2 – Claims Handling Process

# 1 – Overview of the Claims Handling Process

**Objective**: Evaluate how the claims handling process provides a consistent and effective method for responding to losses

To provide consistent and effective claims handling, claims representatives follow a systematic process.

**Consistency in the claims process helps ensure that claims are handled in a manner conforming to legal and ethical standards**. Although different types of claims may require unique treatment, the same basic activities are performed in every claim, providing a framework for handling all types of property, liability, and workers compensation claims.

**Activities in the Claims Handling Process**

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| **Acknowledging a claim and assigning it to a Claim Representative** | **Identify the Policy** | **Contact the insured or representative** | **Investigate & Document** | **Determine the cause of loss, liability and loss amount** | **Concluding the claim** |

**While these activities appear to be sequential, they are not always undertaken in an exact order. A claims representative may sometimes perform several activities concurrently, or may repeat some activities as new information is uncovered.**

## How a Loss is Reported

A loss can be reported to the insurer in several ways. Usually losses are reported by the insured, but they can also be reported by a third party (such as an insurance agent) or by notice of a lawsuit.

Losses are often reported using a loss notice form, also called a First Notice of Loss, designed for a particular type of loss, such as auto or general liability. These form include basic information about the loss, such as the loss date and time, policy number, insured name and address, covered property loss description, accident location, witness names and addresses, and the names and addresses of any injured persons.

Other methods of reporting losses are by phone or through web-based apps that allow the insured to include photos of damaged property, if applicable. Insurers can use ***blockchain processes that instantaneously refer to multiple sources of verified information.*** This can minimize the number of insurer-insured interactions that are necessary to settle a claim, streamlining the process to save both time and money for the insurer.

**How Blockchain Can Assist in Processing Claims**

*Blockchain can make the claims handling process quicker and more cost efficient through the use of smart contracts. As an example, consider flight insurance that provides coverage for late or canceled flights. The insurance contract, which insures the on-time performance of a flight is recorded on the blockchain. If the flight is late or canceled, data can be verified digitally by a trusted third party, which automatically triggers a claim payment.*

*Even when the entire insurance contract isn’t recorded on the blockchain, smart contracts can help. For example, a smart contract tied to sensors or telematics in a car involved in an accident can provide the first report of loss to the insurer while simultaneously notifying recommended repair shops and alerting the insured of next steps. As with any new technology or process, care must be given that this process is used in compliance with applicable laws*.

Regardless of how a loss is reported, the same basic information is recorded and processed before a claim is settled or denied.

## Claims Handling Process

**If the first notice of loss is a lawsuit, the claims representative must be aware of the deadline for response to the lawsuit, which can vary by state. The claims representative should refer the lawsuit to counsel at the start of the investigation and follow the insurer’s procedures to determine whether to issue a reservation of rights letter**. (ROR - A 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.)

Once a loss notice is received and the information is recorded in the insurer’s claims information system, the claim handling process begins. Although the sequence of and time spent on the activities in the claims handling process may vary from claim to claim, all of the activities must be performed. Even if a loss appears straightforward as reported, an investigation of the loss should still be conducted and documented.

**These are the 6 activities in the claims handling process**:

* **Acknowledging and assigning the claim** – informs the insured the claim has been received, and may also provide the name and contact information of the claim representative and claim #
* **Identifying the policy** – determine whether the loss is covered by the insured’s policy and whether it occurred within the policy effective period. This can highlight aspects of the claim that may require further investigation.
* **Contacting the insured or insured’s representative** – first contact with the insured or the party representing the insured, such as a lawyer or public adjuster, allows the representative to make an introduction and explain the claims process. This can reassure the insured that his or her claim is being handled and treated fairly.
* **Investigating and documenting the claim** – the investigation of a claim should begin as soon as possible to ensure that any information that may be available for only a short time, such as evidence at an accident scene, is gathered and taken into consideration. Investigation should be geared toward obtaining information that will help determine the cause of loss, the amount of loss, and liability. The insurer’s claims handling guidelines can help the representative determine the types and extent of investigation needed for satisfactory claim settlement.
* **Determining the cause of loss, liability, and the loss amount** – After conducting the investigation, the claims representative should use the information gathered to determine the cause of loss, such as a faulty toaster that started a fire; the liability for the loss, such as a store manager who did not assign someone to clean up a spill in an isle; and the amount for the loss. For a property claims, the claims 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 a bodily injury claim, the claims representative investigates the extent of the injury, the residual and lasting effects of the injury, the amount of pain and suffering the individual has endured, and out-of-pocket expenses the claimant has incurred.
* **Concluding the claim** – If the insurer must pay the claim, the claims 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. The insured may file a lawsuit if not agreement on the claim can be reached.

**Failure to handle claims consistently can result in serious consequences. The insurer could become responsible for paying claims that are not actually its responsibility under the terms of the policy and/or applicable law, or coverage that is owed may not be provided, which could result in the loss of an account or a bad-faith claim**.

# 2 – Early Steps of the Claims Handling Process

**Objective**: Illustrate these activities in the claims handling process: Acknowledging and assigning the claim; Identifying the policy; Contacting the insured or the insured’s representative.

The first few steps in the claims handling process set the tone for an insured’s experience with his or her insurer. Initial contacts provide the insurer with important opportunities to make a good impression, which could help retain current customers and earn new business through customer referrals.

After the insurer is notified of a loss, the facts of the claim should be compared with the applicable policy to verify whether the loss may be covered. After the loss has been assigned to a claims representative and the initial reserve has been established the claims representative will contact the insured or the insured’s representative to begin the process of settling the claim.

## Acknowledging and Assigning the Claim

The first activity in the claims handling process is acknowledging receipt of the claim, whether filed online, via a phone call, or through a mobile app, and assigning it to a claims representative. Some insurers acknowledge a claim immediately upon receiving the loss notice, while others acknowledge the claim after it has been assigned to a claims representative. The purpose of the acknowledgement is to advise the insured that the claim has been received, but it may also provide the name and contact information of the assigned claims representative and the claim number.

Most insurers have time requirements for the assignment and acknowledgement of claims. For example, an insurer may require a claim to be assigned within one business day of its report. Some states also have requirements for acknowledgement of certain types of claims, such as workers compensation, and may require copies of claim reports to be filed with the state.

***Record-Only Claims***

*Many claims are record-only claims, which are typically assigned to claims personnel to monitor for any subsequent activity. For example, an employee may trip at work but not experience any injury. The employer may report this to the insurer as a record-only claim, and then, if the employee later begins to experience pain attributable to the incident, the employer, employee, or physician would notify the insurer. A claims representative could then begin the claims handling process*.

## Identifying the Policy

Upon receiving and assignment, a claims representative will identify the policy in force on the date of loss. A basic identification of the policy must take place on all claims before the investigation beings. The representative should determine whether the loss occurred within the policy period, whether coverage exists under the policy for the type of loss reported, and whether the insured followed the policy’s terms and conditions. **For some types of losses, the claims representative may need to immediately give the insured instructions to prevent any further loss, such as to cover a damaged roof with a tarp**.

Review of the policy along with the loss notice may identify areas for investigation, such as whether an injured person qualifies for coverage and whether an exclusion may apply.

Any significant doubt regarding coverage under the policy may require a reservation of rights letter and/or immediate referral to coverage counsel. A reservation of rights letter may be sent to the insured with acknowledgement of receipt of the claim.

***Apply your knowledge***:

You are a claim representative for an insurer. You receive a claim assignment after a tornado, and the claim reports that a tree fell onto an insured’s roof. When you make contact with the insured after receiving the claim assignment, what instructions will you likely give to the insured?

***You should instruct the insured to try to avoid any more losses to the insured property. You might advise the insured to move belongings out of the affected rooms of the house if they are exposed to the weather and to make sure that any family members move to more secure housing if necessary, such as a hotel***.

## Contacting the Insured or the Insured’s Representative

The claims representative’s initial contact with the insured serves several purposes; not only can it reassure the insured that the claim will be investigated, but is also provides the claims representative with an opportunity to explain the claims process and begin the claims investigation. **There are four critical aspects of a claim representative’s initial contact with an insured:**

* **Timing and method of contact**
* **Preparation and initial contact**
* **Good faith**
* **Waiver and estoppel**

**Timing and Method of Contact**

For some insurers, or in certain claims as specified in the insurer’s guidelines, the claims representative’s first contact with the insured occurs at the same time as the claim acknowledgement. Generally, the claims representative reviews the initial loss report and the policy and then contact the insured or party representing the insured and schedule a time to speak about the loss. This can be a face-to-face meeting, or it can be by telephone or video call. If the loss involves a third-party claimant, the claim representative will also contact the claimant or the party representing him or her and schedule a meeting to discuss the loss.

By using video conferences or phone calls to discuss losses with the insured, rather than working to fit face-to-face meetings into everyone’s schedules, a claims representative can condense the timeline for the settlement of claims and make the claims process more efficient in terms of time and cost. Some complex losses, however, may still require face-to-face meetings.

For some claims, the insured is represented by an attorney or public adjuster, who is hired by the insured in hopes of improving the settlement offered by an insurer. In these instances, the claims representative should discuss claim-related issues with the public adjuster or attorney until advised otherwise by the insured.

## Preparation and Initial Contact

**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 information on how the claim will be handled and what action the insure or claimant will need to complete as part of the claims process.**

The first meeting or discussion with the insured sets the tone for the claim. For the insured or the claims, the loss has most 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 claim will be handled. The claims representative should be aware of these factors and take them into consideration when initially meeting or speaking with the insured or the claimant.

**Because claims representatives frequently find that insureds do not fully understand the details of their insurance coverages, they should be prepared to explain the policy terms and their meanings in relation to the loss. The claims representative should explain any possible policy violation, exclusion, or limitation that can affect coverage because withholding that information can be considered a breach of the claims representative’ or insurer’s duties**. **The claims representative must be careful to avoid giving the insured or claimant the impression that a claim will be paid when there may be grounds to deny the claim.**

Claims 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. Once contact is made the claims representative should take these steps?

* **Tell the insured how to protect any damaged property and to document the claim. Be specific about what the insured should do and any deadlines that might apply**.
* Describe the inspection, appraisal, and investigation that will be conducted
* Describe what additional investigation is needed to resolve any potential coverage issues. Give complete and clear instructions if the insured needs to provide any additional information.
* **Explain possible policy limitations or exclusions** and obtain a nonwaiver agreement when necessary.
* Obtain authorization to receive medical and wage loss information, if necessary.
* Explain how much time processing and concluding the claim is expected to take.
* Provide a blank proof of loss form for property damage and any necessary written instructions so that the insured can document the claim.

In some cases, the claims representative may record an interview with the insured during the initial meeting or discussion.

***Apply your knowledge***:

*You are a claims adjuster who is preparing to contact an insured for the first time in regard to a property damage claim filed after a fire in the insured’s home*. What should you be prepared to tell the insured if asked when payment for the loss will be received?

***Because this will be your initial contact with the insured, it is unlikely that the claim would be able to be settled, and it may not even be possible yet to determine whether the loss will be covered by the insured’s policy. While you may be able to offer a generic timeline regarding the processing and conclusion of the insured’s claim, she must make it clear that policy limitations or exclusions could apply to the claim, resulting in possible denial of payment***.

## Good Faith

Insurance policies are contracts of utmost good faith. When conducting a good-faith investigation, a claims representative must attempt to correctly and promptly resolve coverage issues. Many situation present coverage issues that require investigation to determine whether the claim should be paid or denied, and until coverage issues are resolved, the claim representative and insurer must avoid any conduct that would lead insureds or claimants to mistakenly believe that the claim will be paid. If they do not, the insurer could unintentionally waive its rights to deny coverage.

While attempting to resolve the coverage issues, claims representatives must focus on the facts of the loss and decide whether those facts support coverage under the insured’s policy. Claims representatives must also quantify the loss so that payment is not delayed if coverage is confirmed.

## Waiver and Estoppel

When discussing a claim with an insured, claim representatives must avoid accidentally granting a waiver for a policy condition or exclusion. For example, a claim representative can **waive** a right contained in a policy condition by telling an insured that a loss is covered before checking the policy. By doing this, the claims representative has waived the insurer’s right to deny the claim if the facts later prove that there is no coverage.

Another example of an action by a claims representative that could hinder an insurer’s ability to rightfully deny a claim is the representative’s providing an insured with bad advice. For instance, 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. This is the principle of **estoppel**.

Frequently, the doctrines of waiver and estoppel are so closely related in meaning that courts often fail to distinguish between them and simply hold that a result based on the doctrine of waiver and estoppel.

***Example of case involving both Waiver and Estoppel***

An insured calls the claim service center 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 explain the coverage under the policy. Because the insured relied on what the customer service representative told her and incurred expenses, the insurance carrier may be estopped from denying coverage. Even though the coverage does not apply to the original loss. 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.

Claims representatives can avoid waiver and estoppel through the use of non-waiver agreements and reservation of rights letter, which serve these 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 in not intended to waive or invalidate any policy conditions.
* To clarify that the intent of the agreement or the letter is to permit a claim investigation and that neither the insured nor the insurer will thereby waive any respective rights or obligations.

A nonwaiver agreement protects the insurer from estoppel by reserving the right to deny coverage based on the information developed during the investigation. The nonwaiver agreement, which must be signed by both parties, is usually 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.

A reservation of rights letter serves the same purpose as a nonwaiver agreement but is in letter from and is a unilateral document; it does not require the insured to sign or agree to the contents of the letter. 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 a nonwaiver agreement, the claims representative can use a reservation of rights letter to protect the insurer’s rights and advise the insured of the potential coverage issue. Each insurer has its own guidelines for usage of nonwaiver agreements and reservation of rights letters.

Nonwaiver agreements and reservation of rights letters are usually sent by certified mail, return receipt requested, so that the insurer has evidence that the insured received it. While they can be used on any type of first-party claim, they can only be used with the insured and are not sent to third-party claimants because in most states third parties have no obligations under the policy.

# 3 – Investigating and Documenting The Claim

**Objective**: Describe the following activity in the claim handling process: Investigating and Documenting the claim.

Claim representatives must conduct thorough claim investigations and clearly document the results in the claim file. The investigation forms the basis for determining whether there is coverage for the loss.

After acknowledging and assigning the claim, identifying the policy and contacting the insured, the next steps in the claim handling process are to investigate and document the claim. The investigation can take many different forms, and all aspects must be documented to create a complete claim file.

## Investigating the Claim

**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 for a short time is investigated first, such as an 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. The focus of investigations should be on obtaining 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 need for a satisfactory claim resolution. Once sufficient information has been obtained to make a reasoned determination, the claim representative does not need to continue the initial investigation unless the determination is disputed.

This section provides a basic outline for the claim representative to follow when investigating 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 these examples, are common to many types of claims:

## 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. The claimant could also be considered an insured under the policy because of a relationship to the named insured, such as a family member. In 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 claimants’ 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 the party named as the insured in the policy, although other persons may qualify as insureds under a particular policy.**

**Witnesses have personal, firsthand 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 challenging 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 reviewing details such as tire tracks, curves in the road, and objects or conditions that may interfere with a driver’s view or that may cause and 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.

In serious accidents, claim representatives may use field investigators or accident reconstruction experts to visit the accident scene, take photographs, and develop a theory of the causes of the accident.

### Property Damage Investigation

**An investigation of the property that was damaged in a loss can be useful in various types of claims to confirm the cause of loss and extent of damage. For example, damage to the rear quarter panel and trunk lid on the insured’s vehicle can confirm that the vehicle was struck in a rear-end collision as well as the nature of the vehicle 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**.

### Medical Investigation

**Claim representatives conduct medical investigations in all bodily injury claims, including workers 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 can also be used to evaluate the degree of pain and suffering that resulted from the accident or injury**.

In certain types of claims, such as workers compensation and first-party auto injury claims, the claim representative should typically have access to the medical records of the treating physician. In liability claims, the claim representative will require an authorization from the injured party to obtain medical records. If authorization is refused, the claim representative may not be able to obtain these records unless a lawsuit is filed; in such cases, the claim representative will not usually agree to settle the claim until medical records documenting the nature and extent of the injury are received.

### Prior Claim Investigation

**Claim representatives conduct prior claim investigations on most incoming claims to avoid paying for property damage or bodily injury that has been paid through prior claims by the same insurer or 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 with an industry database containing information from many different insurers. Insurers describe to these databases and furnish them with claim information (ISO Search). 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 whether 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 conduct further investigation.

### Subrogation Investigation and Recovery

**During the 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 the 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. These examples describe losses for which a claim representative should investigate subro possibilities.

* Workers compensation losses caused by the negligent operation of an automobile or a piece of construction equipment
* Auto claims in which the road was under construction or visibility was restricted because of the property of a third party, such as a sign
* Property damage claims resulting from fire, explosion, or water losses caused by the negligence of tenants or by construction workers at a building site
* Liability claims in which injury was caused by defectively manufactured or poorly designed products from a third party

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. If an insured breaches the subrogation agreement, the insurer has the right o collect from the insured the amount that could have been recovered from the responsible third party.

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 rescind the right of subrogation (such as a lease agreement). Subrogation can be costly to pursue if litigation is required, the insurer many in some cases decide that pursuing subrogation is not cost-effective.

When the subrogation action is against a negligent third party who is responsible for the 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.

## Documenting the Claim

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 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 have expected to receive the requested estimate. If the estimate has not been received, the review prompts the claim representative to follow up.

As claim representatives perform activities in their investigation, they must document the claim files suing both fie status notes and reports.

### File Status Notes

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

* **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 notes are essential because a claim file must speak for itself. The file status notes should present a chronological account of the claim representative’s activities and can include 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 claims 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; any remarks about race, religion, or gender should be avoided. Humor is also out of place in file notes. A note that seem innocuous when written can be devastating when read to a jury, and claim representatives should document their notes as if they are discoverable.

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 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 whether there are abbreviations for terms that are acceptable, such as “PR” for police report or “s/s” for stop sign.

### File Repots

In addition to using file status notes, claim representatives document claim activity using reports to various parties. One such 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 losses 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. Theses 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) reports.** 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, attachments may already be included as images into 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 for attorneys).

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 other who have an interest in the claims, such as reinsurers or excess insurers. Because insurer 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.

# 4 – Bases For Legal Liability

**Objective**: Evaluate three Bases for legal liability

Although a lawyer and a claims representative each have distinct roles to play in good-faith claims handling, a claims professional needs to become comfortable with the concepts and terminology of criminal law, civil law, and the bases of legal liability.

To handle a claim with good faith, a claim representative must investigate and determine the cause of the loss, liability for the loss, and the amount of damages that result from the loss. The claims representative must have a thorough understanding of the concept of legal liability to decide which general investigative tools to use and which aspects of the claim to investigate.

## Bases for Legal Liability

Legal liability is different from criminal liability. Criminal liability arises from wrongful acts that society deems so harmful that the government takes responsibility for prosecution and punishment. Criminal laws are always statutory. In contrast, civil law is based on the rights and responsibilities of citizens with respect to one another; it applies to legal matters not governed by criminal law.

**National, state, and local legislators enact laws (statutes) to deal with perceived problems. Laws made by local governments are often called ordinances. Collectively, these formal enactments of federal, state, or local legislative bodies are referred to as statutory law**.

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|  |  | **Bases for a** | **Legal right** | **To recovery** |  |  |
|  |  |  |  |  |  |  |
|  | **Torts** |  |  | **Contracts** |  | **Statutes** |
| / | I | \ | / | \ | / | \ |
| Negligence | Intentional Acts | Strict Liability | Liability Assumed under contract | Breach of warranty | Not fault auto laws | Workers compensation laws |

Civil laws include common law, or case law, and administrative laws and regulations, as well as some statutory laws. Civil law governs liability for civil wrongs against people, entities, or property (torts), which include negligent acts, intentional acts, and strict liability. It also governs liability for breach of contract. Contract law, a branch of civil law, deals with the creation and enforcement of contracts and with the settlement of contract disputes.

**In contrast to statutory law, common law has evolved in the courts. Common law, or case law, is a boy of principles and rules established over time by courts on a case-by-case basis**. Each decision became a precedent for similar cases in the future. Gradually, certain principles evolved as judges applied them consistently to all cases they heard. These principles became known as the common law, or case law. When neither constitutional nor statutory law applies, judges still rely on precedents of previous cases in reaching their decisions.

The two major categories of US law are not mutually exclusive, and a particular act can often have both criminal and civil law consequences. For example, Felicia’s car is struck by another vehicle, and Felecia is injured and requires extensive medical care. As a salesperson, Felicia loses existing and potential customers by being out of work for two weeks. Following the accident investigation, the other driver is charged and convicted of driving while intoxicated, a criminal offense. However, Felecia may bring a civil suit against the other driver for her lost business opportunities.

## Liability Based on Tort

**A tort is a wrongful act or omission, other than a crime or a breach of contract, committed by one party against another that cause harem and may lead to a civil lawsuit for damages. A person or an organization that commits a tort is called a tortfeasor. Tort law generally applies to civil actions for which damages may be awarded to the harmed person.** The three types of torts are negligence, strict liability, and intentional acts.

### Negligence

Negligence is the most common type of tort that claims representatives encounter. One individual may invade a legally protected right of another by committing an unintentional act through carelessness, neglect, or indifference. A person who fails to exercise reasonable care is held responsible by law for any injury, loss, or damage that results from that failure. Example, Josh was day dreaming while driving and failed to stop at a stop sign, hitting Emily’s car. Josh did not intentionally hit Emily’s car, but he was careless and therefore negligent. Josh is responsible for the damage to Emily’s car and for any bodily injury Emily suffered in the accident.

**Liability based on negligence must establish four elements**:

* **One party’s legal duty to use due care, owed to another party** – if there is no legal duty to use due care, there is not negligence
* **A breach of the duty to care** – such a breach is a failure to conform to the standard required in the situation, creating an unreasonable risk of harm. “What a reasonable person would do”
* **Proximate cause** – a causal connection between the negligent act and the harm or injury
* **Actual injury or damage** – If there is no injury or damage, then no liability exists

In some claims, not all the elements of negligence are present. All four elements of negligence must be present for a liability claim to be viable based on Negligence.

An easy way to remember the elements is: Duty Owed, Duty Breached, Proximate Cause, Damages

Legal principles that affect liability based on negligence include vicarious liability, contributory negligence, and comparative negligence. Vicarious liability is the legal responsibility that arises when one party is held liable for another party’s actions. The liability transfers to this party because of some relationship between the party and the party who is actually responsible. The most common vicarious relationship is between employer and an employee. Employers are held vicariously liable for the acts of their employees.

The concepts of contributory negligence and comparative negligence may apply if a harmed party is partly responsible for the loss. These concepts are used as defenses in negligence cases; the person being sued can raise them to eliminate or reduce the damages that may be imposed, or even to have the case dismissed. **In a state that follows contributory negligence principles, a person who has been harmed cannot recover damages if his or her negligence contributed in any way to the harm**. Even if the harmed party is only 1% at fault for an accident and the other party is 99% at fault, the harmed party cannot collect anything from the other party. Most states have deemed this all-or-nothing approach unfair and have modified the concept of contributory negligence into one of comparative negligence.

**In a state that follows comparative negligence principles, both parties to a loss share the financial burden of the bodily injury or property damage according to their respective degrees of fault.** A harmed party who is partially at fault can recover from another negligent party but only to the degree to which the other party contributed to the loss.

Comparative negligence laws vary by state:

* Pure comparative negligence rule – a plaintiff who is 99% at fault can still recover 1%
* The 50% rule – a plaintiff can recover reduced damages up to an including the point at which the plaintiff’s negligence constitutes not more than 50% of the total in a case involving 2 parties
* The 49% rule – a plaintiff can recover reduced damages as long as the plaintiff’s negligence is less than the other party’s negligence
* The slight versus gross rule – the plaintiff can only recover when the plaintiff’s negligence is slight in comparison with the negligence of the other party – proportional

### Strict Liability

Claims representatives should also be familiar with strict liability torts. Strict liability, or absolute liability, arises from inherently dangerous activities resulting in harm to another, regardless of the degree of care taken. For example; because explosive are inherently dangerous, blasting operations create liability for bodily injury or property damage, even if the explosive are handled carefully. Another activity involves dangerous animals. Allegations of strict liability also occur in many product liability claims. A harmed party can allege that a product was dangerous when the manufacturer, distributor, or retailer sold it. If the allegation proves to be true, the court may impose strict liability against the manufacturer, distributor, or retailer for any resulting harm.

Workers compensation laws create another type of liability without fault, similar to strict liability. An employer is liable for employee injuries sustained in the course of employment, regardless of whether the employer’s negligence caused the injuries.

### Intentional Torts

Another type of tort that claims representatives encounter is an intentional tort. An intentional tort is a tort committed with intent to cause harm or with intent to do the act that causes harm. The tortfeasor may or may not have intended the consequences that resulted from the act. Examples of intentional torts would be assault, batter, liable, slander, invasion of privacy, and trespass. Generally, insurance does not cover acts performed with the intent to cause harm because such a policy could encourage people to cause intentional harm with the expectation that insurance would cover it. **However, claims alleging intentional injury may also include allegations of negligence. In such cases, claims representatives must conduct good-faith investigations to establish whether an act was intentional or negligent before making a coverage determination**.

## Liability Based on Contract

The other basis for legal liability under civil law is contractual liability. **Contractual liability is liability imposed on a party by terms of a contract. It arises when someone’s rights under the terms of a contract are violated. Contractual liability may be based on a written contract or an implied contract**. Parties may be legally liable because of their failure to perform as agreed in the contract. Example; if a contractor is hired to construct a building and fails to build it or builds it improperly, the contract is liable to the owner for damages associated with the failure to build the building. Even though the contractor is liable, insurance does not generally cover damages from this breach of contract. However, insurance may apply to claims involving two types of contractual obligations: assumption of liability stated in the contract and warranties stated in the contract.

Liability assumed by contract arises when, as a condition of a contract, a party agrees to assume financial responsibility for liabilities imposed by law on another party. The responsibilities assumed vary by contract and range from assuming all liability to assuming liability only for the negligence of one’s own employees. (Hold Harmless agreements degree of risk transfer)

**Claims representatives often handle products liability claims that involve warranties. A warranty is a contractual promise that accompanies the sale of a product; express warranties are promises made orally or in writing by the manufacturer or retailer. For example, a manufacturer of infant pajamas may guarantee that the fabric will not burn. An implied warranty is not specifically expressed, but a purchaser could reasonably infer that the warranty exists**.

Whether legal liability is based on tort or contract, understanding the concept allows the claims representative to conduct a thorough, good-faith investigation of a claim. Knowing the legal bases for a claim will help the claims representative make these determinations:

* Whether the claim being presented is valid
* What investigation should be conducted
* Who is ultimately responsible for the claim

## Liability Based on Statute

Statutory liability is legal liability imposed by a specific statute or law. Although common law may cover a particular situation, statutory law may extend, restrict, or clarify the rights of injured parties in that situation or similar ones. One reason for such legislation is to ensure adequate compensation for injuries without lengthy disputes over who is at fault. No-Fault Auto Laws and Workers Compensation Laws. In these legal areas, a specific statute (rather than the common-law principles of torts) gives one party the right of recovery from another or restricts that right of recovery.

**In an effort to reduce the number of lawsuits resulting from auto accidents, some states have enacted “no-fault” laws. These laws recognize the inevitability of auto accidents and restrict or eliminate the right to sue the other party in an accident, except in more serious cases defined by the law (must exceed the threshold). Victims with less serious injuries collect their out-of-pocket expenses from their own insurers without the need for expensive legal proceeding**s.

**A similar concept of liability without regard to fault applies to workplace injuries. Each of the 50 states has a workers compensation statute that eliminate an employee’s right to sue the employer for most work-related injuries and also imposes on the employer automatic (strict) liability to pay specified benefits**.

# 5 – Determining the Cause of Loss, Liability and The Loss Amount

**Objective:** Describe the following activities in the claim handling process: Determining the Cause of Loss; Determining Liability; Determining the Loss Amount

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

The activities required for investigating and determining the cause of loss, liability, and damages depend on the type of claim. The claim representative analyzes the information from the investigation to determine the cause of loss. He or she then evaluates the causes of loss and other claim facts against the policy to determine whether the loss is covered under the policy. The claim representative then determines the amount of the loss and compares this amount to the policy limits.

## Determining the Cause of Loss

**As part of the claim investigation, the claim representative should determine the cause of loss. If there are several causes of loss, the claim representative should identify all of them and determine their relative importance in causing the loss and the responsible party or event**.

The claim representative should be aware that if the investigation uncovers a cause of loss that is not claimed by the insured or the injured party, the insurer is responsible for determining whether the cause of loss discovered through the insurer’s investigation is a covered cause of loss. For Example, an insured may claim flood damage to a home covered by a homeowners policy that excludes flood damage. If the claim representative discovers that the water damage resulted from rain entering through, the wind-damaged roof, not flood, the claim representative must determine coverage based on the cause of loss revealed by the investigation, namely the wind-damaged roof.

**The type and cause of loss are key issues for investigation and coverage determination**. The claim representative must be certain that all of the relevant facts that can possibly be obtained are included in the results of the investigation.

## Determining Liability

After the cause of loss has been determined, the claim representative must determine who is liable for the loss. If the insured is liable, the claim representative must then determine whether coverage exists for that liability under the party. In a first-party claim, the claim representative would have to determine whether the policy provides coverage for the loss.

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 determination by carefully reading the policy form and all endorsements.

**A systematic framework for coverage analysis can guide the claim representative in determining coverage. This process ensures that all of the component parts are reviewed**. These questions outline the framework for coverage analysis:

* 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?
* Is the location of loss covered?
* Do any exclusions, exceptions, or endorsements apply?
* Does other insurance apply?

The questions do not need to be answered sequentially, but claim representatives should address all of them when they are determining coverage for a loss.

### Is the person Involved Covered?

Some policies cover only insureds named or listed in the policy. However, most policies define “insured” to cover additional persons. Example, family members of the named insured; employees of the named insured, a person who was granted permission by a named insured to use a covered auto may be an insured.

Some claims such as those involving contractors and subcontracts, may involve complex analysis regarding who is an insured under the policy. Claim representatives should attempt to obtain copies of all relevant contracts, agreements, and other documents during the investigation to assist in determining whether a person or party qualifies as an insured under the policy

### Did the Loss Occur During the Policy Period?

Most policies are written to cover only losses that occur during a specific policy period.

The date and time of loss occurrence usually determines whether the loss occurred during the policy period. However, the date of loss is not always straightforward. Occupational disease claims in workers compensation, for example, may not have a definite date of occurrence. Environmental damage may not have a readily definable date on which it began.

Although most policies are occurrence forms that cover any occurrence during the policy period, some policies are claims-made forms that cover claims that are made during the policy period for losses that may have occurred before the policy period. Claims-made forms are usually used for environmental, medical malpractice, or directors and officers policies.

### Is the Cause of Loss Covered?

**To answer this question, claim representatives should have thoroughly investigated all of the facts concerning the loss and should apply them to the language in all of the policy provisions. Exclusions must be read carefully to find the exceptions that are contained in many policy exclusions. Policy definitions must also be analyzed**.

Example, fire may appear to be straightforward cause of loss with a clear definition. However, does “fire” cover smoke or excessive heat if there is no actual flame? Does the policy cover “friendly fire”, which is contained in a device such as a stove? Is damage caused by firefighters who extinguish a fire covered?

### Is the Damaged Property Covered?

The claim representative must also determine whether property damaged in the loss is covered. For example, if a claim investigation reveals than an auto involved in an accident does not appear on the declarations or fall within the definition of “your covered auto”, coverage may not exist for the vehicle. IN another example, roofing material is stolen from the garage of a home and reported under the homeowners policy. If the named insured purchased the material to repair the roof of the home, there would be coverage. However, if the named insured is a roofing contractor and planned to use the material in his business, there would be no coverage.

### Is the Type of Loss Covered?

A loss can be classified as a direct loss or an indirect loss. A Crushed fender is a direct loss. Indirect losses reduce future income, increase future expense, 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 is indirect loss. The loss of earning and extra expenses incurred over a period of time are also indirect losses.

Many property policies cover direct losses only. Other policies cover some types of indirect losses, such as the coverage under homeowners policies for certain increases in living expenses after a covered loss renders the home untenable.

### Is the Location of the Loss Covered?

The location where the loss occurred must be within the policy’s territorial limits.

### Do Any exclusions, Exceptions, or Endorsements Apply?

Some losses may be excluded under the policy. Example, homeowners policy usually exclude losses caused by insects or animals, such as termite damage.

When claim circumstances fall within a specific exclusion, coverage does not apply. An exclusion will bar coverage even if all other coverage requirements are met.

However, exclusions can contain exceptions. For example, an auto policy excludes liability coverage for damage to property used by the insured, with an exception for 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.

Endorsements to a policy can grant coverage that is otherwise excluded, exclude coverage that is otherwise provided, add or delete insureds, and otherwise modify the policy.

### Does Other Insurance Apply?

The claim representative should determine during the investigation whether other insurance applies to the loss. Policies usually contain conditions that describe how the policy will apply in the event that there is coverage under one or more additional policies. Some policies provide coverage, some provide excess coverage, while others provide pro rata contribution.

## Determining the Loss Amount

Claim representatives should determine both the type and amount of any damages that are being claimed as a result of a loss. They should then determine whether these types and amounts are covered under the policy.

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.

**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**.

For liability claims, damages for which the insured may be liable include compensatory and punitive damages. Compensatory damages include special damages (medical expenses and lost wages) and general damages (pain and suffering). Punitive damages punish a wrongdoer for a reckless, malicious, or deceitful act with the purpose of deterring similar conduct.

**Some policies do not define or list the types of damages payable under the policy. However, the term “damages” generally refers only to compensatory damages. In some states, the insurer is not permitted to pay for punitive damages because such payment by an insurer would not punish or deter the insured. Even it insurers are not prohibited by law from providing coverage for punitive damages, most policies expressly exclude them**.

In addition to ensuring that the types of loss and damage are covered, claim representatives must verify that the amount of actual or anticipated damages is within the policy limits. In addition to limits of liability in a property policy, there may also be sub-limits for certain types of property or expenses. There are also deductibles and conditions that describe how damaged or destroyed property should be valued, such as actual cash value or replacement cost. There may also be coinsurance clauses, and if so, the total value of the property must be determined and compared to the insured value.

**Some policies contain both occurrence and aggregate limits (your GL policy). The claim representative must determine the available aggregate limit as well as the occurrence limit for losses under these types of policies.**

**Some insureds have a self-insured retention (SIR) in which the insure is responsible for paying losses up to the SIR level. Once the SIR has been exceeded, the insurer is responsible for the payment**.

The claim representative must verify all the policy limits applicable to a loss before making payments to ensure that the payment falls within the available limits of coverage. The claim representative should also notify the insured if it appears that a loss will exceed the policy limits. The claim representative may also need to notify a reinsurer for the insurer or an excess insurer for the insured when a loss is likely to exceed policy limits.

**6 -Claims Handling Process; Concluding the Claim**

**Objective**: Evaluate the role of the claims representative in theses activities that may be involved in concluding a claim: Issuing payments; Denying a Claim; Alternative Dispute Resolution; Litigation, Closing Reports

While there are many simple claims for which the claims representative will face an easy yes or no decision regarding payment or denial, concluding claims can be complicated by negotiations. A savvy rep will know insurer guidelines as well as state and federal laws governing payments, denials, and dispute resolution. A claims representative who fully understands the process of concluding a claim is in a better position to ensure that claims are handled fairly, efficiently, and legally.

Once the investigation is completed and all documentation is received, the claims representative must decide whether to pay the claim or deny it. If the claim is to be paid, the claims 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 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 claims representative or claims 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, the bank must verify that the insurer has authorized payment before disbursing any funds. Because of this requirement authorization, a claimant cannot present a draft at a bank for immediate payment. This delay allows the insurer to confirm that the payment is proper.

**When issuing claim payments, claims 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 claims representative must determine whether an attorney or a lienholder such as medical service provider, should be named as an additional payee on the payment. The claims representative is responsible for including all required payees when issuing a claim payment.

**Claims representative must also check various databases to ensure that the claim payment complies with federal and state laws**. The Office of Foreign Asset Control US Depart of the Treasury, requires all claim payors (insurers, self-insureds, and third-party administrators TPAs) to check the master list of potential terrorist and drug traffickers before making a claim payment.

**Insurers and other claims payors must also be aware of state child support enforcement initiatives that can affect claim payments. Many states have statutes that require a claims representative to check a database to determine whether a claimant or beneficiary owes unpaid child support**. If owed the claim representative must follow specific procedures when issuing the payment.

**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 situation. The settlement must be approved for claimants who are Medicare beneficiaries or who have reasonable expectations of Medicare enrollment within 30 months of settlement and when the settlement is $250,000 or more. Failure to gains CMS approval can expose the insurer to a bad-faith suit.

Claims 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.

## Claims Denial

A claim may conclude instead with a denial. When claims investigations reveal that a policy does not provide coverage for a loss or when an insured fails to meet a policy condition, the claims representative must make a timely claims denial. Insurers often have strict guidelines that claims representatives must follow when denying claims, and some insurers require a claims manager’s approval to issue a claims denial.

Before denying a claim, the claims 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 claims 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 they comply with the jurisdiction’s legal requirements. 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 claims representative, even if it is drafted by a lawyer**.

## 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 to relieve the courts of the burden of handling such disputes. Alternative dispute resolution (ADR) refers to methods of settling disputes outside the traditional court system. The most common are Mediation, arbitration, appraisals, mini-trials, summary jury trials, and pretrial settlement conferences.

* **Mediation – neutral 3rd party examines the issues and develop a mutually agreeable settlement**
* **Arbitration – neutral 3rd party to examine issues and develop a settlement – binding**
  + **Non binding – neither party is forced to accept the arbritrator’s decision**
* **Appraisal – method to resolve an issue over the amount owed on a loss**
* **Mini-trial – abbreviated version of trial and offers opinions based on evidence presented**
* **Summary jury trial – similar to mini trial but panel of mock jurors decide the case**

## Litigation

Despite the variety of ADR methods, many cases are concluded through litigation. Litigation can occur at almost any point during the life of a claim. However, it occurs most often when the parties to the claim are unable to reach and agreement by negotiation or ADR, or when a claim is denied. ADR reduces, but does not eliminate, the possibility that a claimant will sue and take a case to trial.

When litigation cannot be avoided, claim reps participate in developing litigation strategies for the insured’s defense and for litigation expense control. Claim reps must carefully select and direct defense lawyers. The lawyer’s role is to be the insured’s advocate. To mitigate the claim against the insured and to encourage the claimant to settle out of court, the lawyer must address every aspect of the claimant’s case, from liability to damages.

**Closing Reports**

When a claim is resolved, the claim rep 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, subrogation claim reps use these reports to evaluate the likelihood of a successful subro action.

Claims supervisor and managers may use the reports to audit the claim reps performance. These reports can be submitted to reinsurers for reimbursement of loss payment. Claim reps should be aware of claims that should be referred to reinsurers and must complete reports to those claims based on the insurer’s internal guidelines and reinsurance agreements.