation, retirement or on death accumulated contributions (account balance based on current unit price) is used to calculate the benefit amount payable.

The defined contribution scheme will be based on the following product specifications:

- Unit-linked deferred pension plan
- Optional life cover (through Term rider)
- Top-up contributions allowed
- The risk premium & charges deductible from employer float account
- Investments in a judicious mix of equities and debts
- Investments returns are converted into bonus units
- Guaranteed unit value of the units
- Death benefit: accumulated units for purchase of annuity
- Maturity benefits: accumulated units for purchase of annuity

3.11.2 Defined Benefit Schemes

Contribution level is defined. Contributions as well as bonus units thereon will be credited to individual employee's account. At the end of each financial year statement showing opening balance, contributions received and bonus units credited during the year together with closing balance for each member will be furnished.

On withdrawal due to resignation, retirement or on death, the insurer will pay predetermined benefit on happening of event as stated above. This amount may be less or more than the accumulated contributions (account balance based on current unit price). Such difference will be charged back to the client.

3.11.3 Investment Fund

An Investment Fund is a vehicle for collecting investor's funds which are to be invested in a securities portfolio by an investment manager. Investment management is the process of investing and managing a sum of money or other assets over a period of time in order to generate an income or a profit. Each fund managed by the insurance company represents an investment choice that is available for the employer and/or employee. Examples of investment funds are Capital guaranteed fund, Money market fund, Equity fund, Bond fund etc., A fund is typically characterized as a guaranteed or low risk or medium risk or high risk fund. A fund can be a unitised fund or interest bearing fund.

An investment fund is identified by a user defined 2 character code.

3.11.4 Contribution Type

The following three types of contributions exist:

1. Regular monthly contributions on an on-going basis
2. Transfer-in i.e. Transfer of accumulated account balances when an employer changes from one insurer to another insurer or when an employee changes job. Transfer-in can be at policy level or policy/member level.
3. Ad-hoc contributions with no pre-defined frequency

There are many sub-types of Regular contribution. Some examples of subtypes are:

1. Regular contribution
2. Past service contribution
3. Voluntary contribution

Contribution can come from employer or employee or both. In GROUP/Asia, contribution type identifies the type, sub-type of contribution and who it comes from. One contribution type should be defined for each combination of contribution type, sub-type and who it comes from. It will be identified by a user defined 3-character code. There will be no restriction on the number of contribution types the user can define.

3.10.5 Investment Strategy

Investment Strategy refers to the percentage allocation of the contribution amount among the various available investment funds. A default investment strategy is defined at policy/product level with an ability to override at member level.

The investment strategy may or may not depend on contribution type. If the investment strategy does not depend on contribution type, the employer and employee contributions get invested in the same investment fund(s) in the same proportion. In other words, the employee and employer contributions may not get invested in the same investment fund.

3.10.6 Benefit Design

The following system controlled benefit designs are currently supported by the system:
DCI - Defined Contribution Individual
DBE - Defined Benefit Employee (Pooled)

'Individual' refers to the situation where the breakdown of the contribution amount is given by individual employee. A separate account is maintained for each employee.

'Pooled' refers to the situation where no breakdown of the contribution amount is given by individual employee. Pooled is typically used for group gratuity cash accumulation system where contributions comes only from the employer.

For Defined Contribution, only by individual basis is currently available.

The Benefit Design indicator is defined at policy/product level. An investment strategy can be defined for all of the above 3 values.

3.10.7 Allocation Rate

The allocation rate is the percentage of a premium which is used to purchase units.

3.10.8 Bid Price

Bid price is the price at which units are bought (bid for) from the policyholder. The bid price is less than the offer price.

3.10.9 Offer Price

Offer price is the price at which units are sold (offered for sale) to the policyholder. The offer price is greater than the bid price.

3.10.10 Premium Redirection

Premium Redirection is the alteration of investment strategy or fund distribution for future premiums.

3.10.11 Fund Switch

Fund switching is the process of transferring units between funds.

3.10.12 Preserved Benefit

Preserved benefits are pension/superannuation benefits that are retained until the member retires. The preserved part of the benefit can be withdrawn on cases such as:

- Retirement,

- Member becomes totally and permanently disabled,
- Death,
- Obtain release on specified or financial hardship grounds, etc.

In GROUP/Asia, each type of fund can be classified as Preserved or Unpreserved benefit.

3.10.13 Trustee

A Trustee is a person or a company appointed under the terms of the trust deed to make sure that the scheme is operated in accordance with the trust deed.

3.10.14 Interest Bearing Funds and Unitise Funds

Single or multiple Investment funds can be set-up by the user. The system supports both interest bearing and unitised funds.

Refer to section 4 for the setting up of Interest Rates and Fund prices.

3.10.15 Contribution Frequency

The following contribution frequencies are supported:

- Monthly
- Quarterly
- Half-yearly
- Yearly
- Ad-hoc (no pre-defined frequency)

3.10.16 Default Investment Strategy - policy/product and policy/member level

The policy/product should have a default investment strategy. The system will allow multiple investment funds. The investment strategy may or may not depend on contribution type. If the investment strategy does not depend on contribution type, the employer and employee contributions get invested in the same investment fund(s) in the same proportion. If the investment strategy depends on contribution type, the employer and employee contributions will get invested in different investment fund(s).

Individual member under a policy is allowed to have his/her investment strategy. If a member has no investment strategy, the default strategy at policy/product level is used.

3.10.17 Employer Float Account

The employer float account will be used for the following situations:

- Use it as policy suspense account when entering a receipt for contribution received
- Refund of excess contributions during member termination
- Refund of risk premium when there is a decrease of sum insured or during member termination
- Unvested money during member termination
- Unvested money during bulk transfer
- Offset future contributions
- Deduct risk premium
- Deduct membership fees

The employer float account will be invested using its own investment strategy and will earn interest. However, the employer float account is not part of the gratuity or superannuation fund.

3.10.18 Fee Processing

The types of fees available are as follows:

- Contribution fee
- Member flat fee (during addition and renewal)
- Management charge (asset based fee)
- Switching Fee
- Premium Redirection Fee

Contribution fee and member flat fee are deducted from Employer Float account. Management charge and switching fee is taken from the fund by selling units.

3.10.19 Comprehensive Benefit Payment System

Benefit payment happens when a member resigns or retires or when a death claim happens.

The Benefit Payment system will automatically calculate the amount to be payable upon registration of a claim.

The amount payable depends on the following:

1. Claim benefit
2. Vesting rules
3. Type of benefit (Defined Benefit or Defined Contribution)
4. Unit price
5. Account Balance
6. Preservation rules

The system will not allow partial withdrawal / surrender. The system will display a breakdown of the amount payable for each contribution type / investment fund. When the termination of a member is authorised, the system will automatically generate a payment requisition.

3.10.20 Lump Sum Claim Payments

All claim and benefit payments from the system will be a single lump sum payment. Regular claim payment is NOT currently supported.

3.10.21 Regular Contribution Processing

The system supports the following contribution types:

- Regular – Employee
- Regular – Employer
- Past Service – Employee
- Past Service – Employer
- Transfer-in – Employee
- Transfer-in – Employer

The regular contribution processing will be completed based on the following rules:

a) There will be no contributions from a terminated member for an incomplete month
b) For newly joined employees for the first month which involves fraction of a period, the actual earnings for the month cannot be exactly determined by the system because of the variations of the different pay roll systems among different employers. Hence, the system is not expected to calculate the pro-rated earnings. For such members, the actual earnings for the month will be notified by the employer based on which the system can calculate the actual contributions.
c) A contribution batch will not be processed unless the expected bill and the money are received.
d) No contributions will be paid by an employer without an expected bill
e) For each policy, there will be only one Regular Contribution batch per contribution frequency

3.10.22 Transfer-in Contribution Processing

The system should support both bulk transfer-in and individual transfer-in. Following are the differences between Transfer-in and regular contributions.

- There is no expected bill for transfer-in. The actual contributions will be entered by the user.
- The contributions for transfer-in are different from regular contributions
- Transfer-in can be at Policy level or Policy/Member Level where as regular contributions are always at policy level
- Transfer-in is considered single premium whereas regular contributions are considered regular premium

- Contributions from regular contributions are attributable to a contribution period where as contributions from transfer-in is not attributable to any contribution period.

3.10.23 Member Termination

The system will use the last date of employment as the date of termination of a member.

When a request for termination of one member from a policy is registered, the system will check for the following:

- All contributions have been received and processed for the previous months.
- No contributions have been received on or after termination month.

For example, if the request is to terminate a member with effect from 10th September 2008, the termination will proceed, if all contributions have been received up to August and no contributions have been received for September or after September. However if the request is to terminate a member with effect from 30th September 2008, the termination will proceed if all contributions have been received up to September and no contributions have been received for October or after October.

When the termination of a member is authorised, the system will check the unvested amount rule. If the rule is to offset against future contributions, the system will automatically transfer the unvested amount to unvested amount (leavers) – to be used to offset against future contributions.

3.10.24 Features on Unitised Investment Funds

System supports both historic pricing (now basis) and forward pricing (deferred basis) as well as both buy price (offer) and sell price (bid) for each transaction.

3.10.25 Automatic update of General Ledger

The following processes should automatically generate the financial transaction records for automatic update of general ledger:

- Unit allocation / De-allocation
- Interest capitalisation run

3.10.26 Automatic Reinsurance Processing

The following processes should automatically carry out the reinsurance processing:

- Unit allocation / De-allocation
- Interest capitalisation run

3.10.27 Investment Switching

Defined Contribution:
The system supports investment switching at the following levels:

- Policy/product Level
  - The switching is bye Percentage only.
- Policy/product/member Level
  - The switching can be either in Percentage or Amount. The existing account balances prior to switching are displayed.

For interest bearing funds, the account balance displayed includes the interest from the last capitalisation run till date based on interim interest rate.

Defined Benefit (Pooled Approach):
The system supports investment switching at the following levels:

- Allows switching from a unitised fund to an interest bearing fund or vice-versa
- Allows part or full account balance to be switched.
- Switching price rule
  - Selling (bid) / Buying (offer)
  - Buying (offer) / Buying (offer)

3.10.28 Shortfall on Regular Contribution Batch

Integral GROUP allows shortfall on regular Contribution Batch payment (policy level) up to a certain maximum amount. The shortfall amount will be included in the total amount required for the next contribution batch. Hence, the regular contribution batch can now be processed even if the money available is less than the amount required provided that the shortfall is within the maximum specified amount.

- The system supports different shortfall rules for different contract types.
- The shortfall will be calculated per contribution batch at the policy level. The maximum shortfall amount will be determined by one of the following rules (stored in a new user-definable table):
  1. As a percentage of amount required (including the carry forward shortfall)
  2. A flat amount. If only one rule is specified then that rule will be used to calculate the maximum shortfall amount. If both rules are specified then the lesser of the maximum amounts will be used. Lastly, if both rules are not specified then the shortfall is not allowed.

Interest charged on the shortfalls should be made optional. If interest is to be charged on the shortfall amount then the system will calculate the negative interest on those shortfall amounts at the same time during the interest capitalisation job. These interests will be calculated similarly to the interest on the float account but with the reverse sign.

3.10.29 Loyalty Bonus

Loyalty Bonus is some form of reward given to clients at the policy anniversary.

Integral GROUP supports the loyalty bonus as follows:

- Loyalty Bonus is allocated on the policy anniversary for policies wherein 'Loyalty Bonus' indicator in the Policy Header is set to 'Y'
- Additional units are allocated in equivalent percentage e.g. 0.2%, of the average fund balance during last policy year.
- Loyalty Bonus Rate is defined in table TR9Q6
- Loyalty Bonus Allocation by Contribution Type is defined in table TR9Q7
- Assumption is that all policies with Loyalty Bonus will have a policy year of 12 months.
- Calculation of loyalty bonus is as follows:
  - The fund balance at the beginning of each calendar month during the policy year will be determined to find out the average fund balance during the last policy year.
  - The number of months will be based on full month with the 1st day of the month as the starting day.
    For example:
    1. Policy Period = 01/12/2008 to 30/11/2009
       Full Months are 01/12/2008 to 31/12/2008
       01/01/2009 to 31/01/2009
       01/02/2009 to 28/02/2009
       01/03/2009 to 31/03/2009
       01/04/2009 to 30/04/2009
       01/05/2009 to 31/05/2009
       01/06/2009 to 30/06/2009
       01/07/2009 to 31/07/2009
       01/08/2009 to 31/08/2009
       01/09/2009 to 30/09/2009
       01/10/2009 to 31/10/2009
       01/11/2009 to 30/11/2009
       Total No of Full Months = 12
    2. Policy Period = 15/12/2008 to 14/12/2009
       Full Months are 01/01/2009 to 31/01/2009
       01/02/2009 to 28/02/2009
       01/03/2009 to 31/03/2009
       01/04/2009 to 30/04/2009
       01/05/2009 to 31/05/2009
       01/06/2009 to 30/06/2009
       01/07/2009 to 31/07/2009
       01/08/2009 to 31/08/2009
       01/09/2009 to 30/09/2009
       01/10/2009 to 31/10/2009
       01/11/2009 to 30/11/2009

Total No of Full Months = 11

- The unit price on the 1st of every calendar month will be used. Deferred Pricing will be used by default unless Allocation/De-allocation Basis is defined in table TR93U.
- If no unit price is available on the 1st e.g. Public Holiday, the last known Unit Price before the 1st of the month will be used.
- Fund Balance = Number of units * Unit Price
- Average Fund Balance =

  Sum of Fund balance on 1st of every calendar month /

  No of Months

  If the Start Day is '01':
  - Sum of Fund Balance on 1st of every calendar month will Sum of the Fund Balance for 12 months
  - No of Months will be 12

  If the Start Date is other than '01':
  - Sum of Fund Balance on 1st of every calendar month will Sum of the Fund Balance for 11 months
  - No of Months will be 11
- Loyalty Bonus = Loyalty Bonus Rate x Average Fund Balance
- Loyalty Bonus per Fund = (Loyalty Bonus x Fund Allocation %) / Unit Price

Note: Please refer to attached document for sample cases.

The Loyalty Bonus is processed by the Policy Anniversary Batch job (G3POLANV). Once Loyalty Bonus is allocated, the following accounting entries will be posted accordingly:

Dr Loyalty Bonus (GT/LB)
Cr Fund (GT/IN)
Cr Bid-Offer (GT/BO)

4 Unit Price/Interest Rate

4.2 Unit Price Entry

The Unit Pricing subsystem is required to provide the facilities for entering and maintaining prices for the investment funds held by the system.

The unit price can be entered in the system either by entering the Bare Price as the basis to calculate the Bid/Offer prices or by directly entering the Bid/Offer prices. All price inputs are batched by the use of a job number entered from the submenu. This job number must be unique within any given date so price entries are identified by both effective date and job number.

For Bare prices entered under a specific date and job number, the user can select to calculate the corresponding Bid and Offer prices. The system uses the differential rounding information from the new Investment Fund Details table (TR93C) to calculate the Bid and Offer prices.

Bid Price = Bare Price * Rounding of Bid/Offer (TR93C)
Offer price = (Bid Price * 100) / (100 - Bid/Offer Differential (TR93C))

Prices do not become effective for use by the rest of the system until they have been activated by using this option. Activation is performed upon all prices in a specific date / job number batch.

4.2 Interest Rate Entry

For interest bearing funds, interest will be credited to member and employer account periodically based on the performance of the fund. The performance of an interest bearing fund is indicated by the interest rate which is a % return on the underlying assets based on the actual account balance on an exact day basis. This facility is used to enter and maintain the interest rates.

There are two types of interest rates namely interim and final. This is best illustrated by the following example. Assume an insurer declares and credits interest once a year. Let us further assume that the financial period coincides with the calendar year – 1st January till 31st December of each year. Assume the period under consideration is 1st January 2003 to 31st December 2003. The final interest rate for this period will be known, say in the second week of January 2004. However there is a need to process the member terminations (due to resignation/death etc.,) during year 2003 when the final interest rate is not known. This will be done by declaring an interim rate in advance for the period 1st January 2003 to 31st December 2003 say in the last week of December 2003. All member terminations for the period 1st January 2003 to 31st December 2003 will then be processed using this interim rate until the final rate is known. The final interest rate can be lower or

higher than the interim interest rate. The interim rate for a period need not be same as the final rate for the previous period.

Before entering an interim or final interest rate for a new period, all the rates for the previous period should have been authorised. In other words, there should be no existing pending rates. An effective date must be specified when entering a new rate. Effective date of a new rate should be greater than the previous one entered. Hence the users can declare these rates as often as required. Once the Interim or Final rates are entered, their status will become “Pending Interim” and “Pending Final” respectively. The pending rates can still be Modify at this stage in case there is an error. There is also a facility to display all the pending rates.

After the rates have been checked and confirmed then they can be authorised. The status of the rates will then become “Authorised”. Only after the rates are authorised the system will use them. Lastly, there is also a facility to enquire on the interest rates. A filter facility is provided to enquire the rates for a certain date range or fund code. There is also an option to choose the sort sequence that is either by date followed by fund or fund followed by date.

5 Billing

5.2 Overview

In Integral Group, the billing sub-system consists of the following batch jobs

a. Instalment Billing
b. Provisional Billing

Apart from the bills that gets generated during new business or renewal issue, the system needs to print the following bills:-

a. Normal and adjustment bills for instalment policies
b. Adjustment bills for policies whose frequency for normal bills may be yearly but for adjustment bills could be for monthly

5.2 Types of Bills

The term 'Bill', 'Debit Note' and 'Premium Notice' are used interchangeably in Integral Group. They are one and the same. There are three types of bill supported by Integral Group.

a. Normal Bills
b. Adjustment Bills
c. Provisional Bills

- For New Business, the request for provisional bill is online and the amount either manually entered by the user or system calculated or both.
- During renewal, the system determines whether to send the provisional bill. This is based on setting in T9767.
- If a provisional bill has been sent be it or renewal, the provisional bill amount is automatically adjusted by the system during the normal billing. Therefore the normal bill will only bill the difference between the normal bill amount and the provisional bill amount.

5.3 Billing Frequencies

The frequency for the billing of normal and adjustment bills are supported in the system in the table T3590.

01	-	Annual (Yearly)
02	-	Half-Yearly
04	-	Quarterly
12	-	Monthly
00	-	Single

- Billing Frequency is when the normal bills have to be sent out.
- Adjustment Frequency is when the adjustment bills have to be sent out which could be different but should be more or equal to the billing frequency.

5.4 Normal and Adjustment Premium

- Normal premium is premium billed in advance
- Adjustment premium is premium billed in arrears

5.5 Bill to date and Adjustment to date

The system maintains these 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.

- Bill to date is the date up to when the normal bill has been sent out
- Adjustment to date is the date when the adjustment bill has been sent out

5.6 Instalment Billing Run

The purpose of this job is to prints normal and adjustment bills for all in-force policies with premium that are due for billing.

The bill to date must be specified during the job submission and can be submitted on a Daily, Weekly, Monthly or as many times as specified by user.

The billing run checks against the following for the policies to be extracted for normal bill processing.

a. Bill-to-date specified in the parameter screen
b. Status of policy
c. Value of bill-to-date in the policy header
d. Billing frequency

For adjustment bills, the following criteria are used:-

a. Bill-to-date specified in the parameter screen
b. Status of policy
c. Value of adjustment date in the policy header
d. Adjustment frequency

5.7 Provisional Billing Run (Renewals)

The purpose of this job is to print provisional bill for those policies that satisfy the following conditions.

a. Status of Policy is In-force and policy expiry date plus the no of days in T9767 is greater than system date

b. Status of Policy is Pending Renewal and policy expiry date plus the no of days in T9767 is greater than system date

This job can be run as many times as per the user requirements.

5.8 Billing Controls

5.8.1 Payment Plan

This determines the method and frequency of payments from the policy holder. It controls:

- Frequency of billing
- Number of instalments per billing
- Collection channel
- Initial payment

The default payment plan for a policy or class of business can be set up so the user does not need to key in the various combinations of frequency, mode and so on when creating a new policy.

5.8.2 Billing Channel

The billing channel defines the party to whom bills are presented. For example, the policy payer's bank account, the agent or policy holder. The collection channel and billing channel are synonymous. Valid channels are stored in the Billing Channels Table (T3620).

5.8.3 Billing Frequency

The billing frequency defines how many instalments are to be billed in a year. This could only be monthly, quarterly, half-yearly, yearly or single premium. The Billing Frequencies Table (T3590) contains the valid billing frequencies.

5.8.4 Billing Commencement Date

This is the date on which the automatic instalment billing system will take the policy into the billing cycle. When entering a new policy, this date must be an exact number of bills prior to the expiry date of the policy. We say that these two dates must be in phase.

5.8.5 Billed To Date

This is the latest date up to which bills have been raised. The G3INSTBILL batch job raises the bill in advance so for example in a monthly case, a bill raised on 2nd June 2000, bill for the period of 2nd June 2000 until 1st July 2000. The billed to date is 2nd July 2000. It is therefore also the date on which the next instalment falls due.

5.8.6 Factoring House

The factoring house is also known as Clearing House and is used by contracts payable by periodic debit- via direct debit to a bank account. This identifies the party to which an extract file produced during the media production is sent to. The factoring house is specified when entering bank account detail for the policyholder and therefore cannot be changed.

5.8.7 Mandate

A billing mandate is an authorisation from the payer to allow the bank to honour debits to his account. Normally there is a period of time allowed to permit this mandate to be cleared with the bank and the common FSU subsystem has been provided to offer this control. The status of the mandate is controlled through the Mandate Status Codes Table (T3678).

5.8.8 Billing Cycle

During the billing process, a number of steps are required. These are describes as follows:

6.8.8.1 Policy Issue

When entering the policy, the user would specify the payment plan when creating the policy header. The payment plan indicates the profile of instalment to be raised during the life of the policy including payment frequency, billing channel and so on. Should a policy be defined as Bank billed, then the user will also need to enter the details of the policy holder's bank account.

5.8.8.2 Billing

A batch function/job called G3INSTBILL will be processed regularly to raise instalment bills for policies required it. During this process, the instalment premium will be calculated along with any commission and charges and reinsurance and all accounting transactions created for other subsystems. The Billed-To-Date is also advanced at this time...

5.8.8.3 Media production

After the G3INSTBILL is run, the media production batch function is performed to create the actual media to be presented to the bank, group of other billing channel. Media may be computer tape, diskette, hard copy computer listing etc.

5.8.8.4Dishonour Processing

For bank billed policies, there may be a reason for dishonour, such as insufficient funds, stop order and so on. In these cases, it is necessary to reverse the accounting transactions raised during the billing step. An online function is available to enter these dishonour transactions and create reversal.

5.8.8.5Batch Processing

There are 4 main processes relating to instalment billing. These are:

- G3INSTBILL (GROUP Instalment Billing),
- G3DDAPPLY (Direct Debit Apply),
- G3DDnn (Direct Debit Extraction and Tape Create for Factoring House nn)
- G3DISH (GROUP Batch Dishonours).

G3INSTBILL will bill due instalment and should be run before G3DDAPPLY (Direct Debit Apply) and G3DD01 (Direct Debit Extraction and Tape Create for Factoring House 01).

G3INSTBILL is the primary billing batch job. It selects and processes policies which are due to have an instalment bill. This job should be submitted regularly for raising premium instalment bills. .

G3DDnn. This batch job processes all un-processed instalments for a particular factoring house. The information of amounts to be debited from the clients' accounts is transferred to the tape.

G3DISH. This batch job is for the processing of payments collected by Direct Debit requires to be recorded as dishonoured. Dishonours will only complete a representation and not a reversal. Dishonour processing has two stages. The first part is to register the dishonour, which is an on-line transaction; the second part is the actual processing required which takes place in this batch job.

5.9 Unearned Premium Reserve (UPR)

Although insurance premiums are often paid in advance, insurers typically "earn" the premium throughout the policy term. The portion of a policy's premium that applies to the expired portion of the policy is called the policy's earned premium. The insurer must carry the unearned portion of the policy premium as a liability in case the insurer has to pay back a certain part of the original premium when the policy is cancelled.

To provide insurers flexibility, Integral GROUP provides:

- A facility to allow the selection of using either the UPR calculation basis of Accounting Period or Inception Date.

- The choice of using either Contract Type or Premium Class as part of the item key in the UPR profile rules and definition in the GL Auto Earnings/Accrual table (T2899).

- A source of business to have different UPR calculation methods for different territory (i.e. local, overseas, etc).

- A selection of UPR calculation methods:
  - Earned by 24ths
  - Earned by 12ths
  - Earned by 365ths
  - Earned by 8ths
  - Earned by fixed (25%)
  - Earned over 75-25 ratio-Cargo
  - Fully Earned after 90 days

- Fully Earned after 30 days
- No Earning

The Company Defaults Table (T3711) includes the indicators required to initiate the above features.

6 Underwriting

The New Business function enables the creation of new policy or conversion of a quotation into new business. The screen flow as you complete the data entry of each will provide guidance to the information required. Basically, the process will navigate through the policy header, subsidiary, product/plan creation, addition of members or headcount. The new business can either be issued at the end of the data entry or left pending (saved) for further review or additional data input.

The new business header captures, verifies and stores all necessary data to be stored in the policy header. Policy number will be automatically allocated and present on the policy header screen. Some defaulted values such as branch, billing currency, renewal information, etc for the policy type are displayed. The policy header screen must be completed before being allowed to proceed. On successful completion of this screen, a record will be added to the policy header file and the client record for this policy holder will be updated with the policy owner role flag.

Subsidiaries are optional input. One or more subsidiaries can be added. System allows modify, delete, reinstate, terminate and lapse options.

The product/plan screen is a mandatory option where the relevant products are added to the policy. Plans details such as maximum and minimum age are defined in the Product page and benefits attached to each plan. System will validate that all information must be completed before the addition of members can be carried out.

For non-medical products, there are four fields for Free Cover Limit by maximum age grouping in the product screen. If free cover limit is not required for product such as Group Accidental Death & Dismemberment, the default has to be set as N in table T9797. For Group Disability Product, the systems need to recognize that the relationship between Death Benefit and Total Permanent Death (accelerated death benefit) for subsequent claims processing, the link has to be set up in table TR911.

6.1 Underwriting Decisions Flag

For Non-Medical products depending on the free cover limit, the decision flag will be ‘1’ (no underwriting) when the Sum Insured is below the free cover limit and the decision flag will be ‘7’ (underwriting pending) when the Sum Insured is above the free cover limit. If the member has been underwritten, the user can either approve the Sum Insured above the free cover limit by changing the decision flag to ‘2’ (approved as standard case) or ‘3’ (approved as Sub-standard case) in the members details screen.

Loading by percent (extra mortality) or rate (occupational loading) can be entered for sub-standard life in the member details screen. Once member has accepted the extra loading, revisit the member details screen to change the decision flag to ‘6’ (accepted by member) so that the extra premium will be calculated by system during new business

issue. Rejection of the excess sum issued by the member will have the decision flag as ‘4’ and loading rejected by the user will have decision flag as ‘5’.

Additional Triggers for Underwriting (TR9TB)

6.2.1 Body Mass Index (BMI)

System calculates BMI (Body Mass Index) based on flexible user defined table rules and can automatically build underwriting follow-up requirements based on flexible user defined table rules.

These follow-up codes are in addition to the normal follow-up codes based on age and sum insured range.

6.2.2 Underwriting Questionnaire

System provides flexible user defined table rules to display an individual underwriting questionnaire based on Age & Gender.

The answers to these questions can be a numeric answer or a Boolean. Depending on the answers to these questions, system can automatically build underwriting follow-up requirements. These follow-up codes are in addition to the normal follow-up codes based on age and sum insured range and underwriting follow-up requirements based on BMI.

6.3 Follow Up Option

At the work with members screen, Follow Up option will display all the underwriting requirements set up in TR915 for a member. The status is outstanding till the required information is received and the user has to update it subsequently through pending new business or major alteration.

Additional requirements can be added.

7 Policy Servicing

7.1 Overview

Once a contract has been issued, it is not reasonable to expect that the details for that contract will never change. Circumstances may require that one or more details be altered to ensure that the contract remains accurate.

Integral Group has Major Alteration and Minor Alteration function to allow user to make changes to an in-force policy. The system will monitor all required steps and once the transaction is issued, will ensure all changes are transmitted to all the related sub-systems such as billing, agency claims, general ledger etc.

Some of the common amendments are

- Additions of members
- Terminations of members
- Changes
- Entering Underwriting decisions
- Increase in Sum Insured

Major Alterations have financial implications and it requires an effective date for the change to come into effect. The system keeps an audit trail on all changes by maintaining history records.

Minor Alterations is any alteration that has no financial implication and also requires an effective date for the change to come into effect. Only selected fields are allowed for minor alteration.

Once a minor or major alteration is initiated on a policy contract, it can be completed through a policy servicing issuance. The system performs per-issue validation to check if the policy compiles with the defined rules. System will calculate all the adjustment and normal premium for each member/product/plan or headcount group. Adjustment premium are those resulting from alterations whose effective date is greater or equal to billing date. A bill is produced for the relevant alteration.

7.2 Alterations at Higher Level

The policy servicing movements can be grouped at the following levels

- member/product/plan
- member
- headcount
- plan
- product
- subsidiary
- policy

The lowest level at which premium can be associated is at member/product/plan or headcount group level. Therefore whenever any movement takes place at a higher level, the system has to apply that movement successively for every in-force member member/product/plan or every in-force headcount under that higher level.

For example if a product is terminated all the in force members/headcount groups under each of the in-force plans for that product should be terminated.

7.3 Back-Dated and Future dated Alterations

Integral Group handles both back-dated and future dated alterations.

a) Back-dated alterations is where the effective date is less than or equal to bill-to-date. The alteration can be in same policy year or previous policy year.
b) Future dated alteration is where the effective date is greater than the bill-to-date.

7.4 Multiple Effective Dates in one transaction

Integral Group recognizes that a whole lot of 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 to the followings:-

- 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.

7.4.1 Inserted and Normal Alterations

Integral Group handles both inserted and normal alterations and for both of them, the amendments are always carried out till the expiry date. The processing of inserted alterations is quite complex. It is based on the following overall logic:-

i. First determine how far (to what date) the current amendment should be carried out. For normal alterations, this date is the expiry date and for inserted alterations, the date is the effective date minus 1 day of one of the earlier amendments
ii. Undo or reverse all the earlier amendments whose effective date is greater than the date in DATE-1. This is different from physically deleting the records.
iii. Carry out the current amendment from date in DATE-1 till to-date determined in step (i).
iv. Play forward all the earlier amendments that were wound back in step (ii). While doing so, the system has to re-calculate the annualized premium.

7.4.2 Inserted Alterations

Let DATE-1 be the effective date of the amendment currently being processed. If an earlier amendment has already been made on the same policy with an effective date greater than DATE-1, we will call this an inserted alteration. Inserted alterations can be back-dated or future dated. The following is an example of inserted alteration.

7.4.3 Normal Alteration

Any alteration which not inserted is a normal alteration. Back-dated and future alterations fall under normal alteration.

8 Renewals

8.1 Batch Renewal

Integral GROUP has a Renewals Processing batch schedule (G3OLDRNWRV) that extracts all policies due for renewal and prints all the necessary reports for review by users.

The following outputs are generated.

- List of Policy without Renewal Notices
- Marketing Renewal Underwriting Report
- Details Billing Statement (Member Listing)
- Renewal notification report
- Loss experience report
- Sub-standard risk report
- Maximum age notification report
- Renewal notice

8.2 Online Renewal Review System

In addition to a batch renewal review system, Integral GROUP has a comprehensive online renewal review system to meet the following requirements.

i. Tracking and monitoring of all renewal reviews
ii. Aid in providing the renewal premium rates and other terms & conditions by making available necessary information on-line
iii. Facilitate generation of client correspondence
iv. Provide access to renewal quotation system to make the necessary modifications.

The online renewal records are extracted in the batch job 'G3RNWRVW2' with the following criteria:

i. Policy status must be in-force or pending endorsement
ii. Renewal Type in Policy header must be 'Y'
iii. Renewal Review date must be greater than review date in parameter screen. Where the Renewal Review date is Policy Expiry Date less Renewal months in policy header.
iv. Check Policy is not already extracted and exists in the online Renewal Review
v. Status will be 'RVPN' when extracted into the online Renewal Review.

Integral GROUP also provides a file extract of the policies for renewal review in the event that the printing of the renewal notice and summary listing is done on a printing application. Applicable policy types can be defined for this extraction.

9 Reinsurance

Reinsurance is the process whereby a risk that is underwritten by an insurer is shared with other insurers who are in turn paid for their share of the risk. This process is arranged between the insurers and does not involve the insured party

In the event of a claim, the Reinsurer will be liable for that portion of the claim amount and if the premiums have been paid in advance, moneys may need to be recovered. This is known as reinsurance recovery.

9.1 Retention

A contract is reinsured when the amount of the sum insured is in excess of a limit for which the Insurer Company is prepared to be on risk. The amount of risk the Insurer Company is prepared to retain is called Retention. The excess of sum insured above the retention limit is then ceded to Reinsurers, who in turn have their own retention or capacity.

Retention limits are applied to individual Risk Classes. Risk Classes can be further broken down into risks per line of business.

Whilst a retention limit is set, it may be that the amount of sum insured in excess of this limit is not worth reassuring and, therefore, a Discretionary Retention limit may be set. If the amount in excess of the retention limit is within the amount set for the discretionary limit, this excess is covered by the Insurer Company. Should the Insurer Company change its retention limits, the new limits will apply to New Business and alterations occurring subsequently.

9.2 Automatic Reinsurance

Reinsurance is set automatically at New Business, depending on the company retention. If reinsurance is not applicable for certain product, do not set up that product in the RI method table.

9.3 Treaty

A treaty is a defined agreement between the Insurer Company and the Reinsurance Company. Both companies agree to share the risk for an Insured and a particular class of business within given limits. The Reinsurer also has its retention limit on the amount of risk it is willing to accept. The method applied to proportion the sum insured between the Insurer Company and the Reinsurance Company will vary from Treaty to Treaty.

There are three types of Treaty provided under the Reinsurance processing: Surplus, Quota Share and Government/Compulsory.

9.3.1 Surplus

A Surplus Treaty dictates that the Insurer Company will cede all the risks above the company's retention limit, for a particular class of business (e.g. Death or Disability). In return, the Reinsurance Company will accept the excess risk up to its own capacity. There may be more than one Reinsurer within a Treaty, creating a tiered effect. Each of the limits within the tier must be exhausted before the next one is taken up.

9.3.2 Quota Share

Depending on the terms and conditions agreed by the Insurance Company and Reinsurer. There are different ways to apply the quota share percentage. One way is that within this type of Treaty, the Insurer and Reinsurance Company each agree to accept a percentage of the risk. The percentages of risk reinsured under a quota share arrangement must always total up to 100%. Whilst the retention amount is a set percentage, there is also a maximum amount of risk that is acceptable by each party. Once this maximum limit is reached, the next agreed arrangement is used. In the event that the entire limit on all the agreed arrangement has been exceeded, a facultative arrangement is required. Another way is that the Insurance Company wants additional protection on their retention and therefore has arranged a quota share treaty. The ceding percentage will be applied on the sum insured up to the retention limit whichever is the lesser

9.3.3 Government/Compulsory

In certain countries, it is by law that a certain percentage of all classes of insurance must be ceded to the Reinsurance Company appointed by the state. This arrangement is always applied first before any other treaties and usually on the gross sum insured irrespective of the Insurance Company's retention.

9.3.4 Facultative Reinsurance

When a risk exceeds all the retention limits for a treaty, another Reinsurer may be sought to accept the excess after the retention limits if the insurer do not want to retain it. The conditions and costing arrangements are agreed between the insurer and reinsurer. This is known as Facultative Reinsurance.

A Treaty can have more than one Reinsurer associated with it. When defining a treaty arrangement, it is possible to attach a default facultative arrangement. The absence of default facultative arrangement indicates that any excess risk for a product requires facultative arrangement on a case by case basis.

9.4 Costing

The premiums relating to sums reinsured must be calculated on terms agreed between the company and the reinsurer. There are two types of costing basis: Original Terms and Risk Premium. The Original Terms basis calculates the premium for the sum reinsured based on direct proportion of the premium raised for the entire sum insured, using the rates of the company. While the Risk Premium method calculates the premium for the sum reinsured, from first principles, using a set of rates provided by the reinsurer. This basis describes the mechanics of the actual calculation of the premium based on sums reinsured and rates as applicable.

9.5 Extra Premium Ratings

When sub standard ratings are applied to a risk for either medical or nonmedical reasons, there is often an extra premium to be paid. The extra premium applied is based on Percentage loading or Rate loading and depends on the RI Loading Indicator at the Product Definition screen S9114. If the indicator = ‘3’ (set as a default), this will follow the inward and when it is ‘set to 2’, it is different from inward. At the Group Member Entry screen S9106, the actual costing for reinsurance for extra premium will follow the underwriting flag indicator ‘6’. When the RI indicator is ‘2’, the system will prompt the user to enter the RI loading under Option 13. Currently the system calculates the extra premium base on the RI sum insured.

9.6 Commission

The determination of commission amounts on premiums for sums reinsured may be carried out in a number of ways, depending on the arrangement and product type. The commission is payable by the reinsurer to Insurer that cedes the risk. Since the Insurer has to settle the ceded premiums, the commission due is normally deducted from the premium or calculated in the rates applied. This is the normal arrangement for most of the treaties, but there is also a possibility the rates provided by the reinsurer may incorporate a discount representing the commission due to the insurer. The definition of the

commission basis for treaty is therefore supported by the system.

9.7 Calculation of RI Refund after termination

When the benefits are terminated either by a claim or otherwise, it is important that the reinsurance costing for that benefit also ceases and the reinsurer is notified. The costing of premiums in advance for reinsurance must be made regardless of whether renewal premiums have been paid by the policy payer.

Thus if payment is not made by the client due to various reasons, the cover may be terminated. In this situation part of or all of the premiums paid to the reinsurer in advance for the period may no longer be a risk and may be refunded by the reinsurer to the company.

The basis for such a refund will be partial refund based on proportion of period of cover remaining as at the date effective of the termination (365 days method). Refunds should be calculated automatically upon terminations only when the type of termination attracts a refund.

The refund should be recorded against premium accounts for the reinsurers from whom the refund is sought and thus will be deducted from premiums due to the reinsurer. The commission applicable to a premium must also be repaid to the reinsurer. The commission claw-back should be a proportion of the original commission paid based on the amount of the refund.

9.8 Calculation of RI Endorsements

Increases in sum insured may require reinsurance where all or part of the increase results in excess of cover that is above the company retention for the risk. Currently, the system applies the Non-Contractual method, which means the increase is not treated any differently to new business. The terms of the treaty are applied and rules relating to retention for a treaty and facultative arrangements are used as per normal. This means any alteration related to sum insured will be recalculated as for a new business

9.9 Recovery

When a claim is authorized the system will automatically calculate the RI claim recovery. The procedure for handling death claims should be included and after processing a death or dread disease claim, the member terminated which should include the RI.

9.10 Claims Processing

The recovery of the reinsurers' portion of the claim value will require debiting the reinsurers accounts when payment is made to the beneficiary. Normally, if the amount to be recovered is not excessive, the recovery will actually take place after the reinsurer is issued with a monthly statement of account.

The amount to be recovered is dependent upon the product, the risk, the costing basis and the claim type.

Death, Permanent Disability and Dread Disease: The amount to be recovered should be the sum reinsured on the date of the claim.

Temporary Disablement, Hospital (for Dread Disease) and Medical Expenses: Regular benefits claims are not paid as a single lump sum. Instead the sum insured is paid at regular intervals determined by the rules of the particular contract, normally for an indefinite period. The entire amount that will be paid on a claim for a regular benefit is not known at the time the claim is admitted.

However, the amount of the regular payment to be made to the insured is known whilst the duration of the regular payment is not. The recovery will take place as and when the benefit is paid out. Thus with every payment of the benefit to the insured, the company must recover the reinsurers portion of that benefit by debiting the reinsurers accounts for their share. As mentioned the regular recoveries made by way of the statements of accounts.

9.11 Reinsurance Details Set-up

9.11.1 Reinsurer Details

Reinsurer details are created, amended and enquired upon via the Group Account Maintenance Submenu. The agent type for Reinsurer is set for 14. All other details will be followed as per agent creation...

In order for the Reinsurer Account to be used to reinsure the contracts, the Reinsurer should be entered against RI Treaty Arrangement on table TR9D6 or RI Fac Arrangement on table TR9DC.

9.11.2 RI Method TR9DH

The reinsurance method is a means of linking the various reinsurance arrangements that form the hierarchy of rules for reinsurance for the policy type and product type combination. If reinsurance is not applicable for a certain product it should not be set up in this table. The item code for this table is a concatenation of Policy type (3 characters), the Product type (4 characters) and Rate variation code (1 character) from table TR9D7. Table TR9DH contains the product specific rules on the risk group that it attached and the reinsurance is based on the treaty/default facultative arrangement groups set up. Every risk group is divided into risk classes that are defined in Table TR9D1 (RI Risk Group).

Firstly, the RI Method Table TR9DH must be set up for any reinsurance processing.

If the reinsurance is necessary, the following steps are processed for each product of

the member. Each product is dealt with in sequence of priority as held on the RI Method Table TR9DH, e.g. Policy/Product type combination for example GTLABC1 has a priority of 1, whereas GTLABC2 has a priority of 2. Therefore, Reinsurance processing on GTL contract will process the ABC1 product before the ABC2 product.

9.11.3 Reinsurance Risk Class Retention TR9D0

The company's retention is stored in TR9D0, Reinsurance Risk Class Retention.

This table stores user defined Reinsurance Risk Class (up to 4 characters) and RI method variation code (1 character) from table TR9D7. The grouping of these risk class are done in TR9D1 and retrieved in TR9DH to link the policy/product type combinations to specific Risk Class and retention. A risk class can be defined by per line of business. This is a dated table allowing different values to apply for different date ranges.

9.11.4 Risk Group Split into Risk Class TR9D1

Risk Group is the combination of Risk Classes in Table TR9D1, RI Risk Group.

This table is user defined and consists of 4 characters. The Risk Group should be entered on TR9DH.

9.11.5 RI Treaty Arrangement TR9D6

The RI Treaty Arrangement defines the Treaty agreements between the Insurer Company and the Reinsurer(s). The arrangement details are stored in TR9D6, RI Treaty Arrangement. This table with the item key of Treaty Arrangement code and Currency code.

9.11.6 RI Fac Arrangement TR9DC

The RI Fac Arrangement defines the facultative agreements between the Insurer Company and the Reinsurer(s). The arrangement details are stored on TR9DC, RI Fac Arrangement. This table with the item of RI Facultative Arrangement code concatenate with Currency code.

When all the Treaties are exhausted and if there are still some risk exposed, Facultative Reinsurance is required. It is also required if the Treaty Reinsurance arrangements do not accept Sub Standard Life or the Sub Standard limits are exceeded.

If a default Facultative arrangement is held on the RI Method Table TR9DH, clicking on function key Fac RI will the system will default facultative arrangements defined on the RI Method Table TR9DC on the Work with Facultative Reinsurance. Please note that the user is required to key in RI Sum Insured and Commission percentage if any, as the default will leave it blank. Also the Total Facultative Required is referred to total facultative required per risk class.

The fields that are allowed to change are RI Sum Insured, Premium Method, Rate

Variation code and Commission %. Please note that the system does not default to any commission percentage and the user is required to key in commission if applicable. The user is allowed to delete any default facultative reinsurer or add in any additional reinsurers. If ceding percentage is entered in, the system will calculate the RI Sum Insured based on the inward sum insured.

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9.11.7 Sub Standard Life Retention SR9F7/SR9F5

A window is available from the client Details Screen that allows the creation of Client specific retention limits. This would normally be used if a Client has had sub standard underwriting and Insurer Company is therefore unwilling to accept the standard retention against the client and wishes to set a lower retention.

There is check box at the foot of the Client details screen, 'S/S Retention'. Enter an 'X' in this check box to display the initial Sub Standard retention window SR9F7.

9.11.8 RI Sub Standard Life Limits TR9DF

Whether or not a Reinsurance Arrangement includes sub standard lives depends on Sub Standard Lives Allowed indicator on table TR9D6 or TR9DC, Reinsurance Arrangement.

If reinsurance is accepted on sub-standard lives, i.e. those with an extra rating or loading, this may only include certain rating or loading limits. These limits are held on Sub Standard Life Limit Table TR9DF. This dated table is accessed using the Sub Standard Limit code entered on TR9D6 or TR9DC. Any loading or rating above these limits for a particular member will automatically disallow this member to be covered under the specific treaty and therefore a facultative reinsurance will have to be arranged for him/her

9.12 RI Costing Batch Job

Costing is processing automatically by Reinsurance Costing batch schedule (G3RICOST). Reinsurance premiums are costed by following the frequency of inward premium. The main purpose of the Reinsurance Costing is to summarize the RI posted premium in the following order and create a financial transaction.

The Costing batch schedule selects all Cession due for processing based on inward premium bill number not equal to zeroes and reinsurance Credit Note number is equal to zeroes on the Reinsurance Posted Premium File

The above batch schedule can be run as and when required.

9.13 RI Commission

Reinsurance Commission is calculated during Reinsurance Costing batch job. The calculation is based on the summarized amount of the posted premium transactions in the above order.

9.14 Reinsurance Premium Refund

Costing of Reinsurance normally covers an advance period. If the cover should then not be required for the period which has been paid for, example a Risk has been terminated, a refund of premiums may be due to the Insurance Company. A refund may also happen if the sum insured has been reduced as a result of Major Alteration.

The reinsurance premium refunds are costed in the Reinsurance Costing batch schedule; i.e. the ceded premium on financial transactions ZTRN will be included the refunded premium if any.

10 Managed Healthcare

10.1 Overview

Private healthcare can be broken down into two broad categories, Traditional and Managed Healthcare. Traditional indemnity plans are often called fee-for-service plans while Managed Healthcare has various types such as Preferred Provider organization (PPO), Point-of-service plans (POS) and Closed-panel Health maintenance organization (HMO).

All Managed Healthcare plans involved an arrangement between the insurer and a selected network of health care providers and they offer significant financial incentives to use the providers in the network.

One step over the Managed Healthcare border is the P**referred Provider Organization** (PPO). Insurer using PPO will make arrangement with a network of healthcare providers for lower fees. PPO gives their policyholders a financial incentive to stay within the network

For example, a visit to an in-network doctor might mean no out-of-pocket expenses (deductible and/or co-payment). If you wanted to see an out-of-network doctor, you will have to pay the entire bill up front and then submit to the insurance company for 80% reimbursement. In addition, you might need to pay a deduction if you go outside of the network or pay the difference between what the in-network and out-of-network doctors charge.

Point-of-Service plan are similar to PPO but they introduce the primary care physician or gatekeeper. You will need to select your PCP from among the plan's network of doctors.

As with the PPO, you can chose out of network but still get some kind of coverage. You may need to pay a deductible if you chose to go out-of-network.

Health Maintenance Organization plans are the least expensive and the least flexible type of health plan. They are more geared towards members of group plans than individuals. In exchange for a low co-payment or no-pay at all, an HMO requires you to see only its doctors and that you get a referral from your primary care physician before you see a specialist.

In general, you must see HMO-approved physicians or bear the entire cost of the visit yourself. HMO has the best reputation for covering preventative care services and health improvement programmes.

10.2 Set-up of Procedures / Drugs & Medic

10.2.1 Work with Procedures

In Integral GROUP claim system, claims are entered against procedure & drug codes and the system will automatically map the procedure code to benefit code(s) by a process known as benefit mapping. This screen is used to enter the procedure codes. Every benefit should have one or more associated procedure codes. The relationship between procedure codes to benefit code is many to many. This means one procedure code can map to many benefit codes. Also one benefit code can have many procedure codes associated to it.

Integral GROUP does not come with pre-defined procedure codes. The user can define their own procedure codes or use standard international codes such as CPT codes. The following sources could be useful (for diagnosis & procedure codes)

10.2.1.1 Fee schedule method for a procedure

The fee schedule method is required to be set up after the procedure code is created. It should be defined for every procedure 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.

The system supports the following two fee schedule methods:-
- Method 01 -Fee schedule database (PFSH & PFSD screen SR9BH)
- Method 02 -From Table TR9H9

The fee schedule method can be defined separately for every network level

10.2.1.2. Link procedure code to benefits and surgery categories

For every procedure code whose fee schedule method is ‘02’, this screen should be visited to link the procedure code to the benefits code(s) and the associated surgery category for each of those benefits. Each of the benefit and surgery category defined in this screen should also be defined in table TR9H9 for the system to pick-up the fee amount to be reimbursed to a provider organization.

For those procedures whose fee schedule method is ‘02’, this screen should not be visited

10.2.1.3 Work with Drugs and medical supplies

In Integral GROUP the following options are available as far as the drug codes are concerned.

Option-1: Use the above drug database to create as many drug codes as necessary and for these drugs which are defined in the drug database, enter the claims directly against the drug code.

Option-2: For those drugs which are not defined in the drug database (could be none), define a generic procedure called ‘drug’ and enter the claims against this procedure code.

The user can also use a combination of option-1 and option-2. In other words, use option-1 for some drugs and optio-2 for all the remaining drugs. Whether to use option-1 or option-2 is a trade-off between the effort in set-up and the level of detail for claims statistics and claim controls such as system checking for exclusion of drug codes etc.

Whether option-1 is used or option-2 is used, the system supports only one fee schedule method for drugs which is method '01'

10.3 Provider Organisation Maintenance

Every provider organization must first be created as a corporate client in the system. In the client additional information, the client special indicator must be defined.

The special indicators values are stored in TR391 which is a system controlled table with the following values:-

01 Provider organisation
02 Provider individual
03 CPF Board/Med saving a/c Admin
04 Third Party Claim Processor

For each provider organization, the following values can be entered.
- Medical provider category. E.g. Hospital, Clinic, etc.
- Alternate reference number, any other identification for the provider organization.
- Area code. This is required if policy is subject to area code concept.
- Provider group. It can be used as a dissection for GL in claim related accounting transactions such as claim reserves, claim paid etc. The GL mask for this field is ????.
- Default fee-schedule.
- Office hours.

10.3.1 Link Providers to a Provider Organization

The attachment of individual providers to a provider organization must involve the creation of the individual as a personal client. In the client additional information, the client special indicator must be defined.

The special indicators values are stored in TR391 which is a system controlled table with the following values:-

01 Provider organisation
02 Provider individual
03 CPF Board/Med saving a/c Admin
04 Third Party Claim Processor

The relationship between provider organization and individual providers is many to many. This means 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 provider capacity is used if the provider fees depend on the individual provider who performs the service. The list of procedure classes is an optional information and

is entered by clicking on Procedures button in Provider Details screen.

In Integral GROUP system it is optional to enter the details of individual providers. Only in situations where the provider fees 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 organization), it becomes mandatory to enter the details of individual providers. Even if the provider fees do not depend on individual providers, it will be a good practice to capture the details of the individual providers who performed the specific services for the following reasons:

- Claim statistics at provider individual level
- Accountability for consistent pricing and treatment patterns at individual provider level
- Matching patients needs to the skill sets of individual providers (who live 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.

This screen captures the list of procedure 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 the above list.

10.4 Provider fee-schedule

In Integral GROUP, the user can create as many fee schedules 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.

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 an independent service code, the catchall code '****** can be used. When the system looks for a match, it first looks for the exact service code entered in claim screen. If no match 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.

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.'.

For the same service/provider organization, the fees may be different for day time and night time. This can set using the work hour slab.

Provider capacity and Network level are also variables that can be used to create different fees schedule.

10. 5 Provider Network

The Provider network contains information of Fee schedule, Payee and payment method or requisition type.

For each Provider Network, the provider organization can be attached with the following details – Claim Type, Place of Service, Start Date, End Date, Fee Schedule, Network Level, Working hours slab, Payee and Payment method.

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.

The combination of fee schedule, network level and work hour rule 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 organization, the system assumes the default provider schedule at network level will apply

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

11 Claims (Non-medical)

11.1 New Claims

Once a new claim request is received it is registered into the system by the claims department. One claim request is for a policy/claimant/product.

Claim is registered with a pending status. Based on the incurred amount, the system will automatically calculate and display the default claim amount payable for each benefit. This amount can be overwritten by user.

RI claim recovery is automatically calculated by the system subject to the treaty terms and is applied throughout any changes.

System allows Claim fees which are fees charged by a third party administrator for handling the claims processing to be paid out as claim payment.

Unlimited amount of remarks (general page) can be entered along with each claim. User can also specify the reason why the claim is still pending.

When a claims request is received for a headcount member, before registering the claim submitted, the headcount member has to be created in the policy administration module using function ‘Add Headcount member’.

11.2 Claims Modification

The claim data on a pending claim can be reviewed and corrected for clerical and factual errors. Once an advance payment has been made, the system will automatically adjust the advance payment with the final payment.

11.3 Claims Occurrence

Integral GROUP allows multiple claims at different points of time on the same disability. All the claim limits are applied to the entire disability and not against each occurrence.

11.4 Claims approval / rejection / ex-gratia

During claim approval, the total claim payable to all payees should tally with the total claim amount approved.

For rejected claims, the amount payable is always zero. Ex-gratia payment on reject claims is allowed. Reject claims are not deleted from system and are available for enquiry and reporting.

Ex-gratia payments are those claims that are rejected but due to business reasons, the assurer may want to pay a certain amount to the claimant.

Advance payment is usually made to the medical provider as the hospital may ask for an early settlement when the claimant is in for a long-term stay or upon discharge. Once the amount is paid to the claimant, the claim status becomes ‘AP’. On finalizing the claim, the system will adjust the final amount payable against the advance payment. Should the claim be rejected or the advance payment is in excess of the eligible amount, the system will automatically raise the claim recovery.

Death claims can be paid in a lump sum or in instalments and interests included for the late payment.

System recognizes the relationship between death benefit and TPD benefit (accelerated death) to do the processing correctly. When death is followed by TPD, the claim amount payable under death benefit is the balance of what has been paid from all the TPD instalments. If the full amount has been paid, the amount payable from death benefit will be zero.

11.5 Claim actual payment

The system automatically creates payment requisitions on approved claims. Claim payments can be authorized by another department or automatically authorized by table setup. Multiple payees are allowed and payment can be made through direct credit, manual or machine printed cheques.

12 Health Claims

12.1 Claim Registration

When a medical claim is received by the insurer, 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.
The 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.

The claim number 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:

i. 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 hospitalization or post hospitalization 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 hospitalization of the original claim (occurrence number '00').
ii. Re-hospitalization for the same policy/product/insured-life for the same disability within the separation period. The re-hospitalization 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 organization and date of discharge while looking for a possible match}. This logic will cover situation (i)
- For each previous claim occurrence against the same policy/product/insured-life, let A = Date of discharge + Separation period {ignore diagnosis code and provider organization while looking for a possible match}. If date of visit of

current claim is <= A, prompt. This logic will cover situation (ii)

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.

The claim number + occurrence number should be entered for Modify Claim and Display Claim.

The claim number (without the occurrence number) should be entered for Work with Reserves, Enquire Reserves and Clear Reserves. No other field need to be entered.

12.1.1 Third party claim processor

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 with client special indicator as '04' in the client screen. The reference number is the number (if any) assigned by third party claim processor.

12.1.2 Follow-Ups

Follow-up requirement that may be needed in connection with the claim such as doctor's report, proof of age etc can be entered.

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

12.1.3 Outstanding Premiums

Integral GROUP displays all the debit notes which were invoiced prior to the incurred date of claim for which premiums have still not been received in full. If a policy has subsidiaries, only those debit notes that belong to the subsidiary are considered. The system puts a hold code of '54' if premium is outstanding.

12.1.4 Additional Notes

Provider case notes and Symptoms description can be entered during claims and this is purely for information...

12.1.5 Additional Claim Data

Information on the medical leave period, information pending from 3rd party, the TPA reference number and the input of ICD-10 codes can be entered as well.

12.2 Claims Details

The service code (procedure or drug) and its details are required to be entered. One or more service codes can be entered.

Integral GROUP requires the compulsory input of the start date of service, the service code, the Invoice number and the Room Type.

Place of service is a compulsory input but the value is defaulted from TR9C6. This is one of the variables that determine the fee schedule in network detailed database.

Other values in the claim details screen include

- **Date to** which is the **e**nd date of service. If no value is entered, this date is assumed to be start date.
- **Incurred** which is the amount charged by provider.
- **Provider** which is optional. It is only required if the fees depends on individual provider within the provider organization who did the service.
- **Payable to provider** which is automatically calculated by the system based on the fee schedule method, provider fee schedule and the fee basis. User is allowed to over-write if the user profile has authority and subject to the percentage tolerance limits specified in user profile.
- **Number of days** which 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 i**s 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** which is the basis corresponding to that benefit limit. This is displayed from TR9A6.
- **Member share** amount. 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.

12.2.1 Claim Worksheet

Integral GROUP has a claim worksheet and is the outcome of benefit mapping and is a useful tool to find out how the system calculated the amount payable to provider, HMO share and member share.

12.2.2 Advance Payment

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.

12.2.3 Claim Reserves

The setting up of claim reserves is controlled by the claim reserve flag in product table and the amount set in the Claim Reserve master. 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 users exits from the claim reserves 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 authorization 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).

12.2.4 RI Claim Reserves

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

12.2.5 Benefit limits, Member liabilities & Prior accumulation

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.

12.3 Claim Payee Details

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 authorized, 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

12.3.1 Reinsurance Claim recovery

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

12.3.2 Other Claim Payments

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.

12.3.3 Claim Hold Codes

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.

13 Benefit Payments for Pension

13.1 Overview

The system should allow a member to be identified either by client number or by policy number and member number combination. If the member is identified by client number, the system will automatically find out the policy number if the client has only one group policy. If there is more than 1 policy under the client number the user has to choose the correct policy number from the window of all policy numbers under which the member is covered.

The claim will be registered for a specific benefit code. The system should automatically include all the products that have the benefit code and process it under a single claim.

13.2 Benefit payment status

CP	Claim Pending (System)
RP	Ready for Processing (User)
AU	Authorised (System)
CC	Claim closed (System)

13.3 Benefit payment processing

Integral GROUP system will find out all products under the benefit code and check the preserved amount payable. When there is an insurance product, the sum insured is checked.

For Defined Contribution investment product, system will find out the account balance while for Defined Benefit investment product, the benefit amount payable will be taken.

The vesting rules are applied and check is done to ensure that member is not already terminated.

System will display the maximum amount payable for each product/contribution type/investment fund combination. Users are allowed to enter adjustment amount. The adjustment amount can be positive or negative. System provides three claim related amounts for user to enter additional amount such as interest on late payment of claims.

The unvested amount should be automatically transferred to employer float account.

13.4 Benefit payments

Integral GROUP allows valid claim payee rules to be pre-defined for each product and benefit code combination.

The payee is validated against user defined rules to ensure that it is a valid payee. A check against the amount payable against the user Claim Authorization limit is already performed.

Payment requisition is automatically generated by the system upon approval.

No financial transaction record will be generated when a benefit payment is authorised. The financial records for a benefit payment is generated when G3UNITALOC (Unit deal batch job) is run.

14 Batch Processing

14.1 Introduction

There are two methods of processing within INTEGRAL GROUP, On-Line Real Time and Batch Processing. The latter is the subject of this part of the document. The first part of this note will explain the base system batch jobs with a note of relevant programs and tables called or referenced by the batch programs together with any comments on run dependencies. The second part will show a typical batch schedule for an Insurance company.

Most batch jobs can be run as often as required however, some have an impact on the on-line system and should only be run outside the normal business day when the system is inactive. Most batch jobs need to complete satisfactory before they can be run again. In some cases this is not true and the rules for batch job schedule and processes can be defined by the users in the Run Dedicated area of the individual batch job definition.

A job that updates files must complete properly, for example General Ledger Update, G3GLUPDATE. However, a report type Batch Job that does no updating can be submitted into the batch queue without any dependency on the success of the previously submitted job, for example, General Ledger Unlinked Report, GLUNLNK.

The batch jobs listed below may not be delivered in exactly the same naming convention as hese batch job names can be amended should the Insurance Company or even the CSC Model Office feels that they should have a more appropriate name. In addition to this the current batch schedule definitions will have a prefix of G#, # being the Company numbering practice; for example CSC has nominated Company 3 for the INTEGRAL GROUP application. Therefore, the system batch jobs reference when will be G3AGTCOM. What are important are the program processes and not the batch name.

14.2 Schedule Submission

If the user is authorised to perform batch jobs, then from the Main Menu “Batch Processing” is available for selection. From “Batch Processing”, click on "Schedule Submission". The Schedule Submission screen is used to select Batch Schedules for submission to a job queue.

Each schedule has a Transaction Code to which the user must be authorised in order to submit the schedule. Only those schedules which a user is authorised to run are displayed. Note that all batch jobs is under Company is * in the User Security module.

If a Job is required to be run for a date other than the current system date, change the Effective Date at the top of the screen to the required date.

The Branch, Company, User, Accounting Month and Year are displayed for information only. Note that the accounting month/year may need to be changed if a different Effective Date is entered.

If a parameter screen is used, the next screen to be displayed would be the parameter screen otherwise a message that the job has been submitted will be displayed.

If no parameters are required for the Job to be run, a message will be displayed at the bottom left panel of the screen to indicate that it has been submitted. If parameters are required, a parameter screen will be displayed.

14.3 Base System Batch Jobs (In Alphabetical Order)

14.3.1 F9AUTOALOC Auto Number Allocation for Company 9

This batch job will automatically allocate numbers, policies, receipts, agents, to the ANUM file according to the parameters set in the Auto Number Allocation Table (T3642). It is advisable to keep the number packets topped up so that numbers are not exhausted at any time during a working day. It is suggested that this batch job be completed out of business hours on a monthly basis as part of the Computer Operations housekeeping routines.

14.3.2 G3AGNTRPT Agent Register Version 2

This batch will generate the Agent Register Reports. It reflects the list of agents on register and the clients who are agents.

This job can be submitted as many times as the user requires.

14.3.3 G3AGTCOM Auto-Generate Agents Commission Requisition

This batch job automatically generates payment requisition for commission due to the agent. The requisition type is defaulted to Direct Credit if the agent's bank account is set up in Direct Credit Bank Account for bank code specified in Account Maintenance. Otherwise it will default to Automatic Cheque. The user is allowed to change the default setting.

This job is used in Debtors method (T9804-cash-marry = N).

The user will then have to manually authorise every requisition via payment subsystem. This will provide the user the flexibility to change the payment information before it is issued if required.

The automatic agent commission process will only carry out if:

- The schedule restart method is '2'
- The schedule has not been submitted for the current accounting month and accounting year.

It will produce two reports:

- BR298 - This report prints all successful payment requisition created
- BR299 - This report prints all unsuccessful requisition errors.

14.3.4 G3AGTPAY Agent Commission Payment

This batch job automatically generates the payment requisitions for commissions. It is only meant for clients who use Cash Marry (T9804-cash-marry = „Y).

Refer to G3AGTCOM.

14.3.4 G3AGTPERF Agent Performance All Branches

This job produces the Monthly Agent Performance Report. The Monthly Agent Performance report reflects the current-month and year-to-date figures for the major classes.

This job can be run any time but if it is important to have the most up to date information then obviously these should be run after the SDS Update batch job SDSUPDT.

14.3.5 G3AUTOALOC Auto Number Allocation Company 1

This batch job will automatically allocate numbers, policies, receipts, agents, to the ANUM file according to the parameters set in table T3642. It is advisable to keep the number packets topped up so that numbers are not exhausted at any time during a working day. It is suggested that this batch job be completed out of business hours on a monthly basis as part of the Computer Operations housekeeping routines.

14.3.6 G3AUTOLAP Policy Auto Lapse

This batch job will lapse a yearly renewable policy which has already expired and the policy has not been renewed within the number of days indicated in policy type table T9799. The policy status is changed from In-force(IF) to Lapsed(LA)

14.3.7 G3AUTOLAP2 Auto Lapse for Grp and Grp Retail when prem not received

This batch job lapse policies or members when premium is not received within the due date plus grace period

This batch job is only meant for clients who use Cash Marry (T9804-cash-marry = Y) and handles Group, individual and Grouped retail policy types

The same batch job is used to auto lapse policies, subsidiaries and members. If the last normal bill for which premium has not been received is at policy level then the policy is lapsed. If the last normal bill for which premium has not been received is at policy/subsidiary level then also the entire policy is lapsed. If the last normal bill for which premium has not been received is at policy/member level then the policy/member is lapsed.

14.3.8 G3BILLTRVL Open Ended Travel Billing

This batch job calculates the end date for open ended members in a Travel policy. This is equal to member attachment date plus Number of days defined for open ended policy at policy/product header level. It deduct man days defined in the product header for ‘Man days deduct’.

14.3.9 G3BNFTBILL Benefit Billing Batch Job

This batch job calculates and deducts the service tax for investments when premiums are paid from the member's account balance.

For DCI - Defined Contribution Individual, the premium will be deducted from member account and for DBE - Defined Benefit Employer, the premium will be deducted from the employer account

14.3.10 G3CASHISS Group Cash Accounting Issue

This batch job is initiated at the Receipt module. It cannot be submitted in the Batch Processing menu.

The system will check if there is outstanding bill and will marry off the outstanding bill if the money is sufficient. The policy status will become in-force and the accounting entries will be generated

14.3.11 G3CASHLIST Cash Report

This job reports on the Cash Receipts processed through the system and if required will produce actual receipts for the clients of moneys entering the system. It also produces a Bank Deposit listing that has been designed to be run whenever it is required to bank money that has been received. This listing is intended to be used to balance the payments received against the cash and cheques. This job also produces a Cash Book List that is a list of moneys received by either method, Banked Receipt or Receipt to be Banked.

This job may be run daily, twice a day, every second day, etc. You must ensure that when this batch job is run that policies and receipt are not being issued as these transactions reference the receipt file and can cause "soft locks". It is suggested that this job is run during the lunch break or if not convenient then disallows the user to use the system (i.e. system is "quiet") until the job has completed successfully

14.3.12 G3CHQLST Auto Cheques Update/Report

In the base system there is offered an automatic machine cheque production system. To be able to keep a track of the machine cheques used then there has to be a control and this batch job is that control. The batch job P1CHQPRN1 will extract all payments from the CHEQ file and the output from this job is needed as the parameters for this batch job.

This job should be run after P1CHQPRNnn and when the system is inactive.

14.3.13 G3CHQPRNnn Auto Cheques - Bankcode nn

The base system supports automatic generation/printing of machine cheque. To be able to keep a track of the machine cheques used then there has to be a control and this batch job is that control. This batch job, P1CHQPRN1, extracts all payments from the CHEQ file and the output from this job is needed as the parameters for the batch job.

14.3.14 G3CLAIMPAY Claim Payments

This batch job creates the claim payment requisitions for non-medical claims.
The system also updates the claim data with the payment requisition number. When this payment requisition is authorized, the system updates the claim data with the cheque number

14.3.15 G3CLAMRECV Claims due for recovery

This batch job prints the Outstanding Claims Recovery report for non-medical claims.

14.3.16 G3CLMHIST6 Claim History Report (V6)

This batch job prints the Claim History Report.

14.3.17 G3CLM2PAY Claims/2 Payments

This batch job is for creation claim payment requisition for health claims.

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 authorized, the system updates the claim data with the cheque number.

14.3.18 G3CLMRCV Claim/2 Outstanding Recoveries

This batch job prints the Outstanding Claim/2 recoveries for medical claims.

Only those claims that have outstanding recoveries will be printed in this report. Once payment (recovery) has been received, the claim should no longer appear.

14.3.19 G3CLMSTMT Claim/2 Statement

This is batch program print the Claim Statement report for medical claims.

14.3.20 G3COMMON Common batch job for 5 reports

This batch job prints the following client documents all in one spool file.

Report 1 - Policy Schedule
Report 2 - Summary Billing Statement
Report 3 - Detailed Billing Statement
Report 4 - Certificate of insurance
Report 5 - Membership Card
- Covering letter for agent

14.3.21 G3DCnn Direct Credit Extract – Bank nn

This process is in two stages. One is the extraction of all the payments from the Requisitions file (CHEQPF) with the relevant pay method. The second stage is to transfer this information to the tape for delivery to the factoring house and eventually crediting the client's bank accounts. The tape format is in the style required by the UK Banking authority BACS. This batch job should be run outside the normal working day.

14.3.22 G3CREDITS Direct Credit Extract – Banknn

This program will read the requisitions file (CHEQPF) to extract valid payments for direct crediting to bank accounts. The job produces the payment extract file (DDBTPF) for the valid payments that the bank will process. In addition, a report listing the details of the payments extracted is also generated.

The Bacs transaction code for direct credits is '99' and the Contra transaction code is '17'.

14.3.23 G3CTBPROC Contribution processing batch

This is the batch job that does member level allocation into various funds based on the contribution amount that has been received and the investment strategy. The system automatically generates a unique contribution batch number.

This job is initiated in the Regular Contribution Batch menu and cannot be submitted in the Batch Processing menu.

14.3.24 G3CTBPROCA Contribution processing batch – Adhoc

This is the batch job that does member level allocation into various funds based on the contribution amount that has been received and the investment strategy. The system automatically generates a unique contribution batch number.

This job is initiated in the Ad-hoc Contribution Batch menu and cannot be submitted in the Batch Processing menu

14.3.25 G3CTBPROCJ Contribution processing batch – Journal

This is the batch job that does member level allocation into various funds based on the contribution amount that has been received and the investment strategy. The system automatically generates a unique contribution batch number.

This job is initiated in the Contribution Journal menu and cannot be submitted in the Batch Processing menu

14.3.26 G3DDAEX1 1st Rejection And Exception Report For Policy

This batch job produces the rejection letter extract file (DDAAPF) and exception report extract file (DDABPF) for policies based on the 1st rejection date and 2nd rejection date in Direct Debit Approval / Reject Details file (BDDAPF).

14.3.27 G3DDAEX2 Approval Letter For Policy

This batch job produces the approval letter extract file (DDACPF) for policies based on the approval date in Direct Debit Approval / Reject Details file (BDDAPF).

14.3.28 G3DDAEX3 Notice Of Cancellation For Policy

This batch job produces the notice of cancellation extract file (DDADPF) for policies based on the policy cancellation date.

14.3.29 G3DDAPLYnn Direct Debit Apply for Factoring house nn

This batch job is very similar to P1DCREDITn the difference being that the information transferred to the tape is amounts to be debit from the clients' accounts. The tape is passed to the Factoring House for processing. It is important to note that the base system for the Direct Debit policies assumes all premiums will be collected and generates the appropriate accounting movement in the Subsidiary Account Movement file (ACMV). Therefore, any dishonour will need to be entered into the system on a case by case basis.

The batch job should only be run when the system is “quiet”/inactive.

14.3.30 G3DDnn Direct Debit Extract- Bank nn [nn = factoring house code]

Refer to batch job G3DDAPLYnn.

14.3.31 G3DISHnn Batch Dishonour for Factoring House nn

This batch job is for the processing of Payments collected by Direct Debit requires to be recorded as dishonoured. Dishonours will only complete a representation and not a reversal. Dishonour processing has two stages. The first part is to register the dishonour, which is an on-line transaction; the second part is the actual processing required which takes place in this batch job.

As this is a processing type batch job it will need to be run overnight when the system is “down”.

14.3.32 G3EXBILLXF Extract file for printing of Expected Bill

This batch job extracts all Expected Bill into an extract file.

14.3.33 G3EXPBILL Create Contribution Batch/Expected Bill

This batch job generates the expected bill for a contribution period. Every expected bill have a unique bill number

No expected bill will be printed if the contributions for the previous expected bill have not yet been received. What this means is at any point of time for any employer there cannot be more than one bill outstanding.

The terminated members should not appear in the expected bill. If a member termination is initiated but not yet authorised, the member should still not appear in the expected bill.

This batch job is initiated in the Regular Contribution Batch menu and cannot be submitted in the Batch Processing menu.

14.3.34 G3EXPBILLA Create Contrib Batch/Expected Bill – Adhoc

This batch job does the same process as G3EXPBILL but is initiated at the Ad-hoc Contribution Batch menu.

14.3.35 G3EXPBILLJ Create Contrib Batch/Expected Bill – Journal

This batch job does the same process as G3EXPBILL but is initiated at the Contribution Journal menu

14.3.36 G3GCLMHIST Claim History Report

This batch job prints the Claim History Report.

14.3.37 G3GCLMSTMT Claims Statement

This batch job prints the Claim Statement.

14.3.38 G3GISSUE GROUP Policy Issue

This batch job is initiated when a policy is issued. It will validate and issue the policy to In-force when there are no errors found.

This job cannot be submitted in the Batch Processing menu.

14.3.39 G3GLBALST GL Balances

This batch job produces a statement of GL balances.

The report produced shows current month to date and year to date actuals together with last year to date results

14.3.40 G3GLAUD GL Audit Report

This report extracts data created from the GLPOLISY, General Ledger Update or Posting Batch Job. The purpose of this report is to allow the user access to this information in a number of ways by completion of a parameter screen. Therefore, a number of Audit Reports can be processed against the same data file but extracting different combinations of data and displaying it in several different ways.

This job can be run any time but if it is important to have Audit style reports on the most up to date information then obviously these should be run the next business day after the General Ledger Update batch job GLPOLISY.

14.3.41 G3GLEARN GL Auto Earnings/Accrual

This batch job is run before the GLPOLISY batch job and will extract all underwriting amount, principally the premium for the 'earning' process. The subroutine 'EARNIE' is called and which will evaluate the earning method and based on the earning rules as defined in the GL Auto Earnings/Accrual Definition table (T2899) to split the premium across the accounting periods to which they relate and

be recognised as “earned” when the relevant period becomes current. It produces and updates an earning matrix or profile for that premium. Upon completion of the earning matrix calculation, the unearned matrix file (GLUM) is updated and accounting records are written to the ACMV file by general ledger account, awaiting general ledger posting. The Unearned Matrix Calculation Audit trail is generated.

This job should be run when the on-line system is inactive.

14.3.42 G3GLEARNRL GL Earning Monthly Rollover

The batch job is run after the GLEARNPOL batch job and it will transfer the unearned figures from the unearned matrix file to be regarded as earned in the accounting period processed. These are done by applicable general ledger account level. The resulting accounting movements are written as ACMV records for general ledger posting. This job should be run when the on-line system is inactive.

14.3.43 G3GLDWNLD GL Extract of SUN Accounts

This batch job extracts the posted transactions from G3GLUPDATE to extract file for use in external Accounting system.

14.3.44 G3GLCMPST GL Comparison Statement

General Ledger Comparison Statement enables you to obtain a hard copy of any account figures to compare to the corresponding budgets or last year's performance, etc. As this report is a read only and therefore, does not complete any processing it may be run at any time.

14.3.45 G3GLEXPLR GL Explosion Report

This report requires that a valid General Ledger account is entered at the parameter screen and all accounts below that account in the Chart of Accounts are listed showing the relationship. This batch job can be run at anytime.

14.3.46 G3GLEXPSL GL Expense Sub-Ledger Report

The General Ledger Expense Sub Ledger Report is run on accounts specified in the Expense Sub-ledger Account Group table (T3669). The report lists all the activities in accounts specified and all accounts linked below the account within the chart of accounts. This report is designed to report on Expense type entries.

Again as this report does not complete any data processing and is just a report it may be run at anytime.

14.3.47 G3GLIMPLR GL Implosion Report

General Ledger Implosion Report requests that a valid General Ledger account be entered into the parameter screen and all accounts above that account are listed showing the relationship. This job can be run at anytime.

14.3.48 G3GLROLL GL Year End Rollover

This job "Rolls Over" the accounts that have an appropriate balance forward flag. The GL account records for the new financial year shows the brought forward balance as the new opening amount in the account. For GL accounts with a Balance Brought Forward flag of Z, the job initialises the brought forward balance. This job requires an Appropriation Account be entered in the General Ledger Dissection Codes table (T3698) item ****GL.

The job is run at the end of the financial year and can be run any number of times. However, it is strongly suggested that this job is not run until the on-line system is inactive.

14.3.49 G3GLUMTPRT GL Unearned Matrix Report

This program reads through the General Ledger Unearned Matrix File (GLUM) and produced a 5 year matrix of unearned premiums. As this job does not process any data processing information it can be run at any time

14.3.50 G3GLUNLNK GL Unlinked Accounts Report

This job extracts all the accounts that exist in the General Ledger, whether created manually or by batch run, which are not linked within the Chart of Accounts. The criteria are that Posting Accounts that are not linked to Summary Accounts are listed, as are Summary Accounts that do not have posting accounts linked below them.

This job can be run at anytime.

14.3.51 G3GLUPDATE General Ledger Update

This job can be run daily, weekly or monthly and will extract batches to post to the General Ledger accounts in accordance with the item B3610 in Batch Extract Rules table (T1697). Once extracted these batches are "flagged" as having been processed so they are not selected again. The extract information is restructured into GTRN's and then the amounts are posted to the General Ledger.

In addition this job will create balancing transactions, should a one sided entry enter the system and also create accounts should an account be used that is not set up in the Chart of Accounts. However, before the system can complete these actions certain information has to be entered into the appropriate tables and Chart of Accounts. Please refer to the section on General Ledger update procedures where these entries are explained in more detail.

Due to the sensitivity of this data this job should only be run when the on-line system is inactive.

14.3.52 G3GLYTDST GL Year to Date Statement

It lists transactions in the specified account, and any subsidiary accounts, for the current month and year. This job can be run as and when required.

14.3.53 G3GTRIAL Group Policy Trial Issue

This batch job validates the policy for any errors and produces reports for user's checking before the actual policy issue.

It is initiated in the Policy Admin menu and cannot be submitted in the Batch Processing menu.

14.3.54 G3INSTBIL2 Instalment billing for one policy

The generation of a bill can be done by submitting this batch job.

It is used for automatic recovery of outstanding premium amount from claims.

14.3.55 G3INSTBILL Instalment Billing

The purpose of this job is to prints normal and adjustment bills for all in-force policies with premium that are due for billing.

The bill to date must be specified during the job submission and can be submitted on a Daily, Weekly, Monthly or as many times as specified by user.

14.3.56 G3INTPROC Interest Capitalization Processing

This job will calculate interest for interest bearing funds and bonus units for hybrid funds. The management charge will also be calculated and deducted from the fund.

The closing balance for the period will be calculated. The interest for the next financial period will also include interest on this opening balance. The member's statement will be generated during this batch job. The output from this process is an extract file and not a report.

14.3.59 G3LOSSEXP Loss Experience Report

This batch job produces the Loss Experience Report for non-medical.

14.3.60 G3LOSSXPV6 Loss Experience Report V6

This batch job produces the Loss Experience Report for medical claims.

14.3.61 G3MBRCASH Group Member Cash Accounting

This batch job is similar to G3CASHISS and is initiated at the Receipts module. This is only applicable for Member billing policies.

It will check that if the money is sufficient for outstanding bill and will marry off the outstanding bill for the member with the money received.

14.3.62 G3MBRDATAI Member Data Upload

This batch job is for the upload client, member and contribution data.

The file format can be specified for each policy and used to read and map the data upload file for processing.

14.3.63 G3MBRFEE Member Fee Processing

This batch job deducts the new member fee after the fund and units have been allocated against each member The fee amount will be apportioned against the number of funds that are invested by the insured member

It updates the counter field in table T9804 and after the processing of the member fees.

14.3.64 G3MBRLOAN Batch member enrolment – Member and Loan

This batch job is similar to G3MBRDATAI but only upload loan and receipt data.

14.3.65 G3MCLSTMT Master Client Statement

The batch schedule generates the Client Statement based on client hierarchy. For a selected client, the job extracts all the outstanding transactions for the client and its subsidiaries (lower level in client hierarchy).

This addresses situations when the Finance Department or Credit Control Department requires a consolidated outstanding premium status for a holding company and its subsidiaries or a group of related companies.

14.3.66 G3MGMTCHRG Fund Management Charge Processing job

This batch job calculates the FMC and deducts the charges by encashing units for unit-linked funds.
- for DC, deducts this amount from this charge will be automatically deducted from the respective member account.
- for DB it will deduct the fees from the employee account

14.3.67 G3MRTARI RI for MRTA

This batch job will automatically reduce RI sum insured based on Loan schedule. The RI sum insured will be reduced monthly or yearly (depending on decreasing frequency defined in policy type table) for all MRTA policies at member level

14.3.68 G3OUTCLAIIM Outstanding Claims Report

This batch job produces the Outstanding Claims Report for non-medical claims.

14.3.69 G3OUTCLMV6 Outstanding Claims Report V6

This batch job produces the Outstanding Claims Report for medical claims.

14.3.70 G3OUTCLRSV Outstanding Claim Reserves

This batch job produces the Outstanding Claim Reserves.

14.3.71 G3OUTPAY Outstanding Payments

This batch job will create a report of all authorised and unauthorised outstanding payment requests.

14.3.72 G3PAIDCLAM Paid Claim Report

This batch job produces the Paid Claim Report for non-medical claims.

14.3.73 G3PAIDCLV6 Paid Claim Report V6

This batch job produces the Paid Claim Report for medical claims.

14.3.74 G3PDCHQPOS Posted Dated Cheques

This batch job extracts post dated cheques that are due and automatically posts these cheques as receipts in the system. The job also generates a report which lists all the post dated cheques processed, its details and corresponding receipt number in the system.

14.3.75 G3POLANV Policy Anniversar

This batch job will automatically renew the policy year for another one year for those policies whose anniversary is due. The age and number of years of service will be automatically incremented by one.

This job will change (decrease) sum insured for those situations where sum insured is related to account balance OR related to number of years of service.

14.3.76 G3PRCPAY Processed Payment

This batch job extracts transaction records for all on-line payments and cheque batches and sorts this information into bank code, payment method, authorising user-id and requisition number.

14.3.77 G3PYPNDAUT Payment Pending Authorization/Authorized Requisition Report

This batch job when submitted shows a parameter screen which allows selection of either one or two of the reports; namely Payment Pending Requisition Report and Payment Authorised/Processed Requisition Report.

The Payment Pending Requisition report prints all the requisition pending Authorisation i.e. requisition pending approval (status 'RQ') or approved requisition pending authorisation (status 'AQ'). It is sorted by Requisition number.

The Payment Authorised/Processed Requisition Report shows all the requisitions that have been authorised or processed ('PR'). This includes cheques that have been processed by bank via E-banking function (status 'CQ').

14.3.78 G3RCTUPLD Group Receipt Upload

This batch job is to upload receipt.

During the upload the system will validate that the total received (receipt) must tally or be greater then the total amount in the upload file. If this does not happen, the upload will not be successful and an exception report will be generated.

14.3.79 G3REGCLM Auto-crt/app Regular Claim Payment Occurrence

This batch job creates the regular claim payments requisitions up to the terminal age of benefit end date whichever is earlier..

14.3.80 G3RICOST RI Costing Batch Process

The main purpose of the Reinsurance Costing is to summarize the RI posted premium in the following order and create a record in ZTRN financial transaction file.

- Contract Company
- Reinsurance Account Number
- Contract Number
- Subsidiary Company
- Subsidiary Number
- Arrangement Code
- Major Class (from T9797)

The above batch schedule can be run as and when required

14.3.81G3RIFACSP RI Fac Slip

This batch job prints the RI Facultative Slip.

14.3.82 G3RNWREM Renewal Reminder Letter

This batch job will print the renewal reminder letters.

Two renewal reminder letters will be printed
- First reminder letter will be printed after the renewal invitation letter has been sent and x days before the policy expiry date
- Second reminder letter will be printed y days after the policy expiry date

14.3.83 G3RNWRVW2 Group Renewal Review 2

This batch job has a parameter screen for user to specify the Renewal Review date.

It will extract policies with in-force or pending endorsement status and the policy review flag is 'Y'. The job will calculates the policy renewal review date as Policy expiry less the Renewal months specified in the Policy header and compares that it is equal or less than the Renewal review date in the parameter screen

Records will be extracted into the Online Renewal Review module.

14.3.84 G3RNWRVW3 Online WW Renewal Review Print

This batch is used by online Work with Renewal Review option 'Prt Clt Doc' and 'Prt Coy Doc' to print reports via batch mode. This batch job cannot be initiated from the Batch Schedule submission menu.

14.3.85 G3SUMBENF Summary of Benefit

This batch job prints the list of policies and their corresponding summary of benefits.

14.3.86 G3SWCBAND Change of band during policy Anniversary

This batch job extracts the policies that are processed by G3POLANV where the flag SWCFLG is set to 'Y' in file GCHP.

For each selected policy, the job will get the total balance for the policy and compare the current slab with new slab. If the slabs are different, 100% switching from old to new slab is carried out.

14.3.87 G3SWCPROC Fund Switching Processing Job

This batch job will be submitted when the Member, Employer and Policy level fund switching is requested. It cannot be submitted through the Batch submission menu.

This job will basically create account transaction records (ACTR) to sell the source funds according to details specified in the group switching source file (GSWS)

If switching fee is payable then it will be deducted from the source fund as well and the proceeds to buy the target funds will be net off the switching fee.

If policy level fund switching is requested then this program will go through the group member file (GMHD) to process all the active members in the policy Lastly it will create member transaction history record (MTRN) for each member whose fund is switched

14.3.88 G3UNAPPR Unapproved Requisitions

This batch job provides a parameter screen for user to specify the requisition entry date range for which the requisitions are awaiting Approval. These requisitions are printed in the report. Machine cheques are separated from non-machine cheques. For each type of cheque, it is then sorted by Requisition number.

14.3.89 G3UNAUTHR Requisitions to be Authorised

This batch job will print a list of unauthorised requisitions

14.3.90 G3UNAUTRP Requisitions Approved, Not Authorised

This batch job provides a parameter screen for user to specify the requisition entry date range for which the approved requisitions awaiting Authorisation are selected for printing. Machine cheques are separated from non-machine cheques. For each type of cheques, it is then sorted by Requisition number.

14.3.91 G3UNITALOC Unit Allocation and Deallocation

This batch job converts amount to units (for contribution & DB claims) and units to amount (for expenses and benefit payment – DC claims). This job does not create new records but re-writes existing records with number of units (when units are bought) and with amount (when units are sold).

This job should be run even if all investment funds are interest bearing. Even though unit price is not required for interest bearing funds, the financial transactions to credit fund investment account and debit premium invested account for all funds is done in this job. Hence this job should be run daily.

14.3.92 G3UNPRCHQ Unpresented Cheques Report

This report is in two parts; the first part will come in three versions. Print cheques in date printed order, latest first. A total line and a page break after seven days, then another page break after the first month and monthly thereafter.

The first version will show only those unprocessed cheques with a "large" value. This "large" amount is selected through a parameter screen. Version two shows only those unprocessed cheques, which were printed within or earlier than the entered accounting period. This will include cheques that are presented after the nominated accounting period. Version three will list all unpresented cheques irrespective of date or amount.

Part two is a summary report. This will print a one-page summary it has six lines and three columns. Detail lines are This Week, This Month, Last Month, 2 Months Ago, 3 to 12 Months Ago and Greater than 12 Months. The Columns are Small Amount, Large Amount and Total.

14.4 Batch Schedule

The batch schedule below provides the suggested list of batch jobs for ad-hoc, daily, monthly and yearly run. This list of jobs may change depending on the client's needs and is by no means exhaustive.

It is important to note that the sequence of the batch job submission is very important when there is a certain degree of dependency from each or several jobs.

The monthly schedule is the daily schedule plus monthly jobs and the quarterly schedule is actually the monthly schedule plus a couple of specific quarter's jobs injected at the appropriate sequence. Similarly, the yearly schedule is an 'expansion' of the quarterly.

Below is the list of the batch jobs and their run frequency.

Run Frequency - Ad-hoc

Run Freq	Job Name	Job Description
Ad-hoc	G3AGNTRPT	Agency Register Version 2
	G3EXBILLXF	Extract File for printing of expected bill
	G3GISSUE	GROUP Policy Issue
	G3GLCMPST	GL Comparison Statement
	G3GLEXPLR	GL Explosion Report
	G3GLIMPLR	GL Implosion Report
	G3GLUNLNK	GL Unlinked Accounts Report
	G3GTRIAL	Group Policy Trial Issue
	G3MBRDATAI	Batch member enrollment
	G3MBRLOAN	Batch member enrollment - Member and Loan
	G3MCLSTMT	Master Client Statement (GROUP)
	G3RCTUPL	Group Receipt Upload
	G3RNWRVW3	Online W/W Renewal Review Print Doc (V6.2)
	G3SUMMBEN	Summary of Benefit

Run Frequency - Daily

Run Freq	Job Name	Job Description
Daily	G3AUTOALOC	Automatic Number Allocation - Company 3
	G3BILLTRVL	Open Ended Travel Billing
	G3BNFTBILL	Benefit Billing Batch Job
	G3CASHISS	Group Cash Accounting Issue
	G3CASHLIST	Cash Reporting
	G3CHQLST	Auto Cheque Update/Report
	G3CHQPRN01	Payments Processing - 01
	G3CHQPRN02	Payments Processing - 02
	G3CLAIMPAY	Claim Payments
	G3CLM2PAY	Claim/2 Payments
	G3COMMON	Common batch job for 5 reports
	G3CTBPROC	Contribution processing batch
	G3CTBPROCA	Contribution Processing Batch - Adhoc
	G3CTBPROCJ	Contribution Processing Batch - Journal
	G3EXPBILL	Create Cont Batch/ Exp Bill
	G3EXPBILL1	Create Cont Batch/Exp Bill - Adhoc
	G3EXPBILLA	Create Cont Batch/Exp Bill - Journal
	G3GLUPDATE	GL Update
	G3INSTBIL2	Instalment Billing for one policy
	G3INSTBILL	Instalment Billing
	G3INTPROC	Interest Capitalisation Processing
	G3MBRCASH	Group mbr cash accounting
	G3MBRFEE	Member Fee Processing job
	G3MGMTCHRG	Fund Management Charge Processing job
	G3MRTARI	RI for MRTA
	G3PDCHQPOS	Post-Dated Cheque Posting
	G3POLANV	Policy Anniversary
	G3PRCPAY	Processed Payment

	G3PYPNDAUT	Payment Pending Authorisation/Authorised Req'n Rpt
	G3REGCLM	Auto-crt/app Regular Claim Payment Occurrence
	G3RIFACSP	RI Fac Slip
	G3SWCBAND	Change of band during anniversary process
	G3SWCPROC	Fund Switching Processing job
	G3UNAPPR	Unapproved Requisitions
	G3UNAUTHR	Requisitions to be Authorised
	G3UNAUTRP	Reqn Approved, Not Authorised
	G3UNITALOC	Unit Allocation / Deallocation
	G3UNPRCHQ	Unpresent Cheques Report

Run Frequency – Monthly and Yearly

Run Freq	Job Name	Job Description
Monthly	G3AGTCOM	Auto-Generate Agents Commission Requisition
	G3AGTPAY	AGENT COMMISSION PAYMENT
	G3AGTPERF	Agent Performance All Branches
	G3AUTOLAP	Group/400 Policy Auto Lapse
	G3AUTOLAP2	Auto Lapse for Grp & Grp Retail when prem not recv
	G3CLAMRECV	Claims due for recovery
	G3CLHISTV6	Claim History Report (V6)
	G3CLMRCV	Claim/2 Outstanding Recoveries
	G3CLMSTMT	Claim/2 Statement
	G3CREDITS	Direct Credits Extraction and Tape Create
	G3DD06 - 20	Direct Debit Extraction - Factoring House 06
	G3DDAEX1	1st Rejection And Exception Report For Group
	G3DDAEX2	Approval Letter For Group
	G3DDAEX3	Notice Of Cancellation For Group
	G3DDAPLY01 - 20	Direct Dibits Apply
	G3DISH	Group Batch Dishonour
	G3GCLMHIST	Claim History Report
	G3GCLMSTMT	Claims Statement
	G3GLAUD	GL Audit Report
	G3GLBALST	GL Balances
	G3GLDWNLD	GL Extract of SUN Accounts
	G3GLEARN	General Ledger Auto Earning/Accrual
	G3GLEARNRL	GL Earning Monthly Rollover
	G3GLEXPSL	GL Expense Sub-Ledger Report
	G3GLUMTPRT	GL Unearned Matrix Report
	G3LOSSEXP	Loss Experience Report
	G3LOSSXPV6	Loss Experience Report V6
	G3OUTCLAIM	Outstanding Claims Report
	G3OUTCLMV6	Outstanding Claim Report V6
	G3OUTCLRSV	Outstanding claim reserves
	G3OUTPAY	Outstanding Payments
	G3PAIDCLAM	Paid Claims Report
	G3PAIDCLV6	Paid Claim Report V6
	G3RICOST	RI Costing Batch Process

	G3RNWREM	Renewal Reminder Letter
	G3RNWRVW2	Group Renewal Review-2 (V6.2)
Yearly	G3GLROLL	GL Year End Rollover