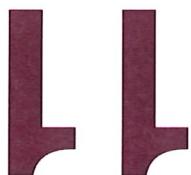


- After learning the content of this assignment, you should be able to:
- Explain how an insurer's claim function achieves its primary goals, provides valuable information to other departments, and interacts effectively with its outside contacts.
  - Describe claims departments in terms of the following:
    - How they can be structured
    - The types and functions of claims personnel
    - How their performance can be measured
    - Explain how the following measures are used to ensure regulatory compliance:
      - Controls
      - Claims guidelines, policies, and procedures
      - Supervisor and manager reviews
      - Claims audits
  - Summarize the activities performed in the claim handling process and the purpose of each.
  - Describe the framework for coverage analysis and the information obtained by following it.
  - Given a claim scenario, demonstrate how a claim representative can use the claim handling process and the framework for coverage analysis to solve a claim.

## Educational Objectives

# The Claim Function



Direct Your Learning



stressful situations. A claim representative should handle a claim in a way that accommodates and its consequences are not routine and can be overwhelming.

From the insurer's perspective, claims are expected, and claim representatives must deal with them routinely. For the individuals involved, the loss might be liable.

Third-party claim made by someone against the insured, or (2) indirectly, by handling a claim made by the insured against the insurer, either (1) directly, when the loss involves a first-party service to the insured, or (2) indirectly, when the loss involves a third-party service to the insured.

The insurer fulfills this promise by providing fair, prompt, and equitable loss is fulfilled.

The first goal of the claim function is to satisfy the insurer's obligations to the insured as set forth in the insurance policy. Following a loss, the promise of the insurance agreement to pay, defend, or indemnify in the event of a covered loss is fulfilled.

### Complying With the Contractual Promise

- Supporting the insurer's financial goals
- Complying with the contractual promise

When establishing goals for the claim function, senior management should recognize the effect the claim function has on both the insurance customer and the insurer itself. The claim function has these two primary goals:

### Claim Function Goals

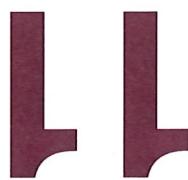
Proper, efficient performance of the claim function greatly influences the insurer's success. When the two goals of the claim function are attained, successful communication with individuals within and outside the insurance organization.

able to interact effectively with individuals within and outside the insurance are among the most visible of insurer employees; consequently, they must be able to interact effectively with individuals within and outside the insurance

An insurer's claim function must fulfill its responsibility to the insured and pay covered claims, while also supporting an insurer's financial goals.

## OVERVIEW OF THE CLAIM FUNCTION

### The Claim Function





The claim function provides valuable information to other insurer departments. The three primary recipients of claim information are the marketing, underwriting, and actuarial departments.

## Claim Information Users

An insurer's success in achieving its financial goal is reflected in its reputation for providing the service promised. A reputation for resisting legitimate claims can undermine the effectiveness of insurer advertising or its goodwill earned over the years. Consequently, the two goals of the claim function work together to help bring about a profitable insurance operation.

Conversely, undervalued claims can result in dissatisfaction insureds, litigation, or regulatory oversights. Insureds and claimants who believe they are being treated fairly are likely to accept the claim representative's settlement offer, but if insureds and claimants are treated unfairly, they might sue the insurer or file a complaint with their state insurance department. Mishandled claims can lead to litigation or regulatory oversight, both of which erode good will and generate increased insurer expenses, thereby reducing the insurer's profitability.

Inureds and other claimants are entitled to a fair claim settlement. By overcompensating an insured or a claimant, the insurer unnecessarily raises the cost of insurance for all of its insureds. Overpaid claims can lower insurer profits and result in higher policy premiums.

By managing all claim function expenses, setting appropriate spending policies, and using appropriate priced providers and services, claim managers can help maintain an insurer's underwriting profit. Similarly, claim staff can avoid overspending on costs of handling claims, claim operations, or other expenses. Finally, by ensuring fair claim settlements, claim representatives prevent any unnecessary increase in the cost of insurance and subsequent reduction in the insurer's underwriting profit.

The second goal of the claim function is supporting the insurer's financial goal. Achieving this goal is generally the responsibility of the marketing and underwriting departments. However, it would be shortsighted not to recognize the role of the claim function in helping insurers achieve an underwriting profit by controlling expenses and paying only legitimate claims.

## Supporting the Insurer's Financial Goals

Were it not for insurance, administration would be slow, inefficient, and difficult. Were it not for insurance, administration would be slow, inefficient, and difficult. Treating all parties involved fairly and equitably, and do so in a timely manner,

*Cost of capital  
Bad faith  
Litigation*

## Marketing

The marketing department needs information about customer satisfaction, timeliness of settlements, and other variables that assist in marketing the insurance products. The marketing department recognizes that the other services the insurer performs for the insured are forgotten quickly if the insurance product fails to perform well after a loss occurrence. Many insurers that market commercial policies have developed "niche" products to address the needs of specific types of insureds. The intent of these products is to become the recognized expert in certain business classes, providing a product and service that cannot easily be equaled elsewhere. The claim handling process can be a source of new coverage ideas and product innovations for niche markets.

e.g. Club of house-hair plaster

Many insurers that market commercial policies have developed "niche" products to address the needs of specific types of insureds. The intent of these products is to become the recognized expert in certain business classes, providing a product and service that cannot easily be equaled elsewhere. The claim handling process can be a source of new coverage ideas and product innovations for niche markets.

## Underwriting

The insurance business operates effectively if underwriters accept loss exposures that are likely to experience only the types and amounts of losses that are consistent with their rates. If underwriters accept loss exposures that experience more losses than anticipated, the rates charged by the insurer will be inadequate, and the insurer could become financially insolvent. Claim periods sometimes help underwriters in this regard by ensuring that claims are paid fairly and accurately, and either negotiate or adjust the premium to reflect the actual experience. Underwriters enable claim handlers to evaluate, select, and appropriately price loss exposures based on consistent claim costs.

When claim representatives inspect accident scenes in homes or at work sites as part of the claim investigation, they sometimes notice loss exposure characteristics, either negative or positive, that were not readily apparent in the insurance application. When claim representatives report such findings to the underwriter, the underwriter may adjust the premium or take other actions to accommodate the difference in the exposure. For example, based on information from the claim representative, the underwriter may cancel coverage or renew it only if the insured implements corrective measures. Alternatively, the underwriter may grant a premium credit based on a claim representative's report of an above-average loss exposure.

A number of similar claims may also alert underwriting management to a problem for a particular type or class of insured. These claims might be the renew it only if the insured implements corrective measures. Alternatively, the underwriter may grant a premium credit based on a claim representative's report of an above-average loss exposure.



lawyers, and state regulators. Other than the producer, claim department personnel are the contacts within the insurer who are most visible to the public. Therefore, the claim department must interact effectively with outside contacts, such as the public.

## Claim Department Contacts

All of the claim information that actuaries collect from claim personnel must be accurately represented through appropriate reserves reporting methods in the insurer's financial statements. Actuaries must update these statements for reporting at various times during the year. When claim payments are recorded accurately, raw data that actuaries use to develop rates will be accurate and the rates will reflect the insurer's loss experience.

In addition to incurred loss information, actuaries need accurate information on losses adjusting expenses and recoverable amounts associated with claims, such as salvage and subrogation, any ceded reinsurance recoverable, and deductibles (when the insurer pays an entire claim and then asks the insurer to reimburse the deductible amount).

Actuaries need accurate information not only on losses that have been paid but also on losses that have occurred and are reserved for payment, collectively called incurred losses. Loss reserves can be increased or decreased as the claim develops, and reserve changes help actuaries more accurately predict loss development. Incurred loss information helps actuaries establish reserves for incurred but not reported (IBNR) losses and project the development of open claims for which the reserves might change substantially before the claim is finally settled.

*claims settlement!*

## Actuarial

Claim representatives, underwriters, and make any needed changes to clarify the coverage. Underwriters, the underwriters can reassess coverage forms and endorsements applications and producers' notes, which may affect coverage interpretation. When claim representatives explain their interpretations of coverage to the intentions of the two parties to the insurance using the insurance authority on coverage interpretation, underwriters can provide insight into validity loss information. Although claim personnel are typically the final authority on coverage interpretation, underwriters is not limited to producing loss information. Although claim personnel are typically the final

of business to deteriorate or could increase the number of claims presented. An adverse court ruling could also cause the loss experience of a class losses. This practice might have caused a number of fire the structure being repaired. This process of replacing composite roofs by moving the tar smelter to the root of whole. For example, some roofing contractors might have tried to speed the process of new technologies being used by the class of insures as a result of new processes or techniques being used by the class of insures as a

*(also, adverse selection)*  
"over time" and "claims terms"



# What duty by claimant vs.

## claimant & insurer?

Most claimants' knowledge of insurance is less sophisticated than that of an insurance professional. Claim representatives must be prepared to explain the policy's claim provisions to the claimant as those provisions apply to the claimant's property damage or injury. A well-prepared, professional claim representative who empathizes with the claimant's perspective and increases the likelihood of reaching a mutually agreeable settlement.

Claim representatives must empathize with claimants to interact effectively with them. Claim representatives must include anger, depression, frustration, or hopelessness to a loss, which may affect some type of emotional reaction. Claimants' sustained a loss. Most claimants suffer some type of emotional reaction directly with claimants influence their satisfaction with the insurance company.

Because the claim representative is an insured's and a claimant's primary contact with the insurer, claim service significantly affects an insured's or a claimant's (referred to as "claimant") through the remainder of this section.

Claim representatives first contact with a claimant occurs after the claimant has sustained a loss. Most claimants suffer some type of emotional reaction to a loss, which may include anger, depression, frustration, or hopelessness. Claim representatives must empathize with claimants to interact effectively with them.

Claim representatives must recognize that claim handling requires a high degree of integrity, involving honesty and diplomacy. If the claim representative is concerned that coverage will not apply to the damage or injury, he or she must explain those concerns to the claimant and preserve the insurer's right to deny a claim that is not covered. Even when a claim is denied, a claim representative who carefully explains the issues and empathizes with the claimant might be able to avoid costly litigation.

Claim representatives must recognize that claim handling requires a high degree of integrity, involving honesty and diplomacy. If the claim representative is concerned that coverage will not apply to the damage or injury, he or she must explain those concerns to the claimant and preserve the insurer's right to deny a claim that is not covered. Even when a claim is denied, a claim representative who carefully explains the issues and empathizes with the claimant might be able to avoid costly litigation.

Technology has allowed many insurers to improve the growth of cell phones and the Internet and progressing to improvements in wireless technology and speed of their claim service. Starting with the growth of cellular devices, claim departments have found new ways to streamline the claim process and improve customer satisfaction.

Technology facilitates communications among field personnel, regional or local claim offices, claimants, vendors, and service providers. In catastrophe losses, floods, tornadoes, hurricanes, and earthquakes can cause significant damage to the infrastructure used for traditional communication systems. Satellite transmissions and other modern communication devices used in damage to the infrastructure used for traditional communication systems.

Local claim offices, claimants, vendors, and service providers. In catastrophe losses, floods, tornadoes, hurricanes, and earthquakes can cause significant damage to the infrastructure used for traditional communication systems.

Wireless technology may overcome some of these problems to enable continued communications for claim personnel and ultimately, faster and better customer service for claimants when they need it most.



## Lawyers

For some types of claims and in certain areas of the United States, claimants are more likely to hire lawyers, often leading to costly litigation. Although legal representation can result in a higher payment by the insurer, representation does not necessarily result in higher settlements for claimants, because legal representation also does not guarantee a faster settlement. Even if litigation ensues, claimants must pay expenses and legal fees from settlement negotiations. Litigation also does not necessarily result in higher settlements for claimants, because it will typically hire a lawyer from the jurisdiction in which the claim is submittted. The lawyer will provide advice regarding specific losses and legal issues. Claim representatives will assist the insurer's lawyers as needed by sharing claims details and assembling information that supports the insurer's legal position.

When an insurer needs a lawyer either to defend the insured or to defend claimants' lawyers, claim representatives should continue to interact in a cordial, professional manner with claimants' lawyers.

State insurance regulators monitor insurers' activities in the claim handling process. Regulators exercise controls by licensing claim representatives. State insurance regulators monitoring activities in the claim handling process. Enforcement is usually handled through the Unfair Claims Settlement Investigations Consumer Complaints, and performing market conduct investigations.

Practices Act or similar legislation.

Not all states currently license claim representatives, and no standard procedure or uniform regulation exists for those that do. Some states require only for independent adjusters, who work for many insurers, or for public adjusters, who represent insureds in first-party claims against insurers. Other states require staff claim representatives to be licensed.

State insurance regulators also handle customer complaints made against an insurer. Most states have a specific time limit within which the insurer must answer or act on inquiries from the insurance department. Failure to respond as part of their normal audit of insurer activities or in response to specific complaints, it audits all departments that interact directly with insureds and practitioners; it audits more than just claim departments.

claimants.

## Regulators

**State Regulators**



A third-party administrator (TPA) provides administrative services associated with risk financing and insurance.

The senior claims officer may have several claim offices or branches country-wide or worldwide. Staff from remote claim offices can all report directly to the home-office claims department, or regional/divisional claims officers may oversee the territory. Regional claims officers may have one or more branch offices reporting to them. Each branch office may have a claims manager, one or more claims supervisors, and a staff of claims representatives. Similar department structures are adopted by third-party administrators (TPAs). A claims representative (a generic title that refers to all who adjust claims, except for public adjusters) fulfills the promise to pay the insured or to pay on behalf of the insured by handling a claim when a loss occurs. People who handle claims may be staff claim representatives, independent adjusters, employees of TPAs, or producers who sell policies to insureds. In addition, public adjusters also handle claims by representing the interests of insureds to the insurer.

## Claims Personnel

Usually, a senior claim officer heads the claims department and reports to the chief executive officer, the chief financial officer, or the chief underwriting officer. The senior officer may have several claim offices or branches country-wide. The senior claims officer may have several claim offices or branches country-wide or worldwide. Staff from remote claim offices can all report directly to the home-office claims department, or regional/divisional claims officers may oversee the territory. Regional claims officers may have one or more branch offices reporting to them. Each branch office may have a claims manager, one or more claims supervisors, and a staff of claims representatives. Similar department structures are adopted by third-party administrators (TPAs).

A sample departmental structure can illustrate the various claim positions within the department. See the exhibit "Claims Department Organization Chart."

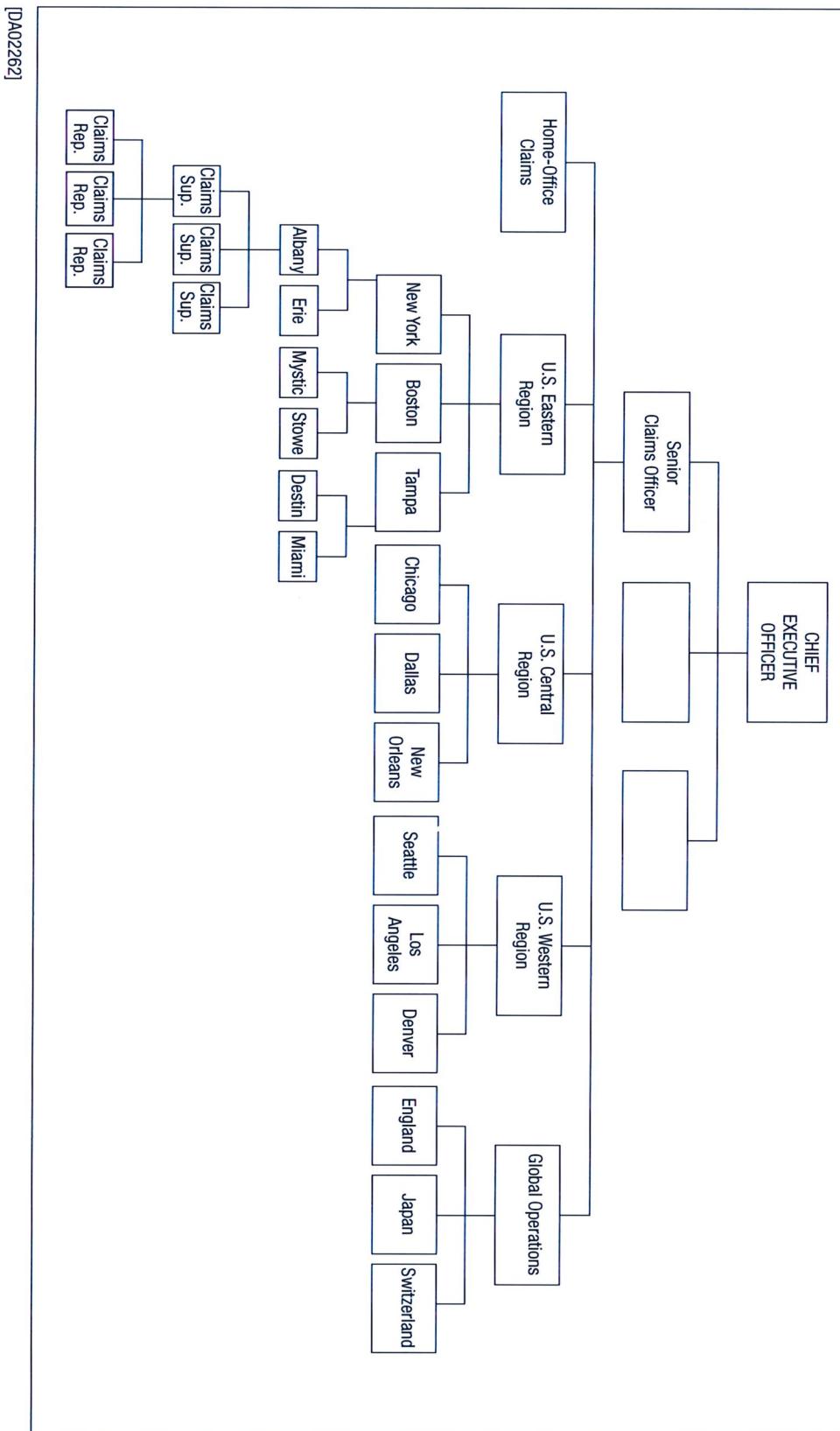
## Claims Department Structure

The loss payments, expenses, and other information generated by the claim losses, an insurer's claim department must operate efficiently. Because the claim function is crucial to an insurer's promise to pay covered departments, an insurer's claim department must operate efficiently. Insurer's claim department helps explain how it operates.

Because the claim function is crucial to an insurer's promise to pay covered departments, an insurer's claim department must operate efficiently.

## CLAIMS DEPARTMENT STRUCTURE, PERSONNEL, AND PERFORMANCE

## Claims Department Organization Chart



[DA02262]



Businesses that choose to self-insure do not use agents, underwriters, or other typical insurer personnel. However, they do need personnel to handle the losses that arise. Self-insured businesses can employ their own claims representatives or contract with TPAs, who handle claims, keep claims records, and perform statistical analyses. TPAs are often associated with large insurance companies. Many property-casualty insurers have established subsidiary companies that serve independent adjusting firms or with subsidiaries of insurance companies. Many and losses that arise. Self-insured businesses can employ their own claims representatives or contract with TPAs, who handle claims, keep claims records, and perform statistical analyses. TPAs are often associated with large insurance companies. Many

## Third-Party Administrators

Some independent adjusters are self-employed, but many work for adjusting firms with many offices employing hundreds of adjusters. Firms that range in size from one small office with a few adjusters to national experts in highly specialized fields, such as investigating aircraft accidents. When special skills are needed. For example, some independent adjusters are insurers may also use independent adjusters to meet desired service levels or large number of claims quickly enough to satisfy the insurer and its insurers. Some insurers hire independent adjusters when a disaster strikes to handle the representatives are too busy to handle all claims themselves. For example, staff claims representatives may need assistance when a disaster strikes to handle the field work.

Some insurers use independent adjusters for all field claims work. These insurers employ claims personnel in their home office or branch offices to monitor claims progress and settle claims but use independent adjusters to handle all claims for insurers for a fee. An independent adjuster represents a claims representative who handles claims for insurers for a fee.

## Independent Adjusters

Certain insurers may not find it economically feasible to set up claim offices in every state in which insurers are located. Insurers may contract with independent adjusters to handle claims in strategic locations. Some insurers use independent adjusters for all field claims work. These insurers representatives to handle claims in areas away from the branch office to enable the insurer to serve insurers efficiently. If the branch or region covers a large territory, the insurer's home office, and others involved in the loss; and inspecting damage. Staff claims lawyers, and others investigating the scene of the loss; meeting with insurers, claimants, tasks as investigating the scene of the loss; meeting with insurers, claimants, also called outside claims representatives, handle claims that require such handling claims both inside and outside the office. Field claims representatives, exclusively from the insurer's office, and field claims representatives, who claims. They may include inside claims representatives, who handle most staff claims representatives are employees of an insurer and handle most

## Staff Claims Representatives



When an insurer's loss ratio increases, the claims department, along with other insurer functions, is pressured to reduce expenses. Claims professionals could quickly reduce loss adjusting expenses in the short term by offering insureds and claimants the settlement demand rather than the settle- tives deserved. However, to reduce loss adjusting expenses in the long term, actuaries failed to price the insurer's products correctly.

A loss ratio is one of the most commonly used measures for evaluating an insurer's financial well-being. It measures losses and loss adjustment expenses against earned premiums and reflects the percentage of premiums being consumed by losses. An increasing loss ratio could indicate that the insurer is improperly pricing the claims function. Increasing losses could also mean that underwriting failed to select above-average loss exposures or that the insurer's financial well-being is deteriorating.

## Profitability Measures

The quality of a claims department's performance can be measured using best practices, claims audits, and customer satisfaction. The department's performance using a loss ratio, which is a profitability measure, fluctuates with insurer profit goals, and insurer measures its claim and underwriting and consistent ratemaking data. Because fair claims payment does not contribute to survival, claims departments play a crucial role in insurer profitability by paying fair amounts for legitimate claims and by providing accurate, reliable, wide geographic area, insurers face special issues in evaluating and measuring their performance. Insurers are businesses and, as such, must make a profit because a claims department staff can be diverse and may be spread over a

## Claims Performance Measures

If a claim is complex, or if settlement negotiations are not progressing satisfactorily with the insurer, the insured may hire a **public adjuster** to protect his or her interests. Some states have statutes that govern the services public adjusters can provide. In general, the public adjuster prepares the insured's claim and negotiates the settlement with the staff claims representative or mediator. The insured, in turn, pays the public adjuster's fee, which is usually a percentage of the settlement.

Public adjuster or outside organization or person hired by an insured to represent the insured in a claim in exchange for a fee.

## Public Adjusters

The term "producer" is used to describe anyone who sells insurance. This can include agents, brokers, insurer employees, or intermediaries. Insurers may give some producers the authority to pay claims up to a certain amount, such as \$2,500. Those producers can issue claims payments, called drafts, directly to insureds for covered claims, thus reducing the time an insured waits for payment. In this capacity, producers function much like inside claims representatives.

## Producers



Claims department best practices are often based on legal requirements specific by regulators, legislators, and courts. For example, a claims department may have a best practice that states "Every claim will be acknowledged within twenty-four hours." This time frame may have been selected because a claim regulation, law, or court decision that requires insurers to acknowledge a claim within twenty-four hours.

In the context of a claims department, the term "best practices" usually refers to a system of identified internal practices that produce superior performance. Best practices are usually shared with every claim representative. An insurer can create best practices by studying its own performance or the performance of similar successful insurers.

Three of the more frequently used methods of evaluating a claims depart-

## Quality Measures

- Feedback: a. and b. Offering insureds and claimants the settlement demanded rather than the settlement deserved reduces loss adjusting expenses in the short term, while the first two choices reduce adjusting expenses in the long term.
- c. Offering insureds and claimants the settlement demanded rather than the settlement deserved.
- d. None of these measures will reduce loss adjusting expenses.

An insurer's chief executive officer is analyzing the organization's profitability. He observes that in 20X0, the insurer's loss ratio was 0.67, while, in 20X1, the insurer's loss ratio was 0.70. In 20X2, the loss ratio was 0.75. Further analysis indicates that the actuarial department is pricing the insurer's products correctly and that the underwriting department was selecting above-average loss adjusters. This leads the CEO to focus on the claims department as potential exposures. Finally underrating the organization's profitability, which of the following are measures that the claims department could employ in an attempt to reduce losses adjusting expenses in the long term?

- a. Resisting; researching; negotiating; and, if necessary, litigating inflated settlement demands.
- b. Following claims procedures.
- c. Offering insureds and claimants the settlement demanded rather than the settlement deserved.
- d. None of these measures will reduce loss adjusting expenses.

## Apply Your Knowledge

- Insurance companies play an important role in managing losses, the claims department plays an important role in handling losses, and controlling expenses associated with handling losses.
- Settlement demands should be resisted; researched; negotiated; and, if necessary, litigated. Loss adjustment expenses can also be reduced by follow-
- ing claims procedures. By managing losses and controlling expenses associated with handling losses, the claims department plays an important role in an insurer's profitability.



However received, the complainant must be investigated by management and responded to in a timely manner. Complaints about issues such as not receiving a return phone call may indicate legitimate service issues. Other complaints can simply indicate dissatisfaction with an otherwise-valid claim settlement. Review of complaints received in a claim office can show whether complainants come directly from the insurance company, or they can be submitted by a state insurance department on behalf of an insured, a claimant, or a vendor.

Complaints may come directly from the insured, claimant, or vendor, or they to complainants, and most claim departments have procedures for doing so. Complaints are usually acknowledged, supervisors or managers must respond to them receive about the performance of individual claim representatives. While former satisfaction, claims supervisors and managers monitor correspondence quality of a claims department's performance is also measured by cus-

[DAO2267]

Quantitative and Qualitative Audit Factors	
Quantitative	Qualitative
Timeliness of reports	Reliable reserving
Timeliness of reserving	Accurate evaluation of insured's liability
Follow-up on subrogation opportunity	Litigation cost management
Number of files opened each month	Proper releases taken
Number of files closed each month	Correct coverage evaluation
Number of files reopened each month	Good negotiation skills
Follow-up on subrogation opportunity	Average claim settlement value by
Percentage of cases going to trial	Thorough investigations
Percentage of claims entering litigation	Claims type
Percentage of cases going to trial	Accuracy of data entry

Insurance use claims audits to ensure compliance with best practices and gather statistical information on claims. A claims audit is performed by auditors can be performed by the claims staff who work on the files (called a self-audit), or they can be performed by claims representatives from other offices or by a team from the home office. Claims audits usually evaluate both quantitative and qualitative factors. See the exhibit "Quantitative and Qualitative Audit Factors."



Claims guidelines  
A set of guidelines and instructions that specify how certain claims handling tasks should be performed by setting policies and procedures for claim handling.

Steps for performing some tasks can be clearly specified in claims guidelines so that claims personnel ensure that information is accurate and that claims are handled properly and in good faith. Claims departments can use guidelines in training new claims personnel because they provide instruction for performing tasks properly. They are also useful as a reference for performing tasks or when one employee must perform another employee's duties because of vacation, illness, or another absence. Lines give specific online directions for handling the file to ensure that all claims guidelines can be in electronic or paper form. Some electronic guidelines must defend a bad-faith lawsuit. Evidence that good-faith claims handling perishes claim issues are addressed.

A combination of compliance measures helps insurers enforce good-faith claims handling, encourages claims personnel to provide complete and accurate information to management, products, reinsurers, lawyers, insurers, claimants, and others, and makes the insurer's operation run efficiently and with sound expense management.

- Claims guidelines, policies, and procedures
- Controls, such as reports, access security, authority levels, and tracking
- Supervisor and manager reviews
- Claims audits

Compliance measures include these:

Insurers institute compliance measures, which are various guidelines that legal and regulatory requirements are met and to promote good-faith claims handling practices.

## COMPLIANCE MEASURES USED TO ENSURE REGULATORY

### COMPLIANCE

### MEASURES USED TO ENSURE REGULATORY



**Activity Log**

A record of all the activities while handling a claim.  
and analyses that occur

exactly what has occurred. Claims representatives should carefully document for itself so that anyone reading the activity log and other documents knows claim are likely to forget important information. A claim file should speak representatives who rely on their memories to recall all the activity on a activity log is a crucial record of activity that has occurred on each claim. Claims because claims representatives handle a large volume of claims, the activity log is a particular claim. See the exhibit "Sample Activity Log."

An activity log is a record of all the activities and analyses that occur regard-

the claim and their investigation plans.

A claims information system might set an automatic diary entry when a claim is first reported. For example, an automatic diary of seven days might be set for each new claim. Claims representatives might modify that date, depending on to review the file or reserves; to make a payment; to contact the claims representative to set intervals to remind the claims representative

send a computer message at set intervals to remind the claims representative claim and a note in the file of that date. An automated diary system might viders. See the exhibit "Sample Automated Diary."

claimsant, or witness; or to request additional information from service providers to review the file or reserves; to make a payment; to contact the claims representative to help them handle all of them properly. A diary, or suspense, is a system to remind claims personnel to perform another activity. Claims representatives usually have many files or perform another activity. Claims representatives usually have many supervisors and managers often use diaries as reminders to review claim

claimants are less likely to find fault with the claims handling. Some will consistently follow company policies and procedures, insures and measures to help guarantee good-faith claims handling. When claims per-

cedures were prescribed and followed demonstrates that the insurer takes

particular task on a claim.  
A system to remind claims personnel to perform a

Diary, or suspense

[DAO3173]

Subject:	Activity Log	Category:	File Documentation	Purpose:	The activity log is a chronological record of file development that describes the activities and analysis on the claim file.	Procedure:	The activity log form should be completed as events occur and include the day, month, year, time, and person making notes. The activity log should be a brief notation of file activities and analyses. Detailed explanations may appear in other documents and file reports.	Responsibility:	Anyone who conducts activity on the file must comply with this procedure.
WORTHY INSURANCE COMPANY CLAIMS GUIDELINES									
<b>Claims Guidelines Sample Page</b>									



Sample Activity Log			
Date	Activity	Diary	Claim # 12345678
12/14/X1	No response from Mrs. Darlington. Called insured—	Spoke with 16-yr-old daughter. She will have her mother (the insured) call me tomorrow.	12/14/X1
12/15/X1	Recd claim from home office. Called insured—	Mrs. Darlington backed out of her driveway and hit the neighbor's mailbox across the street, which belongs to Mr. Bounds, of 1220 NW 84th Street, Anytown, PA 19344. His evening phone number is 111-123-4567. The mailbox was mounted on a concrete post that suffered no damage, and Mr. Bounds told Mrs. Darlington that he would not file an insurance claim for damages. Mrs. Darlington's car is at Sam's Auto Repair. Arranged for inspection. Explained claims process to Mrs. Darlington. Promised Mr. Bounds to verify that his mailbox was not damaged and that he will not file a claim.	12/15/X1
12/20/X1	Estimates rec'd and differences analyzed to ensure fair comparison. Called Mrs. Darlington and reviewed repair estimate with her. Agreed on settlement amount. Processed payment today.	Closed file.	12/20/X1

Sample Automated Diary			
Claim # 12345678	TOL Collision	DOL 12/12/X0	POI # 78-02-3359 Ins Brown, Jackie
DIARY	Claims rep Stone	Date set 12/12/X1	DIARY 12/14/X1
<b>Notes:</b> Insured is to call today. Follow up if no response. Need vehicle location for inspection.			



tive should be assigned to a different territory to reduce independent adjusting reasons for those assignments and determine whether a staff claims representative's claims are assigned to independent adjusters, the insurer can examine the corporate goals for expense management. If the reports indicate that many reports of claims assigned to independent adjusters can help an insurer meet

produced for parties outside the insurer and agents' commission calculations. To the error. The error could then be corrected before it affected reports a \$10,000 reserve as a \$100,000 reserve, the daily report would alert managers to the reserves above \$100,000. If claims personnel mistakenly entered claims with reserves above a daily report listing all possible errors. For example, managers might review a daily report indicating Reports can help insurer personnel monitor claims practices by indicating

- Claims closed without payment by a claims representative
- Claims with reserves larger than a specified amount
- Claims closed by agents
- Claims in litigation
- Claims assigned to independent adjusters
- Claims with reserves above a specified amount

include information such as this:

reports to ensure that claims have been entered correctly. Reports might claims reports. Claims representatives, supervisors, and managers review those Most insurers' claims information systems can be used to generate periodic

information tracking systems. Claims departments can use various electronic controls as compliance measures, such as claims reports, access security, authority levels, and claims

## Controls

review activity logs to provide those details. Activity logs are also useful in claims audits. Producers are sometimes interested in the details of how a claim was handled, and claims personnel can

might work on a claim, the activity log is crucial. Specifically when more than one claims representative matation to the insured. Especially when more than one claims representative the two claims representatives might give contradictory or conflicting information during the evening shift. Without an accurate, complete activity log, and another claims representative might answer a question from the day shift, claims representative might take an insured's statement during the day shift, and hours to provide better service to insureds and claimants. As a result, one Many insurers use a team approach to claims handling and offer extended

activity log to remind himself or herself of previous conversations or other during the claims process, the claims representative can refer to entries in the every activity on a claim. If insureds or claimants develop misunderstandings activity log to communicate.



Authority level	<p>Authority levels refer to the reserve amounts and payment amounts that claims personnel are allowed to set and make. Claim information systems from making changes to claims information that exceed their authority and review or modify claim information. Authority levels restrict claims personnel from requesting crucial information in the claims information system, such as reserve amounts or claim codes, and can prevent them from requesting amounts assigned to claims personnel to limit claims personnel to handle those reserves or payments. Second, if inexperienced claims personnel exceed their authority level, the claims system prevents errors.</p>
Access security	<p>The first method of access security requires a person attempting to access claims information using three methods. A security setting that controls an individual's ability to computer user's ability to review, enter, and change information in a claims department. The system to enter a password maintained by the information systems department. The system will deny access to any person who does not have the password, thereby preventing unauthorized persons from reviewing or modifying claims information to access claims information using three methods. The second method of access security restricts access to certain data in the claims information system to managers only. For example, information pro-vided by a lawyer might be considered highly confidential. Therefore, support staff would not be allowed to access that portion of the electronic claim file.</p>
Access security	<p>The second method of access security restricts access to certain data in the claims information system to managers only. For example, information pro-vided by a lawyer might be considered highly confidential. Therefore, support staff would not be allowed to access that portion of the electronic claim file. The third method of access security prevents unauthorized individuals from changing crucial information in the claims information system, such as reserve amounts or claim codes, and can prevent them from requesting amounts assigned to claims personnel to limit claims personnel to handle those reserves or payments. Second, if inexperienced claims personnel exceed their authority level, the claims system prevents errors.</p>
Claims tracking	<p>Claims tracking refers to an individual's ability to review, enter, and change expenses. Similarly, claims in litigation can be reviewed to ensure that legal expenses are managed properly.</p>



<b>Claims</b>	A review of claim files to examine the technical details of claim settlements; ensures that claim procedures are followed; and verify that appropriate documentation is thorough and detailed.
<b>Claims Audit</b>	A review of claim files conducted by an insurer's internal claims audit staff to examine the details of claim settlements; ensures that claim procedures are followed; and verify that appropriate documentation is thorough and detailed.
<b>Internal Claims Audit</b>	A review of claim files conducted by an insurer's internal claims audit staff to examine the details of claim settlements; ensures that claim procedures are followed; and verify that appropriate documentation is thorough and detailed.
<b>Internal Audit</b>	A review of claim files conducted by an insurer's internal audit staff to examine the details of claim settlements; ensures that claim procedures are followed; and verify that appropriate documentation is thorough and detailed.

The review also allows supervisors and managers to coach claims representatives on how to handle claims, on additional investigation that might be needed, and on negotiation or settlement approaches. Supervisor and manager reviews are another type of compliance measure. Claims audits are a review of claim files, both paper and electronic, to ensure that claims are being handled properly. Claims audits can be conducted by an insurer's internal personnel or by others. Most insurers use claims audits as a type of compliance measure. Claims staff to examine the technical details of claim settlements; ensure that claims procedures are followed; and verify that appropriate documentation is thorough and detailed.

In addition to the various claims guidelines and controls, supervisor and manager reviews are another type of compliance measure that insurers can use. Supervisors and managers use diary systems as reminders to review claims. During a review, they might check the claims codes, services, and payments entered for the claim. They might review the claims representative's reports to physician reports, and damage estimates. During the review, supervisors and managers might detect errors that can be corrected. The review also allows supervisors and managers to help claims personnel learn how to improve job performance.

Often make unintentional errors, tracking systems can identify which employee and are useful for identifying training needs. For example, if claims personnel information system cannot be altered. Tracking systems discourage fraud the individual who made the request. Such information is stored in the claims individual who made the change, the date a payment was requested, and the name of fees might need additional training.



<p>An actuary might review claim files to examine how reserves are set, how frequently they are changed, and how accurate the initial reserves were compared to the final settlement amount. If reserves are habitually lower than the final amount of the claim, the actuary might increase total reserves beyond the amounts set by the claims department. Such a change would help ensure that total reserves for all claims are adequate to maintain the insurer's financial condition.</p>	<p>The underwriting department might audit claim files to see the kinds of claims that are being reported; how much is being paid for those claims; and what, if any, coverage or underwriting standards should be changed to address claims that are being reported; how much is being paid for those claims; and what, if any, coverage or underwriting standards should be changed to address those claims. For example, if an underwriter notices many claims for damage from sewer backup, the underwriter might decide that underwriting standards from sewer backup, the underwriter might decide that underwriting standards should be made more strict for properties likely to experience sewer backup.</p>	<p>Human resources and training might audit claim files to identify training needs for the claims department. For example, a trainer might discover that a claims code for a particular kind of loss is often entered incorrectly. Based on that finding, the trainer might develop a short class to teach support staff about that type of loss and how to code it correctly.</p>	<p>Internal claims audits might also be conducted to ensure that employee fraud is not occurring. In addition, if employees know that claims will be audited, it might deter them from committing fraud.</p> <p>External claims audits are claim file reviews conducted by someone other than an insurer's own employees. External claims audits are conducted to review an insurer's overall claims handling practices; to review consumer complaints; to ensure details of claim settlements; to investigate consumer complaints; to ensure that理赔 reserves were followed; and verifying that appropriate, thorough documentation was included.</p>
<p>A review of claim files</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>
<p>External claims audit</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>
<p>Conducted by organizations other than the insurer that handle claims</p>	<p>involves reviewing overall claims handling practices; to review consumer complaints; to ensure that理赔 reserves were followed; and verifying that appropriate, thorough documentation was included.</p>	<p>Review overall claims handling practices; to review consumer complaints; to ensure details of claim settlements; to investigate consumer complaints; to ensure that理赔 reserves were followed; and verifying that appropriate, thorough documentation was included.</p>	<p>State insurance regulators might conduct a claims audit to review an insurer's handling of claims. State insurance regulators might conduct a claims audit to review an insurer's handling of claims. Whether the insurer routinely engages in any illegal claims handling practices, an insurer is violating any unfair claim settlement practices acts or laws and involves reviewing overall claims handling practices; to review consumer complaints; to ensure details of claim settlements; to investigate consumer complaints; to ensure that理赔 reserves were followed; and verifying that appropriate, thorough documentation was included.</p>
<p>A review of claim files</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>
<p>External claims audit</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>
<p>Conducted by organizations other than the insurer that handle claims</p>	<p>involves reviewing overall claims handling practices; to review consumer complaints; to ensure that理赔 reserves were followed; and verifying that appropriate, thorough documentation was included.</p>	<p>Review overall claims handling practices; to review consumer complaints; to ensure details of claim settlements; to investigate consumer complaints; to ensure that理赔 reserves were followed; and verifying that appropriate, thorough documentation was included.</p>	<p>State insurance regulators might conduct a claims audit to review an insurer's handling of claims. State insurance regulators might conduct a claims audit to review an insurer's handling of claims. Whether the insurer routinely engages in any illegal claims handling practices, an insurer is violating any unfair claim settlement practices acts or laws and involves reviewing overall claims handling practices; to review consumer complaints; to ensure details of claim settlements; to investigate consumer complaints; to ensure that理赔 reserves were followed; and verifying that appropriate, thorough documentation was included.</p>
<p>A review of claim files</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>
<p>External claims audit</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>	<p>than an insurer's own employees</p>



Some insurers assign claims based on territory, type of claim, extent of damage, workload, or other criteria. In the case of more complex claims that insurers use different methods of assigning claims to claim representatives.

Once a loss notice has been received and the information has been entered into the insurer's claim information system, the insurer acknowledges the claim and assigns it to one or more claim representatives. The purpose of the acknowledgement is to advise the insurer that the claim has been received and to provide the claim number and contact information of the assigned claim representative.

## Acknowledging and Assigning the Claim

- Determining the cause of loss, liability, and the loss amount
  - Investigating and documenting the claim
  - Contacting the insured or the insured's representative
  - Identifying the policy and setting reserves
  - Acknowledging and assigning the claim
- The claim handling process begins when the insured reports the loss to the producer or to the insurer's claim center.

These activities provide a framework for handling all types of property, liability, and workers compensation claims:

The claim handling process consists of a series of typical activities. These activities are not always sequential; some can be performed concurrently, and others may need to be repeated as new facts are discovered. Although some claims may require unique treatment, the same basic activities are performed with every claim.

In the claim handling process, To ensure that every claim is handled in good faith from beginning to end, claim representatives must follow a systematic approach. This ensures that every claim is handled in a manner that conforms to legal and ethical standards.

To provide consistent and effective claim handling, claim representatives follow a systematic process that helps ensure that claims are handled in a manner that conforms to legal and ethical standards.

## ACTIVITIES IN THE CLAIM HANDLING PROCESS

Insurance advisory organizations such as Insurance Services Offices (ISO) and the American Association of Insurance Services (AAIS) are also interested in insurers' reserves but rarely conduct a claim audit to study reserves or reserving practices. Instead, such organizations rely on the information provided in insurers' Annual Statements.

involve multiple policies, two or more claim representatives may be assigned to a claim, depending on the structure of the insurer's claim operations and the training and expertise of its representatives. For example, if an insured is responsible for causing a serious automobile accident, the claim representative may involve both damage to property and injuries. The insurer may acknowledge the property damage portion of the claim to one claim representative and the liability portion to another. Regardless of the method used, claims must be filed with the claim assignment and explain the claim to the claim representative.

After receiving the claim assignment, the claim representative contacts the insured, and possibly the claimant (if it is a third-party claim), to acknowledge in a timely manner to comply with insurance regulations. The claim representative may involve both damage to property and injuries. The insurer may make contact immediately after receiving the loss notice, this contact serves as the claim acknowledgement. For some types of losses, the claim representative may give the insured instructions to prevent further loss, such as to cover roof damage with a trap. If the claim involves property damage, the claim representative may arrange a time with the insured to inspect the damage or the damage scene. As an alternative, the claim representative may advise the insured or claimant that an appraiser or an independent adjuster will be in contact to inspect the property damage. If the claim involves bodily injury, the claim representative should get information about the nature and extent of the injury.

After receiving a claim assignment, a claim representative will identify the nonwaiver agreement. A signed agreement indicates that during the course of investigation, neither the insurer nor the insured waives rights under the policy. An insurer's letter that reserves coverage specifies coverage issues and informs the insured that the insurer may later deny coverage should the facts available for the loss, the claim representative must notify the insured of this type of coverage apply to the loss. If it is apparent that coverage may not be available for the loss, the claim representative must notify the insured of this concern through a nonwaiver agreement or a reservation of rights letter. Both of these documents reserve the insurer's rights under the policy.

The claim representative must thoroughly read the policy to determine what information in conjunction with identifying the policy, the claim representative must take place on all claims, including record-only claims, before the investigation begins. The claim representative must read the policy terms and conditions. A basic identification of the policy followed by the type of loss reported, and whether the insured exists under the policy for the type of loss reported, and whether coverage mine whether the loss occurred within the policy period, whether coverage policy in force on the date of the loss to assess available coverage and determine whether the insured has rights under the policy. After receiving a claim assignment, a claim representative will identify the nonwaiver agreement. A signed agreement indicates that during the course of investigation, neither the insurer nor the insured waives rights under the policy. An insurer's letter that reserves coverage specifies coverage issues and informs the insured that the insurer may later deny coverage should the facts available for the loss, the claim representative must notify the insured of this type of coverage apply to the loss. If it is apparent that coverage may not be available for the loss, the claim representative must notify the insured of this concern through a nonwaiver agreement or a reservation of rights letter. Both of these documents reserve the insurer's rights under the policy.

## Identifying the Policy and Setting Reserves

Often in conjunction with identifying the policy, the claim representative will establish claim or case reserves, also called loss reserves. The insurer's claim information system often determines the types of reserves that are established. Some systems require separate reserves for each claimant in a claim. Other systems require separate reserves for each claimant in a claim. For example, in a claim for an auto accident, an individual reserve may be set up for damage to the insured's vehicle, damage to the other party's vehicle, medical expenses for the insured, and bodily injury for the claimant.



Generally, the claim representative reviews the initial loss report and policy and then contacts the insured and schedules a time to speak with the insured or a party representing the insured about the facts of the loss. If the loss involves a third-party claimant, then the claim representative also contacts the claim representative with an opportunity to explain the claim process and it can reassure the insured that the claim will be investigated. It also provides reassurance to the claim representative that the insured services several purposes.

Soon after the loss has been assigned and initial reserves have been established, the claim representative contacts the insured or the insured's insurance company. This initial contact with the insured serves several purposes. It can reassess the insured's ability to write the claim and may ultimately affect solvency.

Although an occasional reserve may be inadequate or inaccurate with little or no effect on the insured, consistently inaccurate or inadequate reserves on claims of claims can distort the ratemaking process. This may eventually affect an insurer's ability to write business competitively and may ultimately affect solvency.

Reserve inaccuracy can sometimes be the result of the claim representative's poor planning, lack of expertise in estimating claim severity, or unwillingness to reevaluate facts. In these cases, the claim representative may set a modest initial reserve, then raise the reserve by a few thousand dollars to issue payments. Later, the reserve is increased again when more bills arrive. This process is called **stairstepping the reserve**. On a claim that concludes in thirty, sixty, or ninety days, stairstepping the reserve. But if the claim remains open for several years, as many liability and workers' compensation claims do, the incremental increase in reserves during those years is not properly reflected in the insurer's ratemaking process. Stairstepping can be avoided if proper claim handling practices and reserving methods are used.

### Stairstepping the Reserve

Setting accurate and adequate reserves is important to an insurer's continued solvency and capacity (ability to write new business). Inaccurate reserves often result when reserves are established based on limited or incomplete information, or when reserves are not reevaluated and adjusted as necessary. When new facts come to light. See the exhibit "Stairstepping the Reserve." Insurers can use different methods of setting reserves, including these six aggregate methods: individual case method, roundtable method, average value method, formula method, expert system method, and loss ratio method. The individual case method and the roundtable method rely on the claim representative's judgment; the other methods rely on statistical analysis.



Claim representatives begin investigating a claim as soon as it is assigned. The insurer's claim handling guidelines help claim representatives determine the type and extent of investigation needed for a satisfactory claim settlement.

Investigation and documentation occur throughout the life of the claim. The investigation of a claim can take many different forms, and all aspects of it must be documented to create a complete claim file.

## Investigating and Documenting the Claim

Good faith  
The manner of handling claims that requires an insured to give consideration to the insured's interests that is at least equal to the insurer's own interests.  
A statement of facts about a loss for which the insured is making a claim.  
Proof of loss

- Supply the insured with a blank proof of loss form for property damage and any necessary written instructions so that the insured can document and actions when communicating with insureds. Claim representatives are required by law to act in good faith; they must be careful not to mislead the claim representatives must be aware of the legal implications of their words of any claim payment.
- Explain the amount of time it will take to process and conclude the claim.
- If medical and wage-loss information is part of the claim, obtain the necessary authorization.
- Explain potential coverage questions, policy limitations, or exclusions and needed.
- Tell the insured what additional investigation is needed to resolve potential coverage issues and provide clear instructions if more information is obtained a nonwaiver agreement.
- Describe the inspection, appraisal, and investigation the claim representative will be conducting.
- Provide deadlines.

## Consequences

- Once contact is made, the claim representative normally takes these actions:
  - Tell the insured what is required to protect damaged property and to document the claim. Be specific about what the insured must do and potential grounds exist to deny the claim.
  - Not to give the insured or claimant the impression that a claim will be paid if representatives or insured's duties. The claim representative must also be careful with holding such information can be considered a breach of the claim representative's policy violations, exclusions, or limitations that can affect coverage. Possible policy meanings in relation to the loss. The claim representative must explain their meanings to the insured. The claim representative must be prepared to explain the policy terms and insureds do not fully understand the details of their insurance coverage.

At the initial contact, claim representatives frequently find that many claims do not fully discuss the facts of the loss.

The claimant and schedules a meeting with the claimant or a party representative.



File reports can take several different forms. Some file reports are prepared by claim representatives for others within the insurance organization. These internal reports may serve as status reports and may also alert others in the organization that follow-up is needed. For example, fraud investigators may file activity logs, also called file status notes, documenting all investigations, claim evaluations, and coverage decisions and include chronological accounts of the claims process.

Activity logs, also called file status notes, document all investigations, claim evaluations, and coverage decisions and include chronological accounts of the claims process. Internal reports may serve as status reports and may also alert others in the organization that follow-up is needed. For example, fraud investigators may file activity logs, so information included in the logs must be accurate, complete, and unbiased.

Dairy systems, also called suspense systems or pending systems, are automated systems that aid the claim representative in handling multiple claims simultaneously. For example, the claim representative may request information from the insurer and then establish a dairy date for follow-up. Dairy systems also ensure that mandated deadlines are met. For example, a state law may require that the insurer receive a status letter on the claim every thirty days. The automated system would set the dairy dates to meet this requirement.

All along with the investigation, all aspects of a claim, including the results of all investigations, must be documented to create a complete claim file. Three crucial components of claim documentation are dairy systems, activity logs,

- Prior claim investigation—A prior claim investigation is conducted on most claims using industry databases to avoid paying for property damage or bodily injury that has previously been paid through prior claims by the same insurer or by other insurers.

- Medical care for the type of injuries the claimant suffered. Medical costs of medical treatment, the expected duration of medical treatment and disability, the need for rehabilitation, and the suitability of mine the costs of medical treatment, the expected duration of medical treatment and disability, the need for rehabilitation, and the suitability of

- Property damage investigation—An investigation of damaged property resulting from covered property damage. Businesses income claims, to determine lost profits or loss of business use is useful to confirm the cause of loss and the extent of damage, or, for

- Accident scene investigation—An investigation of the accident scene may offer crucial clues about the loss and may help determine whether

- Insured/witness investigation—Statements (either written or recorded) from the insured and witnesses can provide valuable information about the circumstances surrounding the loss.

- Claimant investigation—A claimant investigation, usually conducted by taking the claimant's statement, can help determine the value of the injury or damage, how it was caused, and who is responsible.

These are among several types of investigations that are common to many types of claims:



**Amount**

## Determining Cause of Loss, Liability, and Loss

The facts of the loss determine the cause of the loss, liability, and loss amount.

Claim representatives use the information gained during their investigation to determine the cause of loss, liability, and loss amount.

The facts of the loss determine the cause of the loss. For example, in a fire loss, the claim representative may find that a faulty toaster caused the fire. If there are several causes of loss, the claim representative should identify all of them and determine their relative importance in causing the loss, as well as the responsible party or event.

After the cause of loss has been determined, the claim representative must determine the liability for the loss based on the facts. For example, in an auto accident, the claim representative applies statutory and case law on negligence to determine the liability of the parties involved. If the insurance company to determine the cause of loss, liability, and loss amount.

During the course of an investigation, the claim representative may discover that the insured was not liable and that a third party caused the accident. When an insurer pays a claim to an insured for a loss caused by a negligent third party, the insurer can recover that payment from the negligent party through the right of subrogation.

Concurrent to the determination of the cause of and liability for the loss, the claim representative should determine both the type and amount of the damage to, or destruction of, the property under the policy. For a property damage claim, the amount of loss payable is usually limited to physical damage to, or destruction of, the property of the insured. The cost to repair or replace it with property of like kind is usually based on the cost to repair or replace it with property of like kind and quality. For a bodily injury claim, the loss amount is usually based on the extent of the injury, the residual and lasting effects of the injury, and the amount of pain and suffering the individual has endured.

Once the amount of the loss has been determined, the claim representative must verify that the actual or anticipated damages are within the policy limits. An insurance policy provides coverage for a loss that an insurer will pay for a covered loss is reduced.



A claim representative begins the process of coverage analysis by carefully reading the policy form and all endorsements. With experience, claim representatives learn to recognize the types of losses covered under the policy often believe are covered, but are not. This policy knowledge aids coverage forms. They are aware of the types of losses that insures and claimants analyses. But experience does not remove the necessity for the claim representative to read the applicable policy forms carefully and to analyze the types of losses of a claim.

Coverage analysis is the process of examining a policy by reviewing all its components and applying them to the facts of a claim.

## FRAMEWORK FOR COVERAGE ANALYSIS

When a claim is resolved, the claim representative may complete a closing or final report, which can include the claim representative's recommendations on subrogation, advice to underwriters, and other information required by the insurer or reinsurer.

ADR reduces, but does not eliminate, the chance that a claimant will sue and take a case to trial. According to insurers, must be prepared to litigate some claims; however, it occurs most often when a claim is denied. Even with the variety of ADR methods available, many claims are concluded through litigation. Litigation can occur at almost any point during the life of a claim; however, it occurs most often when a claim is denied.

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Even with the variety of ADR methods available, many claims are concluded through litigation. Litigation can occur at almost any point during the life of a claim; however, it occurs most often when a claim is denied.

If the claim is to be paid, the claim representative often must negotiate the amount with the insured or the claimant. Negotiation involves discussing disputed matters and mutually agreeing on a settlement. In some cases, alternative dispute resolution (ADR) methods may be used to resolve a disagreement and, ultimately, the claim. After an agreement on the settle- ment amount is reached, the claim representative secures the necessary final documents so that payment can be made.

When the investigation has been completed and all documentation has been received, the claim representative must decide whether to pay the claim or deny it.

Alternative dispute resolution (ADR) procedures to help settle disputes without litigation, including arbitration, mediation, and negotiation.

## Concluding the Claim



- A systematic framework for coverage analysis can guide the claim representative to the parts of the policy that may provide or exclude coverage. It also ensures that all of the components parts are reviewed and reduces the incidence of erroneous conclusions. These questions outline a systematic framework for coverage analysis and the information it will yield:
- Is the person involved covered?
  - Did the loss occur during the policy period?
  - Is the cause of loss covered?
  - Is the damaged property covered?
  - Is the type of loss covered?
  - Are the amounts of loss or damages covered?
  - Is the location of the loss covered?
  - Is the amount of loss covered?
  - Do any exclusions apply?
  - Does other insurance apply?
- In any case, the answers help the claim representative make a coverage determination.
- The claim representative can follow this framework by answering the questions in the order they appear here. However, in some cases, the policy may prompt the claim representative to answer the questions in a different order.
- Some policies cover only insureds named or listed in the policy. Most policies define "insured" broadly, so the claim representative must determine whether the persons who suffered the loss are covered. For example, the homeowners (HO) policy covers the financial loss that the insured suffers as the result of a fire. For coverage to apply, the policy must cover the person who has suffered fire. For example, the personal Auto Policy (PAP) Part A—
- B. "Insured" as used in this Part means:
1. You or any "family member" for the ownership, maintenance or use of any auto or "trailer".
  2. Any person using "your covered auto".
  3. For "your covered auto", any person or organization but only with respect to legal responsibility for acts of omission of a person for whom coverage is afforded under this Part.
  4. For any auto or "trailer", other than "your covered auto", any other person or organization does not own or hire the auto or "trailer".

## Is the Person Involved Covered?



Many policies are written to cover only losses that occur during the policy period. The HO-3 states:<sup>4</sup>

## Did the Loss Occur During the Policy Period?

For example, Kathy owns a house jointly with her parents, who live in another state. All three have an insurable interest in the house, but Kathy is the only named insured on the policy. If a tornado damages the house, Kathy would be paid for the loss because she has an insurable interest in the house and is a named insured. Kathy's parents are not residents of the house or named insureds, so even though they have an insurable interest, they are not insureds under the policy. See the exhibit "Adjusting Tip".

Making the claim is entitled to coverage under the policy and whether that or on an endorsement. Claim representatives determine whether the person under the policy because the person's name is not listed in the declarations have an insurable interest in a building but not be considered an insured interest alone does not guarantee coverage. For example, an individual may insureable interest in the damaged or destroyed property. However, insurable property insurance limits recovery to the amount of a person's

2. Any other person while "occupying" "your covered auto",  
any type.
- a motor vehicle designed for use mainly on public roads or a trailer of
- b. As a pedestrian when struck by;
- a. While "occupying"; or
1. You or any "family member":

According to the HO-3 definition, a sixteen-year-old international exchange student who lives in the household is an insured. An independent twenty-four-year-old friend who visits over the weekend is not an insured. The PAP to include:

the definition of "insured" is expanded for Part B—Medical Payments Coverage of

may be defined differently in other sections of the policy. For example, the four-year-old friend is not an insured. "Insured"

- (2) Other persons under the age of 21 and in the care of any person named above;...
- (1) Your relatives; or
- a. You and residents of your household who are:

3. "Insured" means:

In contrast, the HO-3 defines "insured" in part as:<sup>5</sup>

According to the PAP definition, a friend who borrows your car and drives it is an insured. A friend who uses your car and pays you for that use is not an insured because of the last sentence in Item 4.



Special coverage	Loss causes of accident
Coverage for direct and	Accidental loss caused by fire, lightning, explosion,
theft, windstorm, hail,	earthyquake, flood, mischief,
and vandalism.	From the striking, bursting,
Collision, or dereliction of a	Conveyance transporting the
Covered auto.	Covered auto.
Special coverage	Property insurance coverage
Covering all causes of loss	not specifically excluded.

Covered causes of loss, or perils, vary by type of policy and may include fire, theft, hail, windstorm, collision, or a legal obligation to pay damages.

Specified causes of loss covered, also called named-perils coverage, covers only if it is a direct result of a specifically listed or named cause of loss in the policy. For example, in the HO-3 policy, personal property is covered for losses only if it is a direct result of a specific cause of loss.

Causes of loss are not often defined in the policy because the definitions are subject to court interpretation and therefore vary by state. For example, fire may seem easy to define, but does fire include smoke or explosive heat with no actual flame? Does it include damage the firefighters cause while extinguishing the fire? See the exhibit "Adjusting Tip."

Special form coverage, also called all-risks or open-perils coverage, covers every cause of direct physical loss that is not excluded. The HO-3 provides special form coverage on the dwelling and other structures. Section I—Perils

## Is the Cause of Loss Covered?

B. Policy Period. The policy applies only to loss which occurs during the policy period.

[DA03105]

Claim representatives must determine whether others have an insurable interest in the property on which a claim is based. In Kathy's case, the claim representative checked with a supervisor or manager to determine how to handle the claim payment. Leinholders or mortgagees often have an insurable interest in property, and the claim representative must determine when they should be included as payees on any claim payments.

### Adjusting Tip



In following the framework for coverage analysis, the claim representative must determine whether the damaged property is covered. Insurance policies may not cover all of the insured's property. Certain property must be specified in order for coverage to apply. For example, the AAP defines "your covered auto" as:<sup>6</sup>

## Is the Damaged Property Covered?

In answering the question "Is the cause of loss covered?", claim representa-  
tives should thoroughly investigate all the facts concerning the loss and apply  
them to the language in all the provisions of the policy.

[DAO3108]

An insured accidentally spills a caustic chemical in the kitchen. The chemical splashes on the linoleum floor, table, chairs, and area rug. Because spills are not excluded under special form coverage on the dwelling, the damage to the linoleum floor is covered.  
Because spills are not named peril under specified perils coverage on the contents,  
the damage to the table, chairs, and area rug is not covered.

### An HO-3 Claim Example

Example:

Insured Against in the HO-3 states, in part, "We insure against risk of direct losses to property described in Coverages A and B" [emphasis added].<sup>5</sup> Following that statement is a list of causes of loss that the policy does not cover, such as smog, rust, birds, and rodents. Any cause of loss that is not listed among the excluded causes of loss is covered. See the exhibit "An HO-3 Claim Example."

[DAO3107]

When the policy does not define a cause of loss or another term, claim representatives can use other resources to determine the meaning. For example, statutory provisions and court decisions have defined many terms that are not defined in policies. Standard dictionaries are also resources for defining terms.

### Adjusting Tip



Direct loss  
A reduction in the value of property that results directly from damage to that property.  
Indirect loss  
A loss that arises as a result of damage to property, other than the direct loss to the property.

Losses can be classified as direct losses or indirect losses. A crumpled car window that results in immediate damage to that property. Losses that arise from property damage to that property is a direct loss. Indirect losses reduce future income, increase future expenses, or both. For example, if fire destroys an insured's home, the cost of rebuilding the home is a direct loss. The rental cost for temporarily living elsewhere for the time it takes to rebuild the home is an indirect loss. The loss of earnings and the extra expenses incurred over a period of time after a fire damages a business are also indirect losses.

## Is the Type of Loss Covered?

For example, if Jeff reported the theft of four bundles of shingles and two rolls of tar paper that were stored in his garage, and the claim representative investigated the theft of those materials to repair his roof, then the stolen property would be covered based on the policy provision just mentioned. If the claim representative's investigation revealed that Jeff is a roofing contractor and planned to use those materials to repair his roof, then the damaged property is covered under the policy.

- The dwelling on the "residence premises", shown in the Declarations, including structures attached to the dwelling; and
- Materials and supplies located on or next to the "residence premises" used to construct, alter or repair the dwelling or other structures on the "residence premises".

In another example of property that must be specified for coverage to apply, the HO-3 describes the property covered under Coverage A—Dwelling as: "If a claim investigation reveals that an auto involved in an accident does not been added to the policy or is a temporary substitute vehicle. In another example of property that must be specified for coverage to apply, a coverage question may exist. However, the question may be easily resolved if the insured can prove that the car was recently purchased but has not yet appeared in the declarations or fall within the definition of "your covered auto," a coverage question may exist. However, the question may be easily resolved if the insured can prove that the car was recently purchased but has not yet been added to the policy or is a temporary substitute vehicle.

- Breakdown;
- Repair;
- Service;
- Loss; or
- Destruction

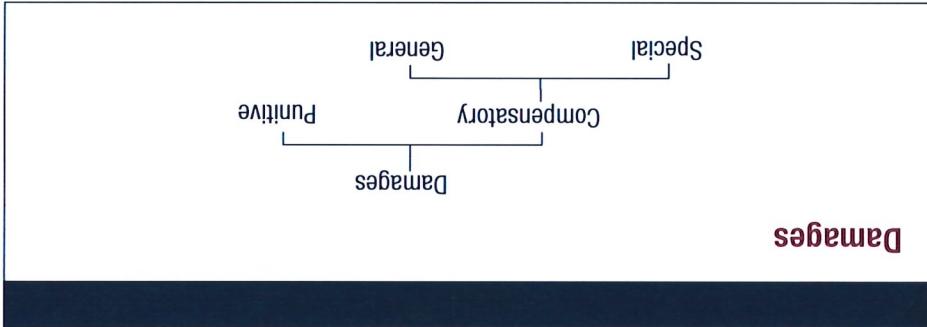
- Any vehicle shown in the Declarations.
- A "newly acquired auto".
- Any "trailer" you own.
- Any auto or "trailer" you do not own while used as a temporary substitute for any other vehicle described in this definition which is out of normal use because of its:

4. Any auto or "trailer" you do not own while used as a temporary substitute for any other vehicle described in this definition which



Some policies do not define or list the types of damages payable under the policy. For example, the term "damages" refers only to compensatory damages, such as expenses for medical bills, lost wages, and pain and suffering. In some states, an insurer is not permitted to pay for punitive damages because such payment by an insurer would not have the same deterrent effect as forcing the manufacturer to pay for punitive damages, imposition of punitive damages would not have the same deterrent effect as forcing the manufacturer to pay for punitive damages, because such damages are not related to a party's actual damages.

(DAO311)



Punitive damages punish a wrongdoer for a recklessness, malice, or deceiptful act and deter similar conduct. See the exhibit "Damages".

Compensatory damages, which include special damages (which pay for specific, out-of-pocket expenses, such as medical expenses, wage loss, funeral expenses, or repair bills) and general damages (which pay for losses, such as pain and suffering, and do not involve specific measurable expenses), reimburse or compensate claimants for their bodily injury or property damage.

For liability claims, damages for which the insured may be liable are of two types:  
Claim representatives should always check the policy to determine whether the amounts of loss are covered. For property damage claims, the amount of loss payable is usually limited to physical damage to, destruction of, or loss of use of tangible property. The amount is usually based on the cost to repair or replace the damaged property with that of like kind and quality. Claims for indirect loss, such as loss of business income, can be payable if indirect loss coverage is included or has been added to the policy.

## Are the Amounts of Loss or Damages Covered?

Many property policies cover direct losses only. Other policies cover some types of indirect losses. Homeowners policies cover increases in living expenses after a covered loss renders the home untenable.



Some losses may be excluded in the policy. For example, the HO-3 excludes losses caused by deterioration, such as a wooden garage door that rots. The

## Do Any Exclusions Apply?

Accidents occurring in Mexico would not be covered because they are outside the territory covered by the policy. Property policies cover buildings only at the locations listed in the declarations, but personal property can be covered at other locations.

This policy also applies to loss to, or accidents involving, "your covered auto" while being transported between their ports.

3. Canada.

2. Puerto Rico; or

1. The United States of America, its territories or possessions;

To illustrate, the PAP defines policy territory as:<sup>9</sup>

The location where loss occurred must be within the policy's territorial limits and, for property policies, be shown on the policy as a covered location.

## Is the Location of the Loss Covered?

In addition to ensuring that the type of loss and types of damage are covered, the HO-3 contains a limit on the dwelling and contents as well as special limits for money and theft of jewelry and silverware. First-party losses are also subject to deductible provisions that specify how the loss is to be valued (either actual cash value or replacement cost), and coinsurance clauses also have sublimits for certain types of property or types of losses. For example, policy limits. A first party property policy will have limits of liability and may claim representatives must verify that the amount of damage is within the HO-3.

In addition to ensuring that the type of loss and types of damage are covered, the HO-3 contains a limit on the dwelling and contents as well as special limits for money and theft of jewelry and silverware. First-party losses are also subject to deductible provisions that specify how the loss is to be valued (either actual cash value or replacement cost), and coinsurance clauses also have sublimits for certain types of property or types of losses. For example, policy limits. A first party property policy will have limits of liability and may claim representatives must verify that the amount of damage is within the HO-3.

In a liability insurance policy, the insurer agrees to pay judgments and settle claims up to the policy limit. In addition, some liability policies contain deductibles. They may also include coverage for certain expenses, such as defense costs and bail bonds, outside the limit of liability. Others may have self-insured retention (SIR) in which the insured organization adjusts and pays its own losses up to the SIR level. Once that SIR is exceeded, the insurer makes payment. The claim representative must verify all the policy limits applicable to a loss before making a settlement to ensure that any payment made falls within the available limits of coverage.

to pay the damages directly from its assets. Therefore, some policies expressly exclude coverage for punitive damages.

## Adjusting Tip

A claim representative must make sure that the exclusion upon which the denial is based has not been declared invalid by a court having jurisdiction over the claim or by a state statute.

Sometimes exclusions contain exceptions, meaning they clarify what is excluded. For example, the PAP excludes liability coverage for damage to property used by the insured. However, an exception in the exclusion states that the exclusion does not apply to property damage to a residence used by the insured. Claim representatives who carefully read the policy can avoid incorrectly denying coverage based on an exclusion when an exception applies. See the exhibit "Adjusting Tip."

Then the claim representative would ask another question: "Do any exclusions apply?" On reviewing the exclusions, the claim representative would find that the PAP excludes loss that occurs while the car is used as a public orivery convenience, and the claim representative would rightfully deny the claim.

- Is the location of the loss covered? The loss occurred within the policy's territorial limits.
- Are the amounts of loss or damages covered? The amount of the loss is within the policy limits but more than the deductible.
- Is the type of loss covered? The policy covers collisions.
- Is the damage property covered? The vehicle is listed in the policy's declarations.
- Is the cause of loss covered? The policy covers physical damage to the insured's car.
- Did the loss occur during the policy period? In this case, it did.
- Is the person involved covered? The driver is the named insured.

When claim circumstances fall within a specific exclusion, coverage does not apply. An exclusion applies even if other coverage requirements are met. For example, suppose that an insured uses his car as a taxi and is involved in an accident, severely damaging the driver's side door. The insured subsequently example, suppose that an insured uses his car as a taxi and is involved in an accident, severely damaging the driver's side door. The insured subsequently submits a claim. That claim appears to be covered according to these criteria:

- Other circumstances
- Types of damage
- Types of property
- Causes of loss
- Persons

PAP excludes damage caused by wear and tear, such as the wear on a tire. Exclusions to coverage can involve these elements:



was hospitalized.

On April 12, 20XX, Susan and Thomas received a phone call from John's roommate informing them that John had been in an auto accident while driving the Honda Civic. John suffered minor injuries after failing to obey a stop sign and then hitting another car. The driver of the other car, Karen Jones, was hospitalized.

Susan and Thomas have an HO-3 (2000) policy covering their home. They have a Personal Auto Policy (PAP) covering all three cars.

Susan and Thomas own their home and three cars. The ABC Loan Company holds a mortgage on their home. They also have a car loan, from Union Trust Company, on their 2010 Lexus. They do not have leaseholders for their other two cars (a 2007 Toyota Camry and a 2006 Honda Civic).

Susan and Thomas own three cars and three children. The ABC Loan Company owns a small company called Universal Widgets. Susan's mother, Marie, also lives with them. Susan is a schoolteacher. Susan's mother lives at home when not attending Columbia College in New Mexico. Susan's husband has two children: Ann, age 16, who lives at home, and John, age 19, who

## CASE FACTS

The claim representative to settle the loss in a timely and professional manner. Language of the policy and the facts of the claim provide the details to enable help dictate the procedures for each claim handling activity. Ultimately, the information about handling property, liability, and bodily injury claims will work for coverage analysis as a guide for every claim they handle. Specific claim representatives can use the claim handling process and apply the frame-

To ensure good-faith handling of property and liability claims, insurers' claim departments adopt specific procedures and guidelines.

## ANALYSIS

### APPLYING THE CLAIM HANDLING PROCESS AND THE FRAMEWORK FOR COVERAGE

Some policies are intended to apply only if no other insurance applies or only above the limits provided by other insurance. For example, the PAP states that coverage provided under that policy is excess over other collectible insurance for vehicles the insured does not own. In other cases, a policy may pay a portion of the loss based on the limit of insurance available from other policies. Having answered all the questions in the framework for coverage analysis, the claim representative can apply the policy to the facts of the claim and make a coverage determination.

## Does Other Insurance Apply?



- Bodily injury liability claim from Karen Jones—reserve \$5,000
- Property damage claim from Karen Jones—reserve \$2,500
- Collision coverage for the 2006 Honda—a reserve of \$2,500
- PIP coverage for John's injuries—a reserve of \$1,000

Jim identified the Reeds' auto policy and performed an initial review. He established that the 2006 Honda Civic had liability coverage, collision coverage with a \$1,000 deductible, and Personal Injury Protection coverage. Based on the limited information on the first notice of loss, Jim set up these parts of the claim with preliminary reserves:

After he received the claim assignment, Jim acknowledged receipt of the claim to the agent. Then he entered the claim information into the insurer's claim-processing system.

Jim Smith was assigned to handle all aspects of the claim. After talking with John, Thomas called his insurance agent and reported the claim. The agent then reported the claim to the insurer. Claim Representative

## Acknowledging and Assigning the Claim

- Acknowledging and assigning the claim
- Investigating the claim
- Contracting the insured or the insurer's representative
- Determining the cause of loss, liability, and the loss amount
- Documenting the claim
- Determining the cause of loss, liability, and the loss amount
- Concluding the claim

A thorough understanding of these activities in the claim handling process will lead to the conclusion described in the Correct Answer section and other possible conclusions to this case study:

## Activities in the Claim Handling Process

To handle a claim such as the one provided in this case study, a claim representative would need to have an understanding of the coverages provided in the HO-3 policy form and in the PAP form. However, to resolve the case study, only a thorough understanding of the activities in the claim handling process and the framework for coverage analysis is required.

## Case Analysis Tools



will pay damages for bodily injury or property damage for which any insured person involved covered? The insurance agreement states that the insurer according to the definition of insured, John is covered by the policy. (Is the

1. You or any "family member" for the ownership, maintenance or use of any auto or "trailer".

Jim determined who is covered by the PAP. According to the liability coverage part, "insured" is defined in this manner:

Within the policy period. (Did the loss occur during the policy period?) Jim cause of loss covered? He also confirmed that the damaged property covered? Is the policy and that it has collision coverage. (Is the damaged property covered? Is this claim. Jim had already confirmed that the Honda is listed on the Reed's and reviewed the PAP to answer some questions he had regarding coverage for After concluding his conversation with John, Jim requested a police report

## Investigating the Claim

Mexico.

- The Honda was taken to Sam's Auto Body Shop in Columbus, New Mexico.
- ticket for careless driving.
- Karen Jones was also taken to the emergency room. John believed she had a concussion and a deep laceration on her forehead. John received a minor cuts, and released.
- John was wearing his seatbelt at the time of the accident. His air bag deployed on impact. He was taken to the emergency room, treated for John's car struck the car driven by Karen Jones on the driver's side door. down or stopping.
- The accident occurred at 11:30 AM on a Saturday morning. John was driving to a sandwich shop. He did not see a stop sign or the car on his right because of sun glare, so he entered the intersection without slowing
- John is a full-time college student in New Mexico. He lives in a dormitory on campus. He has had the Honda at school since the beginning of the semester and parks it on a campus parking lot.

Jim called John and took a recorded statement that provided these facts:

that John was using the car with their permission.

are the registered owners of the car, that the car is registered in Texas, and happened. While talking with Susan and Thomas, Jim confirmed that they the accident and asked Jim to contact John for all of the details about what Jim contacted Susan and Thomas Reed. They gave him a brief description of the accident and asked Jim to contact John for all of the details about what

## Contacting the Insured or the Insurer's Representative



U.S. (Is the location where the loss occurred covered?)  
Next, Jim examined the policy period and territory provision of the PAP. The  
PAP provides out-of-state coverage, so the policy complies with New  
Mexico's financial responsibility laws. New Mexico does not have no-fault  
laws, so the liability portion of the Reeds' coverage will apply to Karen's  
bodily injury and property claims. (Do any other policies apply to  
Karen, Jim believes that the liability limit on the Reeds' policy is sufficient  
Based on the limited medical information available at this time concerning  
Karen, Jim believes that the liability limit on the Reeds' policy is sufficient  
to cover the bodily injury and property damage that Karen sustained. (Are  
the amounts of loss or damages covered?) However, Jim will have to review  
this portion of the claim frequently as more information about Karen and her  
injuries becomes available.

Jim confirmed that Karen was released from the hospital after she received  
treatment for her injuries and was kept for 24 hours of observation because  
of blood loss. He called her the next day to take her claim statement also revealed  
that Jim's account of the accident. Karen's statement also revealed  
these details:

- Karen is 38 years old and single, and lives at 2227 North Casa Avenue,  
Apt. 215, Pueblo, New Mexico.
- Karen received sixty stitches for the wound in her forehead. While in the  
hospital, she received blood to replace blood she lost because of the lac-  
eration to her forehead. The emergency staff confirmed through an X-ray  
that she had suffered a minor concussion, and the physician prescribed a  
pain reliever for her headaches.
- Karen was placed under observation for one week to monitor any prob-  
lems that might ensue because of the concussion.
- Karen's 2008 Buick Lucerne was taken to Roy's Auto Damage, where an  
estimate for \$3,800 was prepared to cover repairs to the driver's-side door  
and front fender. Karen agreed to mail the estimate to Jim.
- Based on the estimate, Jim adjusted the property damage reserve for  
Karen's auto to \$3,800.

Jim then checked the Part A exclusions. None of the exclusions appear to  
apply. (Do any exclusions apply?)  
Becomes legally responsible because of an auto accident. The insuring agree-  
ment also states that the policy will pay defense costs in addition to the limit  
of liability. (Is the type of loss covered?)  
Next, Jim examined the policy period and territory provision of the PAP. The  
PAP provides out-of-state coverage, so the policy complies with New  
Mexico's financial responsibility laws. New Mexico does not have no-fault  
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to cover the bodily injury and property damage that Karen sustained. (Are  
the amounts of loss or damages covered?) However, Jim will have to review  
this portion of the claim frequently as more information about Karen and her  
injuries becomes available.



Jim assigned an appraiser to assess the amount of damage to the Reeds' Honda and to Karen's Buick and to prepare estimates to repair the damages. Based on the description of the accident that John gave in his statement, Jim decided that the \$2,500 reserve for the Honda is adequate. He will review the reserves after he receives the appraiser's estimates.

## Property Damage Claims

- exclusions apply.
- revived the exclusions to Part D coverage and determined that none of the coverage on the Reeds' Honda. Based on the facts currently known, Jim for Damage to Your Auto of the PAP, Jim confirmed that there is collision action that caused the injurious outcomes. After reviewing Part D—Coverage acts, as John did not intend the result of his actions or intend to commit the damage? The investigation also addressed the PAP exclusion for intentional This investigation resolved the questions to which answers are required to Thomas's policy, the policy will cover the damages up to the policy limits. accident through tort liability. Because John is an insured under Susan and Based on the police report, the ticket issued to John, and John's own admission of fault, Jim determined that John was liable for the damages in the section of loss occurring during the policy period?
- Do any other auto policies apply to this loss?
  - Is the loss location covered by the policy?
  - Did the loss occur during the policy period?

As part of his analysis of liability coverage, Jim answered some of the questions that needed to be asked when analyzing coverage for the damage to the Reeds' Honda:

## Amount Determining Cause of Loss, Liability, and Loss

The claim diary system created an automatic entry for follow-up two weeks after the date of Jim's initial entry. Jim changed the diary date to two weeks from the date he completed this phase of the investigation. Documentation of changes in the claim information, reserves, and settlements will be ongoing. Jim will also have to continue his investigation to determine who is liable for the accident.

Karen's auto estimate, and the recorded statements of the two claimants with a diagram of the scene (that matched John's and Karen's accident descriptions), in his file status notes for this claim. He included the police report with a Jim recorded all of the information he learned through the investigation the claim file documents.

## Documenting the Claim



Jim submitted a query in an injury database to which his employer subscribes. It showed that Karen had never sustained any injuries that were submitted to a workers compensation or liability insurer. This indicated that her injuries from this accident were new injuries.

Six weeks after the accident, Jim reviewed the medical receipts and medical mileage records he received from Karen for treatment of her injury. He determined that they were reasonable and necessary for John's injuries. He reviewed an early photo of Karen's injured forehead and a recent photo showing that scarring was minimal.

## Karen's Medical Claim

Four months after the accident, Jim verified that John's treatment for his injury totaling \$2,400. Jim submitted the bills and mileage figures and determined that they were reasonable and necessary for John's injuries.

Jim also reviewed the exclusions in the endorsement and determined that none of them apply. Jim decided to raise the reserve on John's PIP claim to \$2,500 to cover the emergency room bill and three months of chiropractic treatment.

John had indicated that he suffered a laceration above his eye, which was treated at the emergency room. He also received treatment from a chiropractor for his sore neck and back. John will give his medical bills to Jim for review and reimbursement.

Jim reviewed the appraiser's estimate provided by Karen's Buick to the Reeds' auto policy. This endorsement provides unlimited medical expenses coverage to covered persons. Jim confirmed that the definition of accident and resulting from the use of an auto. The medical expenses must be incurred and paid to an insured who sustains bodily injury caused by an insured applies to a family member. The insurance agreement states that PIP benefits will be paid to both autos. Jim adjusted the reserve for this expected damage to the Reeds' Honda and an estimate for the damage to Karen's Buick that was \$5 less than the estimate Karen submitted. He also received photos of the damage to both autos. Jim adjusted the reserve for this expected damage amount on the Reeds' auto to \$2,700 (after application of the \$1,000 deductible).

Two days later, Jim received the appraiser's estimate for \$3,700 in damages to the Reeds' Honda and an estimate for the damage to Karen's Buick that was \$5 less than the estimate Karen submitted. He also received photos of the damage to both autos. Jim adjusted the reserve for this expected damage amount on the Reeds' auto to \$2,700 (after application of the \$1,000 deductible). The difference in the estimates for Karen's Buick was negligible, so he made no change to that reserve. Jim updated his file status notes and added a note to the file (the difference in the estimates for Karen's Buick was negligible, so he made no change to that reserve. Jim updated his file status notes and added a note to the file).

Jim changed the diary date to two weeks after the requested date to estimate from the appraiser, so that he can follow up if he does not receive the reports. He also updated the file status notes with the cause of loss, liability, and coverage information.



Jim totaled the medical receipts and medical mileage claim at \$4,200. Because she was hospitalized over a weekend and was able to report to work the following Monday, Karen incurred no loss of income. Jim added 10 percent to the total to compensate Karen for her "pain and suffering." Jim then confirmed that the total of \$4,620 plus \$3,800 for Karen's Buick, or \$8,420, was within the Reeds' PAP liability policy limit.

Before issuing any payments, Jim checked the federal and state databases to ensure that neither Karen nor any of the Reeds had any outstanding legal obligations that would require payment before they could receive any payment for their claims.

After Karen's auto was repaired, Jim issued a check payable to Roy's Auto damage and to Karen Jones for \$3,800. He then closed Karen's property damage reserve. After the Reeds' Honda was repaired, Jim issued a check payable to Sam's Auto Body and Thomas and Susan Reed for \$2,700 and closed the Reeds' property damage reserve.

Jim arranged a settlement review with Karen, in which he offered her the calculated total of \$4,620 for her medical expenses. Jim explained how he arrived at that amount and that he believed it was a reasonable settlement. He also showed Karen the total amount of the bodily injury and property damage claims paid by the Reeds' insurer for Karen's damages. (At this time, Jim obtained a full release from liability for the claim, which Karen signed. Later, Jim closed Karen's bodily injury claim reserve.)

Because John was at fault for the accident, no "pain and suffering" compensation was warranted. Jim noted that they had already paid \$2,700 (\$3,700 less the \$1,000 deductible) for repairs to the Honda. The Reeds accepted Jim's settlement offer. He mailed them a check for \$2,400, along with full releases for their property damage claim and for John's PIP claim. The Reeds signed the forms and returned them to Jim's office the following day. Jim closed the file as closed on the insurance company's system. See the exhibit "Correct Answer.\*"

## Concluding the Claim



These activities in the claim handling process are performed on every claim to some degree to create consistency and to help ensure that claims are handled in a manner that conforms to legal and ethical standards:

- Acknowledging and assigning the claim
- Identifying the policy and setting reserves
- Contracting the insured or the insured's representative
- Investigating and documenting the claim
- Determining the cause of loss, liability, and the loss amount
- Concluding the claim

Insurers use a combination of compliance measures to meet legal and regulatory requirements and promote good-faith claims handling practices. These measures include (1) claims guidelines, policies, and procedures; (2) controls, such as reports, access security, authority levels, and tracking; (3) supervisor and manager reviews; and (4) claims audits.

Insurers and other insurance organizations have claim departments, which may be structured in various ways. Claims personnel who handle claims may be staff claims representatives, independent adjusters, employees of TPAs, or producers. In addition, public adjusters handle claims by representing the or producers. In addition, public adjusters handle claims by representing the insurer's interests to the insurer. Claims departments can be managed by mathematicians and also quality through the use of best practices, claim audits, and customer service comments.

Two primary goals of the claim function are complying with the contractual promise and supporting the insurer's financial goals. The insurer fulfills its contractual promise to the insured through the claim handling process. Claim departments provide claim information that is used by marketing, underwriting, and actuarial departments to perform their functions. Additionally, the public, lawyers, and state regulators.

## SUMMARY

[DAO6275]

\*This solution might not be the only viable solution. Other solutions could be exercised if justified by the analysis. In addition, specific circumstances and organizational needs or goals may enter into the evaluation, making an alternative action a better option.

- Bodily injury liability claim payment for Karen Jones—Final payment, \$4,620
- Property damage claim for Karen Jones' 2008 Buick—Final payment, \$3,800
- Collision coverage for the Reeds' 2006 Honda—Final payment, \$2,700
- PIP coverage for John Reed's injuries—Final payment, \$2,400

Claim Payments for Reed/Jones Accident, DOL: 04/12/20XX

**Correct Answer\***



1. Includes copyrighted material of Insurance Services Offices, Inc., with its permission. Copyright, ISO Properties, Inc., 1997.
2. Includes copyrighted material of Insurance Services Offices, Inc., with its permission. Copyright, ISO Properties, Inc., 1997.
3. Includes copyrighted material of Insurance Services Offices, Inc., with its permission. Copyright, ISO Properties, Inc., 1997.
4. Includes copyrighted material of Insurance Services Offices, Inc., with its permission. Copyright, ISO Properties, Inc., 1997.
5. Includes copyrighted material of Insurance Services Offices, Inc., with its permission. Copyright, ISO Properties, Inc., 1997.
6. Includes copyrighted material of Insurance Services Offices, Inc., with its permission. Copyright, ISO Properties, Inc., 1997.
7. Includes copyrighted material of Insurance Services Offices, Inc., with its permission. Copyright, ISO Properties, Inc., 1997.
8. Includes copyrighted material of Insurance Services Offices, Inc., with its permission. Copyright, ISO Properties, Inc., 1997.
9. Includes copyrighted material of Insurance Services Offices, Inc., with its permission. Copyright, ISO Properties, Inc., 1997.

## ASSIGNMENT NOTES

Claim representatives can use the framework for coverage analysis and the claim handling process as guides for every claim they handle. The language of the policy and the facts of the claim will provide the details.

- Is the cause of loss covered?
- Is the damaged property covered?
- Are the amounts of loss or damages covered?
- Is the type of loss covered?
- Did the loss occur during the policy period?
- Is the person involved covered?
- Does other insurance apply?
- Do any exclusions apply?
- Is the location where the loss occurred covered?

Claim representatives use a framework for coverage analysis that involves every policy component, ensuring that all parts of the policy will be considered when making a coverage determination. Using the framework, the claim representative answers these questions:

