Chapter 2

Direct Your Learning

Claim Handling Process

After learning the content of this chapter and completing the corresponding course guide assignment, you should be able to:

- Describe the physical construction of insurance policies and the function of each of the in urance policy components.
- Describe the framework for coverage analysis and the information obtained by following it.
- Describe the activities in the claim handling process, including the following:
  - Acknowledging and assigning the claim
  - Identifying the policy
  - Contacting the insured or the insured' representative
  - Investigating and documenting the claim
  - Concluding the claim
- Given a claim, determine coverage for a loss using the framework for coverage analysis and the activities in the claim handling process.
- Define or describe each of the Key Word and Phrases for this chapter.

OUTLINE

Develop Your Perspective

What are the main topics covered in the chapter?

To properly handle claims, claim repre entatives must know how to analyze an insurance policy, and they must be able to apply that information to the facts they obtain during the claim handling process. This chapter provides the framework for coverage analysis and describes the claim handling process.

Review an insurance policy.

- What is the structure of that policy?
- Which policy components can you identify?

Why is it important to learn about these topics?

Claim repre entatives have an ethical obligation and a legal duty to use good claim handling practices on every claim they are assigned. Using a systematic approach to policy analysis and the claim handling process helps reinforce these good claim handling practices.

Examine how claims are handled in your office.

- What claim handling activities are performed?
- Who performs these activities?

How can you use what you will learn?

Analyze a closed claim and apply the framework for coverage analysis and the claim handling process to that claim.

- Do you agree with the coverage determination? Why or why not?
- What good-faith claim practices were used throughout the claim?
- Does the file contain sufficient documentation for you to answer the first two questions? If not, what information is missing?

Cha ter 2
Claim Handling Process

To fulfill the insurer's promise to pay covered claim , claim representatives should follow a systematic process. A process is important because it creates consistency in claim handling and helps ensure that claims are handled in a manner that conforms with legal and ethical standards. This chapter describes the claim handling process, including the important step of analyzing an insurance policy. Although different types of claims may require unique treatment, the same basic activities are performed in every claim. These activities, listed in Exhibit 2-1, provide a framework for handling all types of property, liability, and workers' compensation claims.

EXHIBIT 2-1

Activities in the Claim Handling Process

- Acknowledging and assigning the claim
- Identifying the policy
- Contacting the insured or the insured's representative
- Investigating and documenting the claim
- Determining the cause of loss and the loss amount
- Concluding the claim

While these activities appear sequential, they are not always undertaken sequentially. A claim representative may sometimes undertake several activities concurrently and may repeat some activities as new information is uncovered.

INSURANCE POLICY STRUCTURE

There are many different types of insurance policies. Claim representatives must carefully examine the structure of each policy and read and analyze all policy provisions to determine if coverage applies based on the facts of a given claim. The following sections describe the physical construction of property and liability insurance contracts, their content, and the framework to be used when analyzing an insurance policy.

Physical Construction

Insurance policies can be classified according to their components, which make up the physical document. Three general ways to classify policies are (1) self-contained or modular, (2) package or monoline, and (3) preprinted or manuscript. Some documents, such as the application for insurance, may be physically attached to the policy; others may be added to a policy by a reference within the policy (incorporated by reference).

A self-contained policy, as opposed to a modular policy, is a single document containing all agreements between the applicant and the insurer. The policy identifies the insurer and the insured; the subject matter of the insurance; and the amounts, terms, and conditions of coverage. Endorsements, which are documents that amend a policy, may be used to add, eliminate, or modify coverages. Self-contained policies are appropriate for loss exposures that are similar among insureds. For example, a private passenger auto policy may apply to all of an insurer's individual auto policyholders in one or more states.

In contrast to a self-contained policy, a modular policy, commonly used in commercial insurance, is a mix-and-match set of components that can be assembled to meet the insured's unique combination of needs. It is designed around one basic policy component, often called a "policy jacket" (or "common conditions form"), that includes condition , definitions, or other provisions that apply to, or match, all documents used with it. Every modular policy contains the common policy conditions and common declaration . An advantage of the modular policy is that a single policy can include several types of insurance, whereas using self-contained policies requires a separate policy for each of the coverages an insured requires.

Insurance policie may also be clas ified as either package or monoline. Package policies contain carefully designed and coordinated provisions in the various component forms that minimize the possibility of coverage gaps or overlaps. The terminology, definitions, and language of the components are consistent, and fewer forms are required than if a series of self-contained policies were used to provide the same coverage. Therefore, underwriting is simplified. An insurer can provide several types of insurance for one insured, offsetting the less profitable types of insurance. Insurers often offer a premium discount on package policies, an added benefit to the insured. An example of a package policy is the homeowners policy, which offers the homeowner coverage for both property damage and liability in a single package.

If the insured needs only one particular type of insurance, a monoline policy would provide that coverage. For example, the commercial property coverage policy includes a commercial property declarations (or information) page, the necessary commercial property coverage forms, and a commercial property conditions form. This combination of documents forming a complete policy for a particular type of coverage or line of business is called a monoline policy.

An insurance policy may also be classified as either preprinted or manuscript. Mo t insurance policies are assembled from one or more preprinted forms and

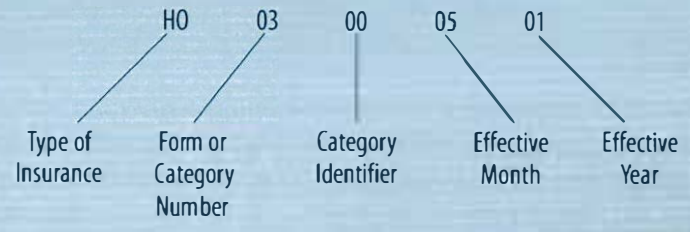
endorsements. These ready-made policies are developed for use with many different insureds and are usually approved by state insurance regulators. An insurer sends the insured the entire preprinted policy with a declarations page that indicates the form numbers and edition dates of the forms that apply. The insurer and the insurance producer generally retain only the declarations page, often as an electronic document. They can review the appropriate coverages by referencing the preprinted forms listed. In contrast to the preprinted policy, a manuscript policy is a one-of-a-kind policy written to meet a unique coverage need. Because it is unique to one insured, the policy form is usually exempt from regulatory approval.

Insurance service and advisory organizations, such as Insurance Services Office (ISO) and the American Association of Insurance Services (AAIS), have developed standard insurance forms that are available for use by individual insurers. These standard forms are usually accompanied by endorsements that reflect necessary state variations or that customize coverage. Claim representatives should pay particular attention to the policy form numbers associated with a particular standard policy so that they are analyzing coverage for a particular claim using the correct policy form. It is common for an insurer to have several different editions of a policy form in use at the same time, often because that insurer does business in several states and the same forms are not approved for use in every state. For example, an insured with locations in four states can have different versions of the commercial general liability policy in each location, with different coverage supplied by each.

Policy Form Numbers

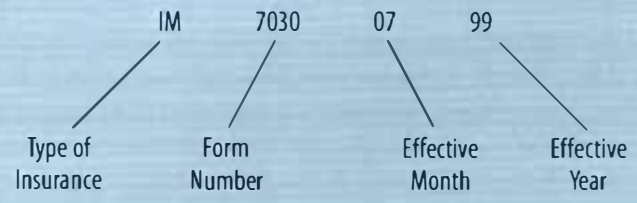
ISO and AAIS each have a key to understanding their policy form numbers. ISO policies can be read as follows:

HO 03 00 05 01



AAIS policies can be read as follows:

IM 7030 07 99



While ISO and AAIS develop standard policies, many insurers develop their own nonstandard, company-specific preprinted policies, often for high-volume types of insurance (such as auto or homeowners) or for coverages in which they specialize. The language and content in these nonstandard insurance policies can vary from provisions used by other insurers and from standard policy provisions. Many nonstandard policies contain coverage enhancements not found in standard policies.

Manuscript policies
Nonstandard, custom policies developed for one specific insured or for a small group of insureds, such as a business association, with unique coverage needs.

Manuscript policies, as distinguished from preprinted policies, are nonstandard, custom policies developed for one specific insured or for a small group of insureds, such as a business association, with unique coverage needs. A manuscript policy can be specifically selected or drafted for a particular need, such as products liability coverage for a pacemaker manufacturer. Manuscript endorsements can also be used for covering insureds with specific needs. Most manuscript policy provisions are adapted from the language in standard contracts or other insurance contracts. Some manuscript policies' wording is developed through negotiation between the insurer and the insured.

Other documents can become part of any policy by physical attachment or by reference within the policy. Some examples of attached documents are the completed application for insurance, endorsements, the insurer's bylaws, and the terms of relevant statutes. Examples of documents incorporated by reference are the rules and rates that have been approved by an insurance regulator, promissory notes (accepted by an insurer instead of cash premium payment), inspection reports, specification sheets, and operating manuals that describe safety equipment or procedures.

Policy Components and Their Functions

The various property, liability, and workers' compensation insurance policy components indicate the coverage that is provided, losses that are not covered, and the responsibilities of the parties to the contract. This section describes the functions of the following insurance policy components:

- Declarations
- Definitions
- Insuring agreements
- Exclusions
- Conditions
- Miscellaneous provisions
- Endorsements

The claim representative must review each of these policy components to determine if they apply to a given claim. The circumstances of the specific claim determine how often this review must occur. For example, if a loss to a building is reported as water damage, the claim representative would review the policy to see what type of water damage is covered. On investigation, the claim representative may learn that the water has entered the building as a

result of rain that accumulated and backed up from a storm drain. With this information, the claim representative would again review the policy to see if coverage applies to water damage from that specific cause.

Declarations

A property, liability, or workers' compensation policy's declarations (information pages) are typically the first page(s) of an insurance policy. Declarations contain basic information about the insured taken from the insurance application, a description of the coverage provided under the policy, and information about what i unique to the policy.

Information Found in the Policy Declarations

A policy's declarations usually include the following information:

- Policy number
- Policy inception and expiration dates
- Name of the insurer
- Name of the producer
- Name of the insured(s)
- Mailing address of the insured
- Physical address and description of the covered property or operations
- Numbers and edition dates of all attached forms and endorsements
- Dollar amounts of applicable policy limit(s)
- Dollar amounts of applicable deductibles
- Names of persons or organizations whose additional interests are covered (such as mortgagees, loss payees, or additional insureds)
- Premium

Policy forms or endorsements may also contain information that qualifies as declarations. For example, a glass coverage endorsement may contain a narrative description or diagram of the covered glass o that it can be identified in the event of a loss.

APPLY YOUR LEARNING

Adjusting Tip

Claim representatives should carefully check policy declaration information against information submitted in a claim. Any differences in the insured's name, address, building locations, and policy forms must be resolved with the underwriter and producer before the claim representative settles the claim.

Definitions

Another component of many property-liability policies is the definitions section, which contains definitions of terms used throughout the policy or form. The purpose of the definitions is to establish a common understanding of what the terms in the policy mean. The definitions can be included anywhere in the policy or be presented in a glossary.

Examples of "definitions" vary. Many current policies explain that the term "we" is used to indicate the insurer and "you" to indicate the named insured. Similarly, policies may also describe the use of the pronouns "us," "our," and "your."

Many court cases rest on the definitions of words not defined in a policy. Courts and insurers follow the rules of contract interpretation to resolve such issues, as follows:

- Everyday words are given their ordinary meaning.
- Technical words are given their technical meaning.
- Words with an established legal meaning are given their legal meaning.
- Words that have local, cultural, and trade-usage meanings are considered, if applicable.

APPLY YOUR LEARNING

Adjusting Tip

When analyzing coverage, a claim representative should consult the definitions, such as "bodily injury," "property damage," and "insured." When the claim's circumstances do not fit within the definitions, the coverage promised in the insuring agreement does not apply.

Insuring Agreements

Insuring agreement
A statement in an insurance policy that the insurer will, under described circumstances, make a loss payment or provide a service.

The **insuring agreement**, a fundamental component of any insurance policy, is any insurance policy statement indicating that the insurer will make a loss payment or provide a service under described circumstances. The insuring agreement broadly states the promises made by the insurer about coverage. For example, the insuring agreement of the standard Insurance Services Office (ISO) homeowners policy (HO-3)[1] reads as follows:

> We will provide the insurance described in this policy in return for the premium and compliance with all applicable provisions of this policy.

The insuring agreement of the liability coverage part of ISO's Personal Auto Policy (PAP)[2] begins as follows:

> A. We will pay damages for "bodily injury" or "property damage" for which any "insured" becomes legally responsible because of an auto accident.

The words and phrases enclosed in quotation marks in the policy are defined in the policy's definitions.

Policies can have more than one insuring agreement if they provides more than one type of coverage. For example, the Personal Auto Policy typically provides liability, medical payments, uninsured motorists, and physical damage coverages. Each coverage has its own insuring agreement, which states what the insurer agrees to do, subject to policy clarification.

APPLY YOUR LEARNING

Adjusting Tip

Insuring agreements usually contain one or more defined terms, and the definitions are crucial to understanding the coverage provided.

Insuring agreements fall into the following two categories:

1. Comprehensive, all-purpose insuring agreements describe extremely broad, unrestricted coverage that applies to virtually all causes of loss. The broad coverage is clarified and narrowed by exclusions, definitions, and other policy provisions. An example of this type of insuring agreement can be found in an HO-3 policy, which provides protection against causes of loss that the form does not specifically exclude.
2. Limited or single-purpose insuring agreements restrict coverage to certain causes of loss or to certain situations, which are clarified, narrowed, or sometimes broadened by other policy provisions. An example of this type of insuring agreement can be found in an HO-1 or HO-2 policy, which provides named peril, specified peril, or specified cause of loss coverage.

Insuring agreements can also apply to extended, additional, or supplemental coverages. A coverage extension generally extends a portion of a basic policy coverage to apply to a type of property or loss that would not otherwise be covered. An additional coverage adds a type of coverage not otherwise provided. A supplementary payments coverage clarifies the extent of coverage for certain insurance expenses. Other policy provisions grant or restore coverage otherwise excluded. Therefore, these provisions serve as insuring agreements. They may appear within a definition, as an exception to an exclusion, or elsewhere in the policy.

Exclusions

Exclusions are policy provisions that state what the insurer does *not intend* to cover. The primary function of the exclusions component is to clarify the coverages granted by the insurer in the insuring agreement, and not to remove coverage from the insured. Adding exclusions to a policy is a legally enforceable way of clarifying property or situations that the insurer does intend to cover. For example, the ISO HO-3 policy contains the following exclusion:

> A. We do not insure for loss caused directly or indirectly by any of the following. . .
>
> 5. Neglect

> Neglect means neglect of an "insured" to use all reasonable means to save and preserve property at and after the time of a loss.[3]

For example, during a storm, a tree falls on the insured's home, creating a substantial hole in the upstairs bedroom wall. After the storm ends, the insured has the tree removed but does nothing to seal off the hole in the wall. Another storm occurs and rain enters the bedroom, ruining the carpet. The damage to the carpet is caused by the insured's neglect and would not be covered under the HO-3 policy.

Six Purposes of Exclusions

Exclusions can serve one or more of the following purposes:

1. *Eliminate coverage for uninsurable loss exposures.* Some exposures (such as intentional acts) are not insurable loss exposures. Exclusions allow insurers to preclude coverage for those exposures.
2. *Assist in managing moral hazards and morale (attitudinal) hazards.* Exclusions help insurers minimize loss exposures that are affected by moral hazards. Some exclusions also force insureds to bear any losses that result from their own carelessness (from morale hazards).
3. *Reduce the likelihood of coverage duplications.* In some cases, two applicable insurance policies cover the same loss. Exclusions ensure that such policies provide complementary, not duplicate, coverage.
4. *Eliminate coverages not needed by the typical insured.* Exclusions sometimes allow insurers to decline coverage for loss exposures that typical insureds do not face. These exclusions eliminate the chance that all insureds would have to share the costs of covering substantial loss exposures of relatively few insureds.
5. *Eliminate coverages requiring special treatment.* These coverages might require rating, underwriting, loss control, or other treatment that is different from that normally applied to the insurance policy.
6. *Assist in keeping premiums reasonable.* Exclusions allow insurers to decline those loss exposures that would increase overall insurance costs. By declining such loss exposures, insurers can offer premiums that most insureds consider reasonable for their exposures.

Exclusions can appear straightforward; however, the meaning of an exclusion i often contested in court. If an exclusion (or any other policy component) i unambiguous, then it is usually enforced according to its common meaning. If an exclusion (or any other part of the policy) is ambiguous, courts typically hold that the exclusion does not apply, because ambiguities are construed against the writer, in thi case, the insurer.

Conditions

Policy condition
Any provision that qualifies an otherwise enforceable promise made in the policy.

Another property-liability and workers' compensation policy component is the conditions. A policy condition is any provision that qualifies an otherwise enforceable promise made in the policy. In a policy's insuring agreement, the

insurer promises to pay covered losses, furnish a defense, and provide other services to the insured only if the insured has fulfilled his or her contractual duties as specified in the policy conditions. If the insured fails to meet these requirements, the insurer is released from any obligation to keep its promises under the contract.

Some policy conditions are included in a "Conditions" section, while others are found in the forms, endorsements, or other documents in the insurance contract.

APPLY YOUR LEARNING

Adjusting Tip

Claim representatives must carefully read the applicable conditions throughout the policy to determine the duties, rights, and options of both the insurer and the insured.

Conditions cover a broad range of topics, including the following:

- The insured's duty to pay the premium
- The insured's duties after a loss occurs
- The geographic area in which coverage applies
- The way disagreements between the insurer and the insured can be resolved
- The procedures that should be followed to cancel the policy

For example, the "Loss Payment" condition of Section I of the HO-3 reads as follows:

> 1. **Loss Payment**. We will adjust all losses with you. We will pay you unless some other person is named in the policy or is legally entitled to receive payment. Loss will be payable 60 days after we receive your proof of loss and:
>
> 1. Reach an agreement with you;
> 2. There is an entry of a final judgment; or
> 3. There is a filing of an appraisal award with us.[4]

These policy provisions are called "conditions" because each party's obligations under the policy are conditional. If either party fails to fulfill the required obligations, the other party is released from its obligations under the policy. For example, an important condition prohibits fraud committed by insureds, as indicated in the following excerpt from the HO-3:

> Q. **Concealment or Fraud**. We provide coverage to no "insureds" under this policy if, whether before or after a loss, an "insured" has:
>
> 1. Intentionally concealed or misrepresented any material fact or circumstance;
> 2. Engaged in fraudulent conduct; or
> 3. Made false statements;
>
> relating to this insurance.[5]

If the insured commits fraud, the insurance policy is void and the insurer is under no obligation to pay claims.

Miscellaneous Provisions

Miscellaneous provisions are a component of a property-liability policy that can be found throughout the policy. These provisions do not strictly qualify coverage as do declarations, definitions, insuring agreements, exclusions, or conditions, but they do affect coverage. They may describe the relationship between the insurer and the insured or establish procedures for implementing policy conditions. However, they do not have the force of conditions, meaning if the insured does not follow procedures specified in miscellaneous provisions, the insurer typically must still fulfill its contractual promises.

An example of a miscellaneous provision is a valuation provision that sets procedures for determining the value of losses covered by the policy. Other miscellaneous provisions may be unique to a particular type of insurer; for example, for a mutual insurer in which policyholders have voting rights, the miscellaneous provisions may describe the policyholders' rights to elect the board of directors.

Endorsements

Endorsements, a key component of many policies, become part of a policy when they are listed in the declarations and attached to the policy. An endorsement adds to, deletes, replaces, or modifies another policy provision. Other terms that refer to endorsements are "policy change," "addition," "amendment," and "codicil." Some endorsements have a descriptive title, such as "Loss Payable Clause." An endorsement can be preprinted, computer-printed, typewritten, or handwritten on a separate sheet of paper attached to the policy. An endorsement takes precedence over any conflicting terms in the policy to which it is attached. A handwritten endorsement supersedes a computer-printed or typewritten endorsement. These rules are based on the premise that an endorsement added to a policy, particularly if it is handwritten, tends to reflect the true intent of the parties more accurately than do other, preprinted policy terms.

Knowing the components of the policy and what each is meant to accomplish helps the claim representative analyze coverage applicable to a claim. In order to analyze coverage, claim representatives also need a framework.

FRAMEWORK FOR COVERAGE ANALYSIS

Coverage analysis is the process of examining a policy by reviewing all its component parts and applying them to the facts of a claim. 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 forms. They are aware of the types of losses that insureds and claimants often believe are covered, but are not. This policy knowledge aids coverage analysis. But experience does not remove the necessity for the claim representative to read the applicable policy forms carefully and to analyze coverage systematically.

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 component parts are reviewed and reduces the incidence of erroneous coverage determinations. The following 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?
- Do any exclusions apply?
- Does other insurance apply?

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. In any case, the answers help the claim representative make a coverage determination.

Is the Person Involved Covered?

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 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 the financial loss. For example, the PAP Part A—Liability Coverage defines "insured" as follows:

> 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 or omissions 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 but only with respect to legal responsibility for acts or omissions of you or any "family member" for whom coverage is afforded under this Part. This provision (B.4.) applies only if the person or organization does not own or hire the auto or "trailer".[6]

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.

In contrast, the HO-3 defines "insured" in part as follows:

> 3. "Insured" means:
>
> a. You and residents of your household who are:
>
> (1) Your relatives; or
>
> (2) Other persons under the age of 21 and in the care of any person named above;...[7]

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. "Insured" may be defined differently in other sections of the policy. For example, the definition of "insured" is expanded for Part B—Medical Payments Coverage of the PAP to include:

> 1. You or any "family member":
>
> a. While "occupying"; or
>
> b. As a pedestrian when struck by;
>
> a motor vehicle designed for use mainly on public roads or a trailer of any type.
>
> 2. Any other person while "occupying" "your covered auto".[8]

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

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 insured under the policy.

APPLY YOUR LEARNING

Adjusting Tip

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, on discovering that Kathy's parents have an insurable interest in the house, should check with a supervisor or manager to determine how to handle the claim payment. Lienholders 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.

Did the Loss Occur During the Policy Period?

Many policies are written to cover only losses that occur during the policy period. The HO-3 states the following:

> P. **Policy Period.** The policy applies only to loss which occurs during the policy period.[9]

The policy period typically begins and ends at one minute after midnight (for example, from 12:01 AM on January 25, 2006, to 12:01 AM of January 25, 2007). The Loss of Use section contains an exception to the policy period provision. For example, if a fire leaves a home unfit to live in, the insured can claim expenses for living elsewhere, even if the policy expires the next day. However, the fire must have begun during the policy period.

The date and time of loss occurrence is used to determine whether a loss occurred during the policy period. However, court decisions have offered different interpretations of date of occurrence. For example, a court may determine that the date of occurrence for an occupational disease is the first date of exposure to the harmful condition that caused the disease, the last date of exposure to the harmful condition that caused the disease, or the date the disease was diagnosed.

Is the Cause of Loss Covered?

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 coverage, also called named-perils coverage, covers a loss 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 specified perils.

Specified causes of loss coverage
A named perils coverage that covers loss caused only by the specifically listed perils.

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 excessive heat with no actual flame? Does it include damage the firefighters cause while extinguishing the fire?

APPLY YOUR LEARNING

Adjusting Tip

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.

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

Special form coverage
Property insurance coverage covering all causes of loss not specifically excluded.

Insured Against in the HO-3 states, in part, "We insure against *risk of direct loss to property* described in Coverages A and B" [emphasis added].[10] 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.

An HO-3 Claim Example

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 a named peril under specified perils coverage on the contents, the damage to the table, chairs, and area rug is not covered.

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

Is the Damaged Property Covered?

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 PAP defines "your covered auto" as:

1. Any vehicle shown in the Declarations.
2. A "newly acquired auto".
3. Any "trailer" you own.
4. 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:
   a. Breakdown;
   b. Repair;
   c. Servicing;
   d. Loss; or
   e. Destruction[11]

If a claim investigation reveals that an auto involved in an accident does not appear 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.

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 follows:

a. The dwelling on the "residence premises" shown in the Declarations, including structures attached to the dwelling; and
b. 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".[12]

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's investigation revealed that Jeff planned to use 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 on a job, the loss would not be covered. Therefore, it is important to determine whether the damaged property is covered under the policy.

Is the Type of Loss Covered?

Losses can be classified as direct or indirect. **Direct loss** refers to reduction in property value resulting immediately and proximately from damage caused by a covered cause of loss. A crumpled car fender is a direct loss. **Indirect loss,** sometimes called consequential loss or time element loss, is difficult to define, but generally refers to a loss that arises as a result of damage to property, other than the direct loss to the property. 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 temporary living quarters for the insured while the home is being rebuilt 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.

Direct loss
A reduction in property value resulting immediately and proximately from damage caused by a covered cause of loss.

Indirect loss
A loss that arises as a result of damage to property, other than the direct loss to the property.

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

Are the Amounts of Loss or Damages Covered?

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.

For liability claims, damages for which the insured may be liable are of the following two types:

Compensatory damages
Compensation to claimants for their bodily injury or property damage.

Special damages
A monetary award to compensate a victim for specific, out of pocket expenses incurred because of a loss, such as medical expenses, wage loss, funeral expenses, or repair bills.

General damages
A monetary award to compensate a victim for losses, such as pain and suffering, that do not involve specific measurable expenses.

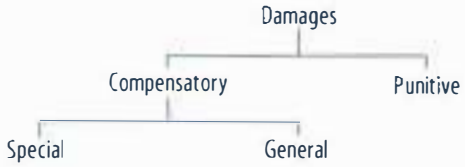
Punitive damages
A payment awarded by a court to punish a wrongdoer for a reckless, malicious, or deceitful act and to deter similar conduct.

1. **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.
2. **Punitive damages** punish a wrongdoer for a reckless, malicious, or deceitful act and deter similar conduct.

Exhibit 2-2 shows the types of damages.

EXHIBIT 2-2

Damages



Some policies do not define or list the types of damages payable under the policy. For example, the insuring agreement for the PAP liability coverage section begins, "We will pay damages for 'bodily injury' or 'property damage' for which any 'insured' becomes legally responsible because of an auto accident."[13]

Generally, the term "damages" refers only to compensatory damages, such as expenses for medical bills, lost wages, and pain and suffering. In some states, the insurer is not permitted to pay for punitive damages because such payment by an insurer would not punish the insured. For example, if a manufacturer of a defective product has insurance for punitive damages, imposition of punitive damages would not have the same deterrent effect as forcing the manufacturer to pay the damages directly from its assets. Therefore, some policies expressly exclude coverage for punitive damages.

In a liability insurance policy, the insurer agrees to pay judgments and settlements 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 a 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.

In addition to ensuring that the type of loss and types of damage are covered, claim representatives must verify that the amount of damages is within the policy limits. A first party property policy will have limits of liability and may

also have sublimits for certain types of property or types of losses. For example, the HO-3 contains a limit on the dwelling and contents as well as special limits for loss of money and theft of jewelry and silverware. First-party losses are also subject to deductibles, provisions that specify how the loss is to be valued (either actual cash value or replacement cost), and coinsurance clauses designed to ensure that the appropriate amount of insurance is maintained on the property.

Is the Location of the Loss Covered?

The location where the loss occurred must be within the policy's territorial limits and, for property policies, be shown on the policy as a covered location. To illustrate, the PAP defines policy territory as follows:

> 1. The United States of America, its territories or possessions;
> 2. Puerto Rico; or
> 3. Canada.
>
> This policy also applies to loss to, or accidents involving, "your covered auto" while being transported between their ports.[14]

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.

Do Any Exclusions Apply?

As stated earlier, 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 PAP excludes damage caused by wear and tear, such as the wear on a tire.

Exclusions to coverage can involve the following:

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

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 submits a claim. That claim appears to be covered according to the following criteria:

- *Is the person involved covered?* The driver is the named insured.
- *Did the loss occur during the policy period?* In this case, it did.

- *Is the cause of loss covered?* The policy covers physical damage to the insured's car.
- *Is the damaged property covered?* The vehicle is listed in the policy's declarations.
- *Is the type of loss covered?* The policy covers collisions.
- *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 location of the loss covered?* The loss occurred within the policy's territorial limits.

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 or livery conveyance, and the claim representative would rightfully deny the claim.

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.

APPLY YOUR LEARNING

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.

Does Other Insurance Apply?

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.

CLAIM HANDLING PROCESS

The claim representative has a responsibility to thoroughly investigate a claim to determine how coverage applies. However, investigation is only one activity in the claim handling process. To ensure that every claim is handled

in good faith, from beginning to end, the claim representative should follow a systematic claim handling process that is discussed in the remainder of this chapter. The process is a group of activities that are standard for anyone who handles claims. The activities are not always sequential. Some can be performed concurrently, and some may need to be repeated as new facts are uncovered. Depending on the severity and complexity of the claim, the process may be completed quickly or it can take months or even years to complete.

Activities in the Claim Handling Process

- Acknowledging and assigning the claim
- Identifying the policy
- Contacting the insured or the insured's representative
- Investigating and documenting the claim
- Determining cause of loss and loss amount
- Concluding the claim

The claim handling process is initiated when the insured reports the loss to the producer or directly to the insurer's claim center. If the loss is reported to the producer, the producer typically enters the loss information into the agency's claim information system, which then transmits the appropriate loss notice to the insurer. If the producer prepares a hard copy of the loss notice, he or she may fax it to the insurer. If the loss is reported directly to the insurer, claim personnel enter the loss information into the insurer's claim information system.

Losses can be reported using a loss notice form, which varies by type of loss. One of the most commonly used loss notice forms is the ACORD form. ACORD forms include basic information about the loss, such as the loss date and time, policy number, insured name and address, covered property, and loss description. For injury claims, the loss notice also includes the accident location, witness names and addresses, and the names and addresses of any injured persons.

However, not all losses are reported using a loss notice. Some losses may be reported in a letter or as part of a lawsuit. Regardless of how a loss is reported, the same information must be entered into the insurer's claim information system. If the first notice of the loss is a lawsuit, the claim representative must be aware of the deadline by which to respond to the lawsuit. The time allowed for response varies by state. The claim representative must turn the lawsuit over to counsel to answer, even while the initial investigation is underway.

Once a loss notice is received and the information is entered into the insurer's claim information system, the insurer begins the claim handling process.

Acknowledging and Assigning the Claim

Generally, the first activity of the insurer in the claim handling process is acknowledging receipt of the claim and assigning the claim to a claim representative. Some insurers acknowledge claims immediately upon receiving the loss notice by contacting the insured by phone, e-mail, letter, or postcard. Others acknowledge the claim after it is assigned to a claim representative. Many insurers transfer claim files to a claim manager for assignment to a claim representative. The claim manager may add comments to the file and then transfer the file directly to the assigned claim representative. The purpose of the acknowledgment is to advise the insured that the claim has been received. The acknowledgment also provides the name and contact information of the assigned claim representative and the claim number. Insurers acknowledge claims in this timely manner to comply with insurance regulations.

Insurers use different methods of assigning claims to claim representatives. Some insurers assign claims based on territory, type of claim, extent of damage, workload, or other criteria contained in the insurer's claim information system. The goal is to assign the claim to the claim representative who possesses the appropriate skills to handle it. Some states require claim representatives who handle claims in the state to have an adjuster license. These licensing requirements must also be considered when assigning a claim to a claim representative. For example, Texas law requires a claim representative adjusting a loss for a Texas insured or a loss that occurred in Texas to be licensed as an adjuster in Texas. Such statutes usually allow exceptions in the event of a catastrophe, such as a flood or tornado, that requires every available claim representative be sent into an area to handle the high volume of resulting claims.

After receiving the claim assignment, the claim representative contacts the insured, and possibly the claimant (if it is a third-party claim), to acknowledge the claim assignment and explain the claim process. For insurers that do not make contact immediately after receiving the loss notice, this contact serves as the claim acknowledgment. For some types of losses, the claim representative may give the insured instructions to prevent any further loss, such as to cover roof damage with a tarp. 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.

Identifying the Policy

Another activity in the claim handling process is identifying the policy. The claim representative first identifies the policy in force upon receiving the assignment. Some insurers do this before they acknowledge the claim. Other insurers identify the policy in force before the claim representative begins the

claim investigation. In either case, the claim representative must thoroughly read the policy, using the framework for coverage analysis described previously, to determine what types of coverage apply to the loss.

If it is apparent from the loss notice 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, discussed later in this chapter, reserve the insurer's and policyholder's rights under the policy.

Reserves

Often, in conjunction with identifying the policy, claim representatives establish claim or case (loss) reserves, although this can occur at almost any point in the claim handling process, depending on the insurer's internal guidelines. While the exact timing may differ among insurers, the setting of an initial reserve(s) usually occurs early in the claim handling process. A **reserve** is the amount the insurer estimates and sets aside to pay on an existing claim that has not been settled. The insurer's claim information system often determines the types of reserves that are established, such as one reserve for property damage and another for bodily injury. Some systems require separate reserves for each claimant in a claim, and some systems require separate expense reserves for the costs of handling the 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. Setting accurate reserves is an important part of the claim representative's job. Reserves that are too high or too low can affect the profitability of the insurer. Establishing and maintaining adequate reserves is important for the insurer's financial health because reserves affect the insurer's ability to maintain and increase its business.

Reserve
The amount the insurer estimates and sets aside to pay on an existing claim that has not been settled.

Insurers can use different methods of setting reserves. Six common methods are discussed here.

Common Methods of Setting Case Reserves

1. Individual case method
2. Roundtable method
3. Average value method
4. Formula method
5. Expert system method
6. 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 to set the reserve.

One method of setting claim reserves is the individual case method. Claim representatives set an individual or case reserve for each claim or cause of loss, based on the claim representative's expectation of what the insurer will pay. When the **individual case method** is used on each claim, the claim

Individual case method
A method of setting reserves based on the claim's circumstances and the claim representative's experience in handling similar claims.

representative estimates the loss reserve based on the claim's circumstances and experience in similar claims.

Because of the subjective nature of the evaluation, reserves can vary widely by claim representative. Factors that claim representatives may consider when using the individual case method for a bodily injury claim are shown in Exhibit 2-3.

EXHIBIT 2-3

Individual Case Method Considerations

Considerations a claim representative may use when setting reserves on a bodily injury claim using the individual case method include the following:

1. Claimant profile (factors in calculating economic loss)
   a. Age
   b. Gender
   c. Occupation
   d. Level of education
   e. Dependants, if any, their ages, and to what extent they rely on the claimant financially and for companionship
2. Nature and extent of the injury (factors in calculating general damages)
   a. Whether the injury is permanent
   b. Extent of pain and suffering
   c. Extent of disruption the injury creates in the individual's lifestyle
3. Special damages (factors in calculating special damages)
   a. Anticipated medical bills incurred to date and for future care
   b. Type of medical care that has been or is being provided; whether it includes diagnostic care or treatment
   c. Whether the claimant will lose any wages
4. Claimant representation (factors in determining the likelihood of a lawsuit and predicting general damages that could result)
   a. Whether the claimant is represented by a lawyer
   b. If so, the lawyer's reputation
   c. Typical value of local court verdicts
5. Liability factors (factors in calculating compensatory and/or punitive damages)
   a. Whether the case involves ordinary negligence or gross negligence
   b. Whether the case involves any comparative or contributory negligence
   c. Any legal limits to recovery, such as a cap on certain types of damages
   d. Any other parties' contribution to the loss or responsibility for contributing to the settlement

6. Miscellaneous factors
   a. General economic conditions in the geographic area (factor in calculating economic loss)
   b. Whether the insured's conduct in causing the loss was outrageous (factor in calculating compensatory damages)
   c. Whether drinking or drug use contributed to the loss (factor in calculating liability)
   d. The insured's credibility as a witness (factor in determining likelihood of successful lawsuit)
   e. The claimant's credibility as a witness (factor in determining likelihood of successful lawsuit)

Another method of setting claim reserves is the roundtable method. The **roundtable method** involves two or more claim personnel independently evaluating the claim file, each suggesting a reserve based on his or her evaluation. Ideally, the claim personnel should not initially know the reserves the others have set. After the evaluation and a discussion, a consensus reserve figure may be reached, or an average of all the figures may be calculated. Because this method is time-consuming, it is not appropriate for setting initial reserves. However, for serious or prolonged claims, it is a suitable method to review initial reserves.

Roundtable method
A method of setting reserves by using the consensus of two or more claim personnel who have independently evaluated the claim file.

Claim representatives may also set claim reserves using the **average value method**, which uses a predetermined dollar amount that is set aside for a particular type of claim when it is reported. This method is useful when there are small variations in loss size for a particular type of claim and when claims can be concluded quickly. The average values are usually based on data from past claims and adjusted to reflect current conditions. For example, auto physical damage claims may be initially reserved at $1,500 based on an insurer's previous loss experience with those claims. That figure may remain the same until the claim has been concluded. For some claims, the initial reserve is set based on the average value method, but claim representatives are required to modify the initial reserve within a specified number of days to reflect each claim's circumstances.

Average value method
A method of setting claim reserves by using a predetermined dollar amount that is set aside for a particular type of claim when it is reported.

Another method of setting claim reserves is the **formula method**, in which the claim representative uses a mathematical formula to set reserves. For example, a formula may be based on the assumption that a certain ratio exists between the medical cost and the indemnity (or wage loss) in a workers' compensation claim. Based on an insurer's loss history with many similar claims, the indemnity reserve may be set at a certain percentage of the medical reserve. The formula method may also be used to set the additional living expense reserve under a homeowners policy if the home is destroyed by fire. The reserve may be set as a certain percentage of the coverage limit. The formula is determined by the insurer and is automatically created for the claim representative, based on the facts of the claim.

Formula method
A method of setting claim reserves by using a mathematical formula.

Expert system method
A method of setting reserves with a software application that estimates losses and loss adjustment expenses.

Claim representatives may also set claim reserves by the **expert system method**, using a software application containing business rules to assist in estimating losses and loss adjustment expenses (LAE). The details of a particular claim are entered into the computer, and the program applies the appropriate rules to estimate the amount of the loss and the LAE. An expert system can provide greater consistency in reserving than the individual case method. While similar in operation to the formula method, the expert system includes more subjective information, such as loss location or the name of the treating physician, in creating the reserve.

Loss ratio method
A method of setting reserves by establishing aggregate reserves for all claims within a type of insurance or a class of loss exposures.

The **loss ratio method** of setting claim reserves is used to establish aggregate reserves for all claims within a type of insurance or a class of loss exposures. The actuarial department uses this method when other methods of establishing claim reserves are inadequate. For example, in medical malpractice insurance for physicians and surgeons, claims are often reported long after the expiration date of the policy that provided the coverage. To ensure that the insurer has adequate reserves for those claims, the actuarial department may project reserves using the loss ratio method.

The NAIC Annual Statement is another example of the use of the loss ratio method of setting reserves. The Annual Statement requires minimum reserves for certain types of insurance such as workers' compensation. The minimum reserve is a specific percentage of the earned premiums for the year. For example, for workers' compensation insurance, the minimum reserve required by the Annual Statement may be 50 percent of earned premiums. If case reserves are lower than that amount, the Annual Statement uses the set percentage. If case reserves are higher than the set percentage, the Annual Statement uses the case reserves. Exhibit 2-4 illustrates how Annual Statement reserves are established in this situation.

EXHIBIT 2-4

Minimum Annual Statement Reserves

Minimum Statutory Reserve	50%
Earned Premiums	$40,000,000

	Case Reserve	Annual Statement Reserve
Example 1	$16,000,000	$20,000,000
Example 2	$22,000,000	$22,000,000

Additionally, insurers are required by law and good accounting practice to establish reserves for losses that have been incurred but not reported (IBNR). Although the name refers only to incurred but not reported losses, unreported losses account for only a part of the reserve in many cases. Often, the IBNR reserve also includes an amount for reported losses for which the case reserves are judged to be inadequate. A reserve for claims that have been closed and then reopened may also be included in the IBNR reserve.

Actuaries analyze the insurer's experience by comparing paid losses to case reserves to determine whether the insurer typically under reserves or over reserves claims. If the insurer typically under reserves claims, the IBNR reserve will be set at an amount to cover the ultimate cost of the claim.

Causes of Reserve Errors

Reserve adequacy and accuracy are important to an insurer's continued solvency and ability to write new business (capacity). Claim representatives can negatively influence solvency and capacity by undervaluing claim reserves. Although an occasional reserve may be inadequate or inaccurate with little or no effect on the insurer, consistently inaccurate or inadequate reserves on thousands of claims can distort the ratemaking process, eventually affecting an insurer's ability to write business competitively and ultimately affecting solvency.

Reserving errors can be caused in several ways. Initial reserves may be inaccurate because they are determined based on limited information. Thus, many insurers require that initial reserves be reviewed and adjusted for accuracy within a short time frame. In addition, most insurers require reserves to be evaluated whenever a claim file is reviewed. That evaluation ensures that reserves reflect the most current information contained in the claim file.

Reserve inaccuracy can also be the result of the claim representative's poor planning, lack of expertise in estimating claim severity, or unwillingness to reevaluate the facts. In these cases, the claim representative may set a modest initial reserve, but 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 has little effect except to reveal the claim representative's poor claim handling practices. 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.

This does not mean that claim representatives cannot adjust a reserve up or down during the course of a claim. However, they should make those adjustments because of new information or changes in the circumstances of the claim, not because of poor planning or other poor claim handling practices.

Stairstepping can be avoided if proper claim handling practices and reserving methods are used. For example, the roundtable method or expert system method may result in a realistic reserve that would prevent frequent stairstepping.

Because reserves should reflect the ultimate cost of a claim and not the claim's present value, the reserve should account for the claim's future settlement value. For example, a catastrophic injury claim may take years to settle. During that time, inflation may increase the cost of medical care, or new and expensive medical technology may be developed. The reserves for such claims should anticipate those increased costs.

Claim representatives may underestimate the future settlement value of a claim if they are overconfident of their ability to conclude the claim for a lesser amount. Reserves should always be based on the value of a claim, never on the perceived likelihood of successful negotiation and settlement. Analysis of verdicts rendered in similar cases helps show the potential value of a claim and discourages the tendency to base reserves on negotiation expertise.

Some inadvertent errors in setting reserves can be detected using computer software that stores claim information. Some claim information systems provide a data entry check. For example, the software might require that the reserve amount be entered twice to allow the person inputting the data a chance to verify the amount. Additionally, claim managers can review reports of reserves from the preceding day for unusual entries or reserves established in excess of authority. For example, a report listing all reserves of $100,000 or more might uncover a $10,000 reserve that was incorrectly entered as $100,000.

As claim representatives proceed with claim investigations and evaluations, they should increase or decrease the reserve amounts to reflect new information received. For example, if the estimate for car repairs is $5,000, the claim representative would set up a reserve of $5,000. If hidden damage is then found and the estimate is revised to be $10,000, the claim representative should change the reserve to reflect this increase in the repair estimate. Likewise, if an estimate to repair is lowered, the reserve should be changed to reflect the decrease. Because these changes are based on changes in the facts of the claim, they are not considered stairstepping.

Contacting the Insured or the Insured's Representative

Another activity in the claim handling process, which occurs soon after the loss is assigned to a claim representative and initial reserves are established, is contacting the insured or the insured's representative. This initial contact with the insured serves several purposes. It can reassure the insured that the claim will be investigated. It also provides the claim representative with an opportunity to explain the claim process and begin the claim investigation.

For some insurers or in certain claims as specified in the insurer's guidelines, this contact occurs at the same time as the claim acknowledgment. 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. This can be a face to face meeting at the insured's location or the loss location, or it can be a telephone discussion. If the loss involves a third-party claimant, then the claim representative also contacts the claimant and schedules a meeting with the claimant or a party representing the claimant to discuss the facts of the loss.

For some claims, the insured is represented by a public adjuster or an attorney. Public adjusters are active in some states and metropolitan areas, most often in property damage claims. Such adjusters charge a fee to help

insureds present claims to insurers. The claim representative should discuss claim-related issues with the public adjuster or attorney until advised not to do so by the insured.

Not every claim requires a face-to-face meeting with the insured or claimant. Some claims can be handled by phone, supplemented by an exchange of documents. Most insurers have guidelines for claim representatives to determine which claims can be handled by phone.

Before making the initial contact with any of the parties, the claim representative should prepare a list of questions for the insured or claimant along with a set of instructions on how the claim will be handled and what actions the insured or claimant will have to complete as part of the claim process.

The first meeting or discussion with the insured sets the tone for the claim. For the insured or the claimant, the loss has mostly likely created a disruption resulting in strong emotions, such as anger or grief. Those who have never filed an insurance claim may be apprehensive or confused about how the claims will be handled. The claim representative should be aware of these factors and take them into consideration when initially meeting or speaking with the insured or the claimant.

APPLY YOUR LEARNING

Adjusting Tip

Claim representatives should be aware that their words and actions set the insured's or claimant's expectations about the claim. If the claim representative promises that something will be done by a certain date, the insured or claimant will expect it to be done by that date. Therefore, claim representatives demonstrate good-faith claim handling practices by meeting these deadlines.

At the initial contact, claim representatives frequently find that many insureds do not fully understand the details of their insurance coverages. The claim representative must be prepared to explain the policy terms and their meanings in relation to the loss. The claim representative must explain any possible policy violation, exclusion, or limitation that can affect coverage. Withholding such information can be considered a breach of the claim representative's or insurer's duties. The claim representative must be careful not to give the insured or claimant the impression that a claim will be paid if possible grounds to deny a claim exist.

Once contact is made, the claim representative should do the following:

- Tell the insured what is required to protect any damaged property and to document the claim. Be specific about what the insured must do and by when it must be done.
- Describe the inspection, appraisal, and investigation the claim representative will be conducting.

- Tell the insured what additional investigation is needed to resolve any potential coverage issues. Give complete and clear instructions if the insured is to provide any additional information.
- Explain potential coverage questions or policy limitations or exclusions and obtain a nonwaiver agreement, when necessary (to be described in a subsequent section).
- Obtain the authorizations necessary to get medical and wage loss information, if such information is part of the claim.
- Describe the time involved to process and conclude the claim.
- Supply the insured with a blank proof of loss form for property damage and any necessary written instructions, so the insured can document the claim.

APPLY YOUR LEARNING

Adjusting Tip

When speaking with the insured, discuss all potential coverage issues, not just the ones most likely to apply. If the insured or claimant can overcome the first potential coverage issue and then is told of another that may apply, it can appear that the claim representative is trying to avoid paying the claim.

In some cases, the claim representative may conduct a recorded interview with the insured during the initial meeting or discussion.

Claim representatives must be aware of the legal implications of their words and actions when communicating with insureds. They must be careful not to mislead the insured or the claimant about the potential coverage for the claim or the amount of the claim payment. To avoid such pitfalls, claim representatives must understand three legal concepts: good faith, waiver, and estoppel.

Good Faith

Insurance policies are contracts of utmost good faith. When conducting a good-faith investigation, a claim representative must attempt to correctly and promptly resolve coverage issues. Many situations that present coverage issues require further investigation to determine whether the claim should be paid or denied. Until the coverage issues are resolved, the claim representative and insurer must avoid any conduct that would lead insureds or claimants to believe that the claim will be paid. Otherwise, the insurer may waive its right to legitimately deny coverage. While attempting to resolve the coverage issues, claim representatives must focus on the facts and decide if the facts support coverage. Claim representatives must also quantify the loss so that payment is not delayed if coverage is confirmed.

Waiver and Estoppel

Waiver
The intentional or voluntary relinquishment of a known right.

Waiver is the voluntary or intentional relinquishment of a known contractual right, such as one contained in a policy condition or exclusion. For example, a claim representative can waive a right contained in a policy condition or

exclusion by telling an insured that a loss is covered before confirming that by checking the policy. The claim representative has waived the insurer's right to deny the claim if the facts later prove that there is no coverage.

Estoppel is a legal bar to asserting certain contractual conditions because of a party's previous actions or words to the contrary. Estoppel results when one party's action causes another party to rely on that behavior or those words with detrimental results. For example, a claim representative who tells an insured that damaged goods can be discarded before they are inspected cannot later deny the claim on the grounds that the damaged goods were not available for inspection. The claim representative is estopped from denying the claim on that basis.

Estoppel
A legal bar to asserting a certain contractual condition because of that party's previous actions or words to the contrary.

Example of Case Involving Both Waiver and Estoppel

An insured calls the claim service center of Atwell Insurance and reports that a large tree fell into her yard during a windstorm. The customer service representative who answers the call tells the insured to have a contractor remove the debris and send the bill to the insurer.

Two weeks later, the insurer receives a bill from the contractor for $1,200. The customer service representative is authorized to settle claims only up to $500, so she takes the bill to her supervisor. Her supervisor indicates that the policy does not cover this type of loss unless the tree damages the insured's house, fence, or other covered structure. The supervisor further explains that when a falling tree damages property, a $500 limit on debris removal applies.

The insured's policy does not cover this loss. However, the customer service representative waived this coverage defense by telling the insured to arrange for the debris removal and to send the bill to the insurer without first explaining the coverage under the policy. Because the insured relied on what the customer service representative told her and incurred expenses, Atwell Insurance may be estopped from denying coverage. Even though coverage does not apply to the original loss, Atwell may have to pay the $1,200 bill. The insurer's failure to notify the insured at the beginning of the claim process that coverage did not apply estopped it from later denying coverage.

Claim representatives use two common methods to avoid waiver and estoppel: nonwaiver agreements and reservation of rights letters.

Nonwaiver agreements and reservation of rights letters serve the following general purposes:

- To advise the insured that any action taken by the insurer in investigating the cause of loss or in ascertaining the amount of loss is not intended to waive or invalidate any policy conditions.
- To clarify that the agreement's or the letter's intent is to permit a claim investigation and that neither the insured nor the insurer will thereby waive any respective rights or obligations.

APPLY YOUR LEARNING

Adjusting Tip

Claim representatives have a reasonable amount of time, usually specified in state unfair claim practices acts, in which to conduct an investigation and advise the insured of a coverage decision without waiving any of the insurer's rights. Thus, claim representatives should not obtain nonwaiver agreements and reservation of rights letters on every claim because most claims will not require them. If in doubt, claim representatives should proceed cautiously and obtain guidance from supervisors or managers.

Nonwaiver agreement
A signed agreement indicating that during the course of investigation, neither the insurer nor the insured waives rights under the policy.

A **nonwaiver agreement** states that, while the insurer is investigating the claim, neither the insurer nor the insured waives any rights under the policy. This agreement, which must be signed by both parties, protects the insurer from estoppel by reserving the right to deny coverage based on information developed during the investigation. It also alerts the insured to a potential coverage problem. The nonwaiver agreement is usually used when the claim representative is concerned about investigating a claim before the insured has substantially complied with the policy conditions or when there appears to be a specific coverage problem or defense. Such concerns can be identified from the initial claim report, during initial contact with the insured, or at any point during the claim investigation. For example, a claim representative may offer a nonwaiver agreement when the insured reports the theft of an auto but refuses to make a police report about the theft. If the insured refuses to sign the nonwaiver agreement, the claim representative can use a reservation of rights letter to protect the insurer's rights.

Reservation of rights letter
An insurer's letter that specifies coverage issues and informs the insured that the insurer is handling a claim with the understanding that the insurer may later deny coverage should the facts warrant it.

Like a nonwaiver agreement, a **reservation of rights letter** is a letter signed and issued by an insurer and sent to the insured to indicate that the insurer is handling a claim with the understanding that the insurer may later deny coverage should the facts warrant it. It serves the same purpose as a nonwaiver agreement but is in letter form, and it is a unilateral document: it does not require the insured to sign or agree to the contents of the letter. It simply advises the insured of the potential coverage issue. Nevertheless, a reservation of rights letter can be as effective in protecting the insurer's rights to policy defenses as a nonwaiver agreement if the insurer has drafted the letter carefully and can show that the insured received it. Nonwaiver agreements and reservation of rights letters are usually sent by certified mail, return receipt requested, so the insurer has evidence that the insured received it.

Nonwaiver agreements and reservation of rights letters can be used only with the insured and can be used on any type of first-party claim. They are not sent to third-party claimants because third parties have no obligations under the policy.

The claim representative must take steps to ensure that the insured understands why an investigation is necessary to determine coverage and how the reservation of rights letter or nonwaiver agreement will facilitate the investigation. The strength of a reservation of rights letter or a nonwaiver agreement in protecting the insurer's policy defenses in court depends on the circumstances. For example, evidence that an insured received a reservation of rights letter and

understood it may outweigh the insured's argument that the letter is invalid. On the other hand, an insured may sign a nonwaiver agreement but may not understand its meaning; in this case, the nonwaiver agreement would be less likely to be upheld in court.

APPLY YOUR LEARNING

Adjusting Tip

The language in a nonwaiver agreement or a reservation of rights letter is often mandated by case law. The claim representative should consult with counsel to obtain the language for a specific state.

Investigating and Documenting the Claim

Another activity in the claim handling process is investigating and documenting the claim. Investigation and documentation are ongoing throughout the life of the claim. The investigation can take many different forms, and all aspects of it must be documented to create a complete claim file. This section provides an overview of investigations. The next chapter describes investigations in more detail, including how they are used to determine the cause of loss and the loss amount.

Claim representatives begin investigating a claim as soon as it is assigned. They can develop an outline or notes to logically organize the investigation and to ensure that information that may be available only for a short time is investigated first, such as any accident scene or damaged property that may be destroyed or discarded. Claim representatives should contact any third-party claimant early in the investigation. This contact can help establish rapport with claimants, and in turn facilitate the investigation and lead to a timely settlement.

Claim representatives must also know when they have sufficient information on which to base a decision. Investigations should be geared to obtain information that will help determine the cause of loss, the amount of loss, and liability. The insurer's claim handling guidelines help claim representatives determine the types and extent of investigation needed for a satisfactory claim settlement. Once sufficient information is obtained to make a reasoned determination, the claim representative does not need to continue the investigation, unless the determination is disputed.

This section provides a basic outline for the claim representative to follow to investigate any type of claim. Claim representatives must use good-faith claim handling practices and insurer guidelines to ensure a thorough investigation. Several types of investigations, including the following, are common to many types of claims:

- Claimant investigation
- Insured/witness investigation
- Accident scene investigation

- Property damage investigation
- Medical investigation
- Prior claim investigation
- Subrogation investigation and recovery

The following sections describe these common claim investigations and explains when and why they are important.

Claimant Investigation

In a first-party property claim, the claimant is the insured. In an automobile or liability claim, the claimant may be a third party who was injured in the accident or a third party whose property was damaged. In a workers' compensation claim, the claimant is the injured worker. Claim representatives conduct a claimant investigation, usually by taking the claimant's statement, to learn the claimant's version of the incident that led to the claim. This information can help the claim representative determine the value of the injury or damage, how it was caused, and who is responsible.

Insured/Witness Investigation

Claim representatives often take statements (either written or recorded) from the insured and witnesses because they can provide valuable information about the circumstances surrounding the loss. The insured is always the party named as the insured in the policy. Witnesses are any persons who have personal, first-hand knowledge of the incident that resulted in the claim. The witness investigation can support or refute an insured's version of an incident, affecting the liability determination. A statement can also serve as a means of attacking the witness's credibility if later testimony differs from the information given in the original statement.

Accident Scene Investigation

The accident scene offers crucial clues in automobile, third-party liability, and workers' compensation claims. By observing details such as tire tracks, curves in the roadway, and objects or conditions that may interfere with a driver's view or that may cause an accident (such as a pothole in the road), the claim representative can determine whether accounts of the accident are plausible or questionable. Claim representatives also consult weather or traffic reports in certain accident scene investigations to identify external factors that may have contributed to the loss.

Property Damage Investigation

An investigation of the scene at which property was damaged can be useful in automobile and property coverage claims to confirm the cause of loss and extent of damage. For business income claims, a property damage investigation is useful for determining lost profits or loss of business use resulting from covered property damage. The investigation can also help confirm the need to

move operations to an alternate site or to temporarily replace damaged equipment with rented equipment so that business operations can continue while repairs are being made.

Medical Investigation

Claim representatives conduct medical investigations in all bodily injury claims, including worker's compensation claims. A medical investigation helps the claim representative determine the costs of the medical treatment, the expected duration of medical treatment and disability, the need for rehabilitation, and the suitability of medical care for the type of injuries the claimant suffered. This information is also used to evaluate the amount of pain and suffering that resulted from the accident or injury.

Prior Claim Investigation

Claim representatives conduct prior claim investigations on all claims to avoid paying for property damage or bodily injury that has been paid through prior claims by the same insurer or by other insurers. For example, a prior claim investigation may reveal that the claimant has a history of lower back injuries or that the insured's vehicle had sustained similar damage from a prior accident. By conducting a prior claim investigation, the claim representative ensures that the insurer pays only new claims for which the insurer has legal responsibility.

The prior claim investigation is usually performed by comparing the facts of the current claim to an industry database containing information from many different insurers. Insurers subscribe to these databases and also furnish them with claim information. The databases provide a quick way to check for similar prior claims. If the check returns a likely match, the claim representative should investigate the prior claim history in more detail to determine if the current claim is for the same injury or damage. If this is the case, the claim representative may have a basis for denying the claim or may adjust the investigation.

Subrogation Investigation and Recovery

During the course of an investigation, the claim representative may discover that the insured was not at fault 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 amount from the negligent third party through the right of **subrogation**. Subrogation rights are established by insurance policies and by law. When claim representatives investigate any loss, they must be alert to any subrogation possibilities; that is, they should be looking for ways to recover any money paid out on the claim. Claim representatives investigate subrogation possibilities concurrently with other investigations. The following examples describe losses for which a claim representative should investigate subrogation possibilities:

Subrogation
An insurer's right to recover payment from a negligent third party who caused a property or liability loss that the insurer has paid to or on behalf of an insured.

- Losses caused by the negligent operation of an automobile or a piece of construction equipment
- Fire, explosion, or water losses caused by the negligence of tenants

- Fire, explosion, or water losses caused by construction workers at a building site
- After work is completed, losses that result from poor workmanship of contractors
- Losses caused by defectively manufactured or poorly designed products

The subrogation clauses in most insurance policies require the insured to cooperate with the insurer by assigning the rights of subrogation to the insurer through a subrogation agreement. The subrogation agreement could be included in another form, such as a proof of loss form, that the insured completes for a property damage claim. Most subrogation agreements require the insured to give testimony and appear in court, when necessary, so that the insurer can establish the legal basis to recover from the negligent third party.

An insured may breach the subrogation agreement by impairing or interfering with the insurer's right of subrogation, by failing to cooperate in preserving evidence, by giving or failing to give testimony, or by releasing the responsible party from any liability after the loss. If an insured breaches the subrogation agreement, the insurer has the right to collect from the insured the amount that could have been recovered from the responsible third party.

When subrogating, the insurer has the right to recover only the amount that it has paid on the claim. The insurer has no right of recovery for losses that the insured has absorbed because of lack of coverage, exclusions, or coverage limitations under the policy. Therefore, both the insurer and the insured may have rights to recover from the responsible third party. When the insured has absorbed only the deductible amount, however, the insurer usually pursues recovery of that amount as well, as a courtesy to the insured.

Claim representatives must consider the costs required to pursue subrogation as well as the likelihood of success, and must be alert for any contract that may deny the right of subrogation (such as a lease agreement). Subrogation can be costly to pursue if litigation is required, and the insurer may in some cases decide that pursuing subrogation is not cost-effective. However, the insurer's decision does not affect the insured's right to pursue payment from the responsible party for the unpaid portions of the claim.

When the subrogation action is against a negligent third party who is responsible for a loss, the insurer can present a subrogation claim for payment to the third party's liability insurer. Usually, the liability insurer pays the entire loss or offers a compromise settlement on the claim, depending on the assessment of liability. When the two insurers cannot agree on the liability, they can agree to arbitrate the dispute, often through intercompany arbitration.

Intercompany arbitration is conducted by having one or more arbitrators review written submissions from both parties. The insurer submits the claim representative's claim file, usually with highlighted details or tabs on specific documents for the arbitrator's benefit. The file should be legible and in chronological order. An arbitration statement that outlines the

insurer's position in the case should accompany the file. The decision of the arbitrator(s) is final and binding on both insurers.

File Review

Because they simultaneously handle many claims, claim representatives must have a system for working on and reviewing each claim. While the term for this system can vary (some call it a diary system, a suspense system, or a pending system), the purpose is the same. The system allows the claim representative to work on a claim one day and then diary it or calendar it for review. For example, the claim representative may send a letter to the insured requesting a repair estimate and diary that file for review on a date two weeks in the future. During that time the claim representative would expect to receive the requested estimate. If the estimate has not been received, the review prompts the claim representative to follow up.

Diary systems are usually maintained by the insurer's claim processing system, which may automatically set diary dates for the file based on the type of claim. Most systems allow claim representatives to override system-generated diary dates and set a review date manually. Claim representatives who set dates manually must ensure that their handling of the file meets the requirements of any applicable unfair claims practices acts. For example, a state law may require that the insured receive a status letter on the claim every thirty days. The automated system would set the diary dates to meet this requirement, but claim representatives should not reset dates that cause them to miss this or any other requirements.

File Documentation

In addition to reviewing claim files, claim representatives must document the files using both file status notes and reports.

File status notes (or an activity log) must accurately reflect and document investigations, evaluations of claims, decisions to decline coverage, or decisions to settle the claims. Because lawyers and state regulators can obtain copies of claim files, the file status notes and other file documentation must reflect the following:

- Clear, concise, and accurate information
- Timely claim handling
- A fair and balanced investigation considering the insured's and the insurer's interests
- Objective comments about the insurer, insured, or other parties associated with the claim
- A thorough good-faith investigation

Clear, concise, and accurate file status notes are essential because a claim file must speak for itself. The file status notes should be a chronological account of the claim representative's activities and can also include the claim supervisor's

and the claim manager's activities relating to the claim. Ideally, an entry should exist for anyone who works on the file. Additionally, the file status notes should contain short summaries of reports and information received from outside sources. File status notes should be objective; they should not leave the reader with the impression that the claim representative is taking sides, such as in this statement: "The claimant obviously wasn't paying attention." File notes should not express prejudice of any sort, avoiding any remarks about race, religion, weight, or sex. Humor is also out of place in file notes. A note that seems innocuous when written can be devastating when read to a jury.

The box contains an example of some status note entries.

Example: Status Note Entries

4/5/06 Received new assignment. Called insured at work and spoke to Mr. Smith. Took a recorded statement from Mr. Smith about the accident. He indicates that his car was struck from behind while stopped at a stop sign. No injuries reported. Assigned appraiser to inspect the vehicle, which is currently located at Sam's Auto Body, 123 Main Street, Anytown, Any State. Phone number is 555-1234. Requested police report.

4/6/06 Called adverse driver, Mr. Jones, and took his statement. He indicates he was traveling east on Main when he was blinded by the sun and struck Mr. Smith's car, which was stopped at the intersection.

4/10/06 Received and reviewed police report. Report states that vehicle 1 (Mr. Smith's) was stopped at a stop sign eastbound on Main at the intersection of Broad, when struck in the rear by vehicle 2 driven by Mr. Jones. Report confirms statement of the insured. Awaiting estimate from appraiser.

4/15/06 Received repair estimate from appraiser. The body shop agrees with the estimate. The amount of the damages is $5,250. Called Mr. Smith and advised him of the amount and that it was an agreed price with the body shop. Reached agreement with Mr. Smith and processed a payment for $5,000, which is the repair estimate, less the $250 deductible. Confirmed no lienholder or other payee to be on the payment. Referred file to subrogation unit.

From these entries anyone reading this file can see that the claim representative received this claim on April 5, 2006, and began working on it that day. The file status notes indicate what activities the claim representative performed to investigate this claim and how long it took to settle the claim. These entries meet all the criteria for file status notes outlined earlier.

This example is simple and straightforward. Many claims are not. Some file status notes can be lengthy because they continue for as long as the claim remains open, which can be years in some cases. They can also be very detailed, outlining why reserves are set at a particular dollar amount or how settlement figures are determined. File status notes should not be cryptic or written in personal shorthand because the claim representative who writes them may not be available to interpret them later. Claim representatives should determine from their company guidelines if there are abbreviations for terms that are acceptable, such as "PR" for police report or "s/s" for stop sign.

File Reports

In addition to file status notes, claim representatives document claim activity using reports to various parties. One type of report is an internal report. Claim representatives prepare and distribute internal reports to parties within the insurance organization who have an interest in large losses or loss of a specific nature such as death, disfigurement, or dismemberment. Most insurers have guidelines outlining when and under what circumstances internal reports, such as file status reports and large loss reports, should be prepared. For example, large loss reports may be required for claims with reserves that exceed $500,000. These large loss reports summarize all the file status information for management and are updated as additional information is received or on a timetable set by the insurer.

In addition to the large loss report, claim representatives write three other internal reports while a claim is open: preliminary, status (or interim), and summarized (or captioned). These reports may have attachments, such as estimates, police reports, diagrams, photos, statements, and correspondence. If the claim is handled by in-house claim representatives, these attachments may already be included as images in the electronic claim file or included in the paper claim file. Often these reports are typed directly into a claim entry system (the electronic claim file) using an electronic form; distributed electronically to claim supervisors, managers, or underwriters; and then printed for any necessary outside distribution (such as lawyers).

An insurer may require preliminary reports within the first twenty-four hours, within seven days of the claim assignment, or only if the file remains open after thirty days. Preliminary reports acknowledge that the claim representative received the assignment, inform the insurer about initial activity on the claim, suggest reserves, note coverage issues, and request assistance, if needed. For small, uncomplicated claims that claim representatives settle quickly, the preliminary report may be the only report in the claim file.

Status reports tell the insurer how the claim is progressing on a periodic basis, generally every fifteen to thirty days. In these reports, claim representatives record the progress of the claim, recommend reserve changes, and request assistance and settlement authority when the amount payable exceeds their authority. Status reports are one way to confirm that the claim representative is working on a claim and progressing in a timely manner.

Summarized reports are often detailed narratives that follow an established format with captioned headings that give them structure. Claim representatives usually file a summarized report within thirty days of the assignment date. Insurers may require summarized reports for specific claims that require review by managers at regional or home offices. For example, suspected arson and insurance fraud claims are typically reported to the regional and home offices because of their potential for litigation. Managers may also review a file when the reserve exceeds a specified amount. Some insurers require summarized reports on certain types of claims because they want to track trends in certain types of business. Exhibit 2-5 is an example of a summarized report form.

EXHIBIT 2-5

Summarized Report Form

Claim #

Insured: Date of report:

Policy no: Adjustment firm:

Date of loss: Claim representative:

Producer:

1. Assignment Date

   Give date notice of loss received and how. Give date insured first contacted and how (phone or personal).

2. Enclosures

   List items attached (such as photos, estimates, fire/police reports).

3. Activity Requested

   List special requests (such as expense payments and coverage questions).

4. Suggested Reserves

   Suggested reserves should be shown net, by coverage, after any advances.

   List scheduled items separately, as in the following example:

Collision	$22,000
Medical Payments	$10,000

5. Abstract of Coverage

   Give forms applicable and amounts; identify deductible amount(s); identify other contributing insurance, if any; identify any limiting clauses.

6. Ownership/Encumbrances

   List title holder, mortgagee, loss payees, additional named insureds, and liens. Indicate source of information. Also include opinion as to current solvency, cash flow, receipts.

7. Location and Cause of Loss

   Give date, time, and place of loss. Relay cause as determined by authorities. If an outside expert has been employed, identify and give his or her findings. State claim representative's opinion.

8. Insured/Employee Version of Loss

   Give insured version—indicate if statement was secured. Indicate manager, guards, or service personnel on premises at time of loss.

9. Witness Version of Loss

   Give witness version—indicate if statement(s) secured. Indicate persons present at time of loss.

10. Scope of Loss/Estimates of Damage

    Describe property insured. Detail extent of damage. Cover any problems that may be encountered in reaching a settlement. List estimates received. Indicate whether an agreement regarding scope and procedures has been reached with the insured.

11. Salvage/Subrogation

    Identify salvage and give an estimate of worth. Provide and explain theory of subrogation and what steps have been taken to protect the right of subrogation.

12. Work Done to Date

    Itemize work done to date.

13. Work to Be Done/Forecast of Closing

    Itemize work to be done. Give forecast of closing date. Estimate hours needed for completion of each activity.

14. Risk

    Give your overall impression of the insured risk.

15. Remarks

    Give comments on assistance of insured or employee in completing investigation. Identify attorney or public adjuster if involved.

DATE OF NEXT REPORT

Insurers also document claim activity using external reports containing information collected by claim representatives. External claim reports inform interested parties about the claim and inform the public of the insurer's financial standing. These reports are prepared for producers, some states' advisory organizations, and others having an interest in the claim. Because insurers often write business through producers, losses are reported to the producer who sold the insurance. These reports provide details about the losses, such as the amount paid and the amount in outstanding reserve.

Determining the Cause of Loss and the Loss Amount

Claim representatives use the information gained during their investigation to determine the cause of loss, liability, and the 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 toaster caused the fire. The claim representative also determines the liability for the loss based on the facts of the case. For example, in an auto accident, the claim representative applies statutory and case law on negligence to determine liability of the parties involved.

Concurrent to the determination of the cause of the loss and the liability for the loss, the claim representative may determine the amount of the loss. For a property claim, the claim representative investigates the amount of damage to the property and the cost to repair or replace it and may also investigate the amount of business income lost. To determine a loss amount in a bodily injury claim, the claim representative investigates the extent of the injury, the residual and lasting effects of the injury, and the amount of pain and suffering the individual has endured.

The activities required to investigate and determine the cause of loss, liability, and damages depend on the type of claim. The next chapter provides detailed descriptions of the investigations required to make these determinations in a property damage claim, a bodily injury claim, and a workers' compensation claim.

Having determined the cause of loss, liability, and loss amount, the claim representative can apply the policy coverages to the loss. Claim representatives can use the framework for coverage analysis, discussed earlier in this chapter, to assist them in this application.

Concluding the Claim

Generally, the last activity in the claim handling process is concluding the claim. Once the investigation is completed and all documentation is received, the claim representative must decide whether to pay the claim or deny it. 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 methods may be used to resolve a disagreement and, ultimately, the claim.

When an agreement on the settlement amount is reached, the claim representative secures the necessary final documents so that payment can be made. If the claim is denied, the insured or claimant may accept the denial or may choose to file a lawsuit to challenge the denial. Litigation may also be started if no agreement on the claim can be reached.

Payments

When a covered claim is concluded through negotiation or other means, the claim representative or claim personnel must issue a claim payment. Claim payments can be made by check, draft, or electronic transfer of funds.

A check creates a demand for payment on the insurer's bank account and can be presented for payment without further insurer authorization. A draft is similar to a check; however, when the claimant presents the draft to the insurer's bank (often through the claimant's bank transaction), the bank must verify that the insurer has authorized payment before disbursing any funds. Because of this required authorization, a claimant cannot present a draft at a bank for immediate payment. This delay in disbursing funds allows the insurer to confirm that the payment is proper. Funds can also be electronically transferred into an account of the insured's choosing.

When issuing claim payments, claim personnel must ensure that the proper parties are being paid. Many other parties, such as mortgagees on homes and loss payees on autos and personal property, can have a financial interest in the property. Parties named in the policy have rights, described in the policy, to be included as a payee under certain circumstances, such as for property

that has been destroyed. For third-party liability claim payments, the claim representative must determine whether an attorney or a lienholder, such as a medical service provider, should be named as an additional payee on the payment. The claim representative is responsible for including all required payees when issuing a claim payment.

Claim representatives must also check various databases to ensure that the claim payment complies with federal and state laws. The Office of Foreign Asset Control, U.S. Department of the Treasury, requires all claim payors (insurers, self-insureds, and third-party administrators [TPAs]) to check the master list of potential terrorists and drug traffickers before making a claim payment. Claim payors may be prohibited from paying a claim to an individual or entity appearing on this list. Many insurers and TPAs have contracted with third parties to provide an automated means of performing this check. Failure to comply with this requirement can result in substantial penalties to the payor.

Insurers and other claim payors must also be aware of state child support enforcement initiatives that can affect claim payments. Many states have statutes that require a claim representative to check a database to determine if a claimant or beneficiary owes unpaid child support. If child support is owed, the claim representative must follow specific procedures when issuing the payment because the unpaid child support has priority. The claim payment goes toward reducing the amount of the child support in arrears rather than to the injured party. For example, Massachusetts law requires that an insurer licensed to do business in Massachusetts check the database before making payment on a claim of $500 or more. Failure to comply can result in financial consequences to the insurer. Many insurers and claim payors have created ways to automate the process.

Claim representatives handling workers' compensation claims and third-party bodily injury claims must be aware of the Medicare Secondary Payer Program and how this program can affect claim payments. The Center for Medicare and Medicaid Services (CMS) must approve a proposed settlement in specific situations. The settlement must be approved for claimants who are Medicare beneficiaries or who have reasonable expectations of Medicare enrollment within thirty months of settlement and when the settlement is $250,000 or more. Failure to gain CMS approval can expose the insurer to a bad-faith suit because Medicare goes directly to the claimant for reimbursement. Insurers are integrating this approval process into their claim practices to ensure compliance.

Claim representatives must ensure that all of these checks have been completed before issuing payment. If they are not, the insurer can be subject to fines, penalties, and possibly additional payments to satisfy these parties.

Claim Denial

A claim may conclude instead with denial. When claim investigations reveal that a policy does not provide coverage for a loss or when an insured fails to

meet a policy condition, the claim representative must make a timely claim denial. Insurers often have strict guidelines that claim representatives must follow when denying claims, and some insurers require a claim manager's approval to issue a claim denial.

Before denying a claim, the claim representative must analyze the coverage carefully, investigate the loss thoroughly, and evaluate the claim fairly and objectively. Courts often favor insureds when a claim denial fails to meet these requirements, and the insurer can be assessed penalties in addition to the loss amount.

Once claim management gives authority to deny a claim, the claim representative must prepare a denial letter as soon as possible. Some denial letters are drafted by lawyers to ensure that they comply with the jurisdiction's legal requirements. For example, a denial letter must usually state all the known reasons for the claim denial. Specific policy language should be quoted, and the location of the language in the policy should be cited. The policy provisions should be described in relation to the facts of the loss. Also, an insured who disagrees with the denial should be invited to submit additional information that would give the insurer cause to reevaluate the claim. The denial letter should be signed and sent by the claim representative, even if it is drafted by a lawyer.

Insurers usually send denial letters by certified mail with a return receipt requested to be signed by the addressee. Some insurers also send a copy of the letter by regular mail, marked "personal and confidential," in case the certified mail is not claimed. These procedures help ensure that the denial letter reaches the correct party, and they provide documentation that it was received.

Alternative Dispute Resolution

If an insurer and an insured or a claimant cannot agree on the claim value or claim coverage, they may resolve the disagreement in court. However, court costs and delays in the court system have encouraged insurers, insureds, and claimants to seek alternative ways of resolving their disputes about claims that are less expensive and time consuming than litigation. Such processes also help relieve the courts of the burden of handling such disputes. **Alternative dispute resolution (ADR)** refers to methods for settling disputes outside the traditional court system. The most common ADR techniques are mediation, arbitration, appraisals, mini-trials, summary jury trials, and pretrial settlement conferences.

Alternative dispute resolution (ADR)
Methods for settling disputes outside the traditional court system.

Mediation is an ADR method by which disputing parties use a neutral outside party to examine the issues and develop a mutually agreeable settlement. The mediator, often a retired judge or an expert in the field under dispute, manages the process. The mediator may be appointed by the court or selected by the parties. Each party presents its case to the mediator, who leads the parties through in-depth settlement discussions. The mediator points out the weaknesses in each argument or in the evidence presented,

Mediation
An alternative dispute resolution method by which disputing parties use a neutral outside party to examine the issues and develop a mutually agreeable settlement.

proposes solutions, and helps the participants reach a mutually agreeable settlement. If mediation does not resolve the dispute, the parties may consider another ADR method or litigation.

Arbitration is an ADR method by which the disputing parties use a neutral outside party to examine the issues and develop a settlement, which can be final and binding. The arbitrator acts as a judge, weighing the facts of the case and making a decision based on the evidence presented. The advantage of arbitration is that someone other than the insurer and the claimant decides the case.

Arbitration
An alternative dispute resolution method by which the disputing parties use a neutral outside party to examine the issues and develop a settlement, which can be final and binding.

The type of arbitration determines whether the decision is binding on the parties. Under binding arbitration, which some states' laws require for arbitrated claim disputes, the parties must accept the arbitrator's decision. Under nonbinding arbitration, neither party is forced to accept the arbitrator's decision. However, the decision provides the "winner" with leverage for future negotiations. This method of alternative dispute resolution is cost-effective for all parties and relieves the courts of the burden of handling such disputes.

When two policies issued by different insurers cover the same loss, arbitration can be used to settle a dispute about which insurer should pay the claim and how much should be paid. Generally, one insurer settles with the insured. The case is then submitted to an arbitration service to determine what each insurer owes. Insurers may use an organization such as Insurance Arbitration Forums, Inc., or the American Arbitration Association. Insurer trade associations also offer arbitration services and other forms of ADR to member companies.

Property insurance policies include a provision that requires a form of ADR before litigation. This provision, called the **appraisal provision**, is used to settle disputes between insurers and their insureds over the amount owed on a covered loss. It is not used to settle coverage disputes, only the amount of damages. Almost all property insurance policies contain an appraisal provision. For example, the HO-3 provides that the insurer or the insured can demand an appraisal if they disagree on the loss amount. Each party chooses an appraiser, and the two appraisers choose a third appraiser to act as an umpire. Each party pays its own appraiser, and the two parties share the cost of the umpire. The appraisers can hear evidence that is typically excluded from trial. The two appraisers estimate the property damage separately. If their estimates match, the insurer pays the insured that amount. If the estimates are different, the umpire offers a binding decision on the loss amount.

Appraisal provision
A policy condition that provides appraisal as a mechanism for resolving disputes between insurers and insureds over the amount owed on a covered loss.

Mini-trials are another form of ADR. At a **mini-trial**, an abbreviated version of a trial, representatives (usually lawyers) of the disputing parties present the evidence to a panel or an adviser who poses questions and offers opinions on the outcome of a trial, based on the evidence presented. A mini-trial enables parties to test the validity of their positions and continue negotiations. Parties can terminate the process at any time. The parties agree not to disclose in future litigation anything that occurs during the mini-trial, in order to preserve their rights in litigation if the negotiation fails.

Mini-trial
An alternative dispute resolution method by which a case undergoes an abbreviated version of a trial before a panel or an adviser who poses questions and offers opinions on the outcome of a trial, based on the evidence presented.

The parties select an impartial adviser, often a retired judge, an executive, or an expert, and decide the role of the adviser, whether that of passive participant, arbitrator, or judge. The adviser has no authority to make a binding decision; however, he or she can pose questions that test the validity of each side's case and offer an opinion based on the evidence.

Before the mini-trial, parties can exchange information about their anticipated testimony and the documents that they plan to introduce as evidence. Such information may also be given to the adviser. Witnesses and experts may testify during the mini-trial. Lawyers are allotted a limited time to present their cases. The main advantage of mini-trials is that claimants and insurers can learn the likely outcome of their cases without having to contend with delays in the legal system.

Summary jury trial
An alternative dispute resolution method by which disputing parties participate in an abbreviated trial, presenting the evidence of a few witnesses to a panel of mock jurors who decide the case.

A **summary jury trial** is an ADR method by which disputing parties participate in an abbreviated trial, presenting the evidence of a few witnesses to a panel of mock jurors who decide the case. These trials offer a forum for deciding the merits of cases for court proceedings, and they may assist in negotiations. A summary jury trial is staged much like a regular jury trial, except that only a few witnesses are used to present the case. Mock jurors are pulled from a pool of persons selected to serve as possible jurors in an actual court case. Evidence and witnesses' testimony may be presented in both oral and written format for the mock jurors. Lawyers summarize information for the sake of brevity. The mock jurors decide the case based on the limited, though representative, presentation of evidence.

A summary jury trial can be concluded in a relatively short time, so legal costs are significantly reduced. Fewer witnesses mean less expense for witness fees. Although lawyers are required, the time required to develop the case and prepare for trial is considerably less. Summary jury trials can produce an effective settlement and control legal expenses.

Litigation

Even with the variety of ADR methods available, many cases are concluded through litigation. Litigation can occur at almost any point during the life of a claim. It occurs most often when the parties to the claim are unable to reach an agreement by negotiation or ADR, or when a claim is denied. ADR reduces, but does not eliminate, the chance that a claimant will sue and take a case to trial. Accordingly, insurers must be prepared to litigate some claims.

Many insurance policies require insurers to defend their insureds at trial. The HO-3, for example, states that the insurer must "provide a defense at our expense by counsel of our choice, even if the suit is groundless, false, or fraudulent." The duty to defend generally terminates when the amount the insurer has paid in settlements or judgments on the claim equals the insurer's limit of liability.

When litigation cannot be avoided, claim representatives participate in developing a litigation strategy for the insured's defense and for litigation

expense control. Claim representatives must carefully select and direct defense lawyers. The lawyer's role is to be the insured's advocate; he or she must address every aspect of the claimant's case, from liability to damages, in order to mitigate the claim against the insured and to encourage the claimant to settle out of court. Litigation and the claim representative's role in litigation are described in detail in a later chapter.

Closing Reports

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 suggestions. In some instances, these reports are used by subrogation claim representatives to evaluate the likelihood of a successful subrogation action. Claim supervisors and managers may use the reports to audit the claim representative's performance. These reports can also be submitted to reinsurers for reimbursement of loss payment. Claim representatives should be aware of claims that should be referred to reinsurers and must complete reports on those claims based on the insurer's internal guidelines and reinsurance agreements.

APPLYING THE FRAMEWORK FOR COVERAGE ANALYSIS AND THE CLAIM HANDLING PROCESS

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 fill in the details. The following case study is provided as an example of how this can be done.

Case Study

Susan and Thomas Reed live at 104 Fremont Street, Malvern, Texas. They have two children: Ann, age 16, who resides at home, and John, age 19, who resides at home when not attending Columbus College in New Mexico. Susan's mother, Marie, also lives with them. Susan is a schoolteacher. Thomas is the owner of a small company, Universal Widgets.

Susan and Thomas own their home and three cars. They have a mortgage on their home, held by ABC Loan Company. They also have a car loan, from Union Trust Company, on their 2006 Lexus. Their other two cars, a 2003 Toyota Camry and a 2003 Honda Civic, do not have lienholders.

Susan and Thomas have an HO-3 (2002) policy covering their home. They have a Personal Auto Policy (PAP) covering all three cars.

On April 12, 2006, Susan and Thomas receive a call from John's roommate informing them that John has been in an auto accident while driving the Honda Civic. John suffered minor injuries after running a stop sign and hitting another car. The driver of the other car, Karen Jones, has been hospitalized. After talking to John, Thomas calls his insurance agent and reports the claim. The agent reports the claim to the insurer, and claim representative Jim Smith is assigned to handle all aspects of the claim.

Continued on next page.

Upon receiving the claim assignment, Jim acknowledges receipt of the claim to the agent and sets up the claim in the claim-processing system. He identifies the Reeds' auto policy and performs an initial review, learning that the 2003 Honda Civic has 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 sets up the following parts of the claim with preliminary reserves:

- Liability claim from Karen Jones—reserve $5,000
- Property damage claim from Karen Jones—reserve $2,500
- Collision coverage for the 2003 Honda—reserve $2,500
- PIP coverage for John's injuries—reserve $1,000

Jim contacts Susan and Thomas Reed. They give him a brief description of the accident, but tell Jim to contact their son John for all of the details. While talking to Susan and Thomas, Jim confirms that they are the registered owners of the car, that the car was registered in Texas, and that John was using the car with their permission.

Jim calls John and takes a recorded statement from him that provides the following facts:

John is enrolled full time in college in New Mexico. He lives in a dormitory on campus. He has had the Honda at school since the beginning of the semester.

The accident occurred at 11:30 a.m. on a Saturday morning. John was on his way to the sandwich shop. He didn't see the stop sign because of the sun's glare. His car struck the car driven by Karen Jones on the driver's side door. John was wearing his seatbelt at the time of the accident. His air bag deployed on impact. He received a ticket for careless driving. He was taken to the emergency room, treated for minor cuts, and released. Karen Jones was also taken to the emergency room. John thinks she had a concussion and a bad cut on her forehead. The Honda is at Sam's Auto Body Shop in Columbus, New Mexico.

After concluding his conversation with John, Jim requests a police report and reviews the PAP to answer some questions he has regarding coverage for this claim.

Jim has already confirmed that the Honda is listed on the Reeds' policy and that it has collision coverage. (*Is the damaged property covered? Is the cause of loss covered?*) He has also confirmed that the accident date falls within the policy period. (*Did the loss occur during the policy period?*)

Jim determines who is covered by the PAP. According to the liability coverage part, "insured" is defined as:

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

According to the definition of insured, John is covered by the policy. (*Is the person involved covered?*) The insuring agreement says the insurer will pay damages for bodily injury or property damage for which any insured becomes legally responsible because of an auto accident. The insuring agreement also says that the policy will pay defense costs in addition to the limit of liability. (*Is the type of loss covered?*)

Part A exclusions are then checked. None of the exclusions appear to apply. (*Do any exclusions apply?*)

The PAP provides out-of-state coverage, which means that the policy will comply with New Mexico financial responsibility laws.

Next, Jim examines the policy period and territory provision of the PAP. The loss occurred during the policy period and within the policy territory of the U.S. (*Is the location where the loss occurred covered?*)

Based on the information obtained from Mr. Reed and John Reed, no other auto policies are applicable to this accident, as all of the Reeds' cars are insured on this policy. (*Does other insurance apply?*) Based on the limited medical information available at this time on Karen Jones, Jim believes that the liability limit on the Reeds' policy is sufficient to cover the bodily injury and property damage sustained by Karen Jones. (*Are the amounts of loss or damages covered?*) However, Jim will have to review this portion of the claim frequently as more information about Ms. Jones and her injuries becomes available. Jim will also have to continue his investigation in order to determine who is liable for the accident.

As part of his analysis of liability coverage, Jim has answered some of the questions to be asked when analyzing coverage for the damage to the Reeds' Honda, such as the date of loss occurring during the policy period, the loss location being covered by the policy, and no other auto policies applying to this loss.

Upon reviewing Part D—Coverage for Damage to Your Auto of the PAP, Jim confirms that the Reeds' Honda has collision coverage. Jim reviews the exclusions to Part D coverage and determines that none of the exclusions apply, based on the facts currently known. Jim assigns an appraiser to assess the amount of damage to the Reeds' Honda and to prepare an estimate to repair the damage. Based on the description of the accident that John gave in his statement, Jim decides that the $2,500 reserve is adequate. He will review the reserve when he receives the appraiser's estimate.

Jim reviews the Personal Injury Protection (PIP) endorsement attached to the Reeds' auto policy. This endorsement provides unlimited medical expenses coverage to covered persons. Jim confirms that the definition of insured applies to a family member. The insuring agreement states that PIP benefits will be paid to an insured who sustains bodily injury caused by an accident and resulting from the use of an auto. The medical expenses must be reasonable and necessary. John had indicated that he suffered a laceration above his eye, which was treated at the emergency room. He had also begun seeing a chiropractor to treat his sore neck and back. John will give his medical bills to Jim for review and reimbursement. Jim also reviews the exclusions in the endorsement and determines that none of them apply. Jim decides to raise the medical reserve to $2,500 to cover the emergency room bill and three months of chiropractic treatment.

SUMMARY

This chapter introduces the primary functions of a claim representative: analyzing insurance policies for coverage and handling claims using the claim handling process.

Claim representatives must be familiar with all the components of an insurance policy because they can each affect the coverage determination. These components include declarations, definitions, insuring agreements, exclusions, conditions, miscellaneous provisions, and endorsements. 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 the following questions:

- 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 where the loss occurred covered?
- Do any exclusions apply?
- Does other insurance apply?

Claim representatives must also be able to apply the information contained in the policy to the activities in the claim handling process. These activities are performed on every claim, to some degree. Upon receiving a claim, the insurer acknowledges it and assigns it to a claim representative. The claim representative identifies coverage; contacts the insured or the insured's representative; investigates and documents the claim; determines the cause of loss, liability, and the loss amount; and concludes the claim.

The claim representative must perform all these activities with utmost good faith. By using good-faith claim handling practices, claim representatives can avoid situations in which they may waive defenses or be estopped from asserting defenses.

Claim representatives spend much of their time investigating and documenting claims. They often take statements from insureds, claimants, and witnesses. They can do scene investigations themselves or hire independent adjusters to complete them. They use the results of their investigation to determine the cause of loss, liability, and loss amount. With this information, the claim can be concluded.

Claim representatives use file review systems and submit status notes and reports to document the claim file. The timely review of the claim and the reserve noted in the file status notes is one means of showing good faith. Internal and external reports communicate the details of the loss and the loss adjustment process to those who need the information.

Many disputed claims are concluded by negotiation. Those that are not may be resolved by alternative dispute resolution (ADR) methods such as mediation, arbitration, appraisal, mini-trial or summary jury trial. In cases in which all else has failed, litigation is used to resolve the claim.

Because a claim representative's determination of cause of loss, liability, and loss amount can differ by the type of claim, these topics are discussed in greater detail in the next chapter.

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