3 – Setting Case Reserves and Investigating Claims

**1 – Establishing a Case Reserve**

**Objective**: Summarize the five methods of setting a case reserve and the cause of reserve errors

Inaccurate case reserving is a leading cause of insurer insolvency. Claims representatives should be familiar with the advantages and dangers of the methods used to establish case loss reserves.

Insurers can establish case reserves using any of several different methods. These are 5 common methods:

* Individual case method
* Roundtable method
* Average value method
* Formula method
* Expert system method

Reserving errors can occur when any of these methods is used inappropriately, such as when missing the more subjective individual case method results in the need to repeatedly raise the reserve amount.

**Type of Case Reserving methods**

Although the exact timing may differ among insurers, the setting of an initial reserve(s) usually occurs early in the claims handling process. Claims representatives often establish claim or case (loss) reserves in conjunction with identifying the policy. An 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 cost of handling the claim. Example; in a claim for an auto accident, and individual reserve may be set for damage to the insured’s vehicle, damage to the other party’s vehicle, medical expenses for the insured, and bodily injury of 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 insurer’s profitability. Establishing and maintaining adequate reserves is important for the insurer’s financial health because reserves affect the insurer’s ability to maintain and increases its business**.

These are 5 common methods of setting case reserves:

* Individual case method
* Roundtable method
* Average value method
* Formula method
* Expert system method

The individual case method and the roundtable method rely on the claim representative’s judgement. 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 claims representative estimates the case reserve based on the claim circumstances and his or her experience with similar claims.**

Because of the subjective nature of the evaluation and the number of factors a claims representative must consider when using the individual case method for a bodily injury claim, reserves can vary widely by claims representative.

**Individual Case Method Considerations**

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

1. Claimant Profile (factors in calculating economic loss)
   1. Age
   2. Gender
   3. Occupation
   4. Level of education
   5. Dependents, 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)
   1. Whether the injury is permanent
   2. Extent of pain and suffering
   3. Extent of disruption the injury creates in the individual’s lifestyle
3. Special damages (factors in calculating special damages)
   1. Anticipated medical bills incurred to date and for future care
   2. Type of medical care that has been or is being provided - whether it includes diagnostic care or treatment
   3. 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)
   1. Whether the claimant is represented by a lawyer
   2. If so, the lawyer’s reputation
   3. Typical value of local court verdicts
5. Liability factors (factors in calculating compensatory and/or punitive damages)
   1. Whether the case involves ordinary negligence or gross negligence
   2. Whether the case involves any comparative or contributory negligence
   3. Any legal limits to recovery, such as cap on certain types of damages
   4. Any other parties’ contribution to the loss or responsibility for contributing to the settlement
6. Miscellaneous factors
   1. General economic conditions in the geographic area (factor in calculating economic loss)
   2. Whether the insured’s conduct in causing the loss was outrageous (factor in calculating compensatory damages)
   3. Whether drinking or using drugs contributed to the loss (factor in calculating liability)
   4. The insured’s credibility as a witness (factor in determining likelihood of successful lawsuit)
   5. The claimant’s credibility as a witness (factor in determining likelihood of successful lawsuit)

Another method of setting claims reserves is the **roundtable method**. Ideally, at the start of this process, claims personnel should not know the reserves the other have set**. After an 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.

Claims representatives (or claims-processing computer systems) may also set claim reserves using the **average value method**. This method is useful when there are small variations in loss size for particular type of clam 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 windshield claims may be initially reserved at $650 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 reserves is based on the average value method, but claim representatives are required to modify the initial reserve withing a specified number of days to reflect each claim’s circumstances.

Another method of setting claim reserves is the **formula method**, **in which a formula for setting reserve is determined by the insurer and is automatically created for the claims representative based on the facts of a claim**. 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 the 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 sued to set the additional living expense reserve under a homeowners policy if the home is destroyed by fire; the reserve may be a certain percentage of the coverage limit.

Claims representatives may also set claim reserves using the **expert system method. The details of a particular claim are entered into a computer, and the program applies the appropriate rules to estimate the amount of the loss and the loss adjustment expenses**. An expert system can provide more-consistent reserves than the individual case method can. While similar in operation to the formula method, **the expert system includes more subjective information such as loss location and the name of the treating physician**, in creating the reserve.

**IBNR Reserves** 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 portion 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.

Claims representatives are rarely involved in setting IBNR reserves. Actuaries analyze the insurer’s experience by comparing paid losses with case reserves to determine whether the insurer typically under reserves or over reserves claims, IBNR reserves calculate in aggregate rather than associated with an individual case.

**Causes of Reserve Errors**

**Reserve adequacy and accuracy are important to an insurer’s continued solvency and capacity (ability to write new business).**  Claims representatives can negatively influence solvency and capacity by under evaluating claim reserves. Although an occasional inadequate or inaccurate reserve may have little or no effect on an 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, its solvency.

Reserving errors can be cause in several ways. Initial reserves may be inaccurate because of 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 re-evaluate 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 will be increased again when more bills arrive. This process is called stair stepping the reserve**.

On a claim that concludes in thirty, sixty, or ninety days, stair stepping has little effect except to reveal the claim representative’s poor claims handling practices. But if the claim remains open for several years, as many liability claims do, the insurer’s total case reserves will be understated, increasing the risk that future payments will not be fully funded.

This does not mean that claims 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 claims handling practices.

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

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 claim for a catastrophic injury 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.

Claims representatives may underestimate the future settlement value of claim is 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 claims-information systems provide a data-entry check. For example, the software might require that the reserve amount be entered twice to allow the user the chance to verify the amount. Additionally, claims managers can review reports of reserves from the preceding day for unusual entries or reserves that exceed 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 representative investigate and evaluate claims, they should increase or decrease the reserve to reflect new information received. For example, if the estimate for medical bills is $5,000, the claim representative would set up a reserve of $5,000. If further testing revels a need for more costly treatment and the estimate is revised to be $10,000, the claims representative should change the reserve to reflect this increase in the anticipated medical costs. Likewise, if an estimate is lowered, the reserve should be changed to reflect the decrease. Because such changes are based on changes in the facts of the claim, they are not considered stair stepping.

**2 -Reserving Case Study**

**Objective**: Given a claim, asses the factors affecting the reserve amount using the individual case method

**Case analysis tools**

**When the individual case method is used, the representative evaluates the settlement value based on all the circumstances of the claim and his or her experience with similar cases**. Because of the numerous factors that must be analyzed and their subjective nature, the individual case method can yield settlement valuations that vary widely from one representative or attorney to another. However, for serious injuries, the individual case method is still the preferred technique for settlement evaluation.

**Overview of steps**

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

* Claimant profile
* Nature and extent of the injury
* Special damages
* Claimant representation
* Liability factors
* Miscellaneous factors

**Claimant profile**

The claimant profile considers factors that are used to **calculate economic loss**, **which include: Age, Gender, Occupation, Level of education, dependents, if any; their ages, and what extent they rely on the claimant financially and for companionship**

Factors related to the claimant profile include age, occupation, and the fact that he has a wife and 2 small children. **Although the disability caused by the accident does not affect his ability to earn a living, it may limit or preclude his participation in sports and physical activity and outings with his family**. A jury would likely consider those factors.

**Nature and Extent of Injury**

Factors used to calculate general damages that regard the nature and extent of the injury include: **Whether the injury was permanent and/or disfiguring, Extent of pain and suffering, Extent of disruption to the individual’s lifestyle caused by the injury.**

Factor relating to the nature and extent of injuries include permanent nerve damage; the extent of his pain and suffering, which was exacerbated by the infection; and the extent to which the injury will disrupt his lifestyle, which previously included physical activities with this family and friends.

**Special Damages**

Factors used to calculate special damages include: **Medical bills incurred to date and anticipated amounts for future care; Type of medical care that has been or is being provided and whether this includes diagnostic care or treatment; Whether the claimant will lose any wages**.

**Claimant Representation**

Factor used in determining the likelihood of a lawsuit and predicting the general damages that could result are: **Whether the claimant is represented by a lawyer; If so, the lawyers reputation; Typical value of local court verdicts**.

**Liability Factors**

Factor used to calculate compensatory and/or punitive damages include: Whether the case involves negligence ; Whether the case involves any comparative negligence; Any legal limits to recovery amount, such as a cap on certain types of damages; Any other parties’ contributions to the loss or responsibility for contributing to the settlement.

Liability factors that might affect the claim settlement include the manufacturer’s possible liability if the wheel malfunction is found to be the manufacturer’s fault. If it is, it must be determined whether it was caused by ordinary negligence or gross negligence. This may need to be investigated further whether the claimant contributed to the cause of the accident or the severity of his injuries by altering the machine after purchase or by being careless in operating the machine, which could reduce the settlement amount. Also need to determine whether any legal limits might apply to the settlement amount. You may want to demand a contribution towards settlement from the retail that sold the machine.

**Miscellaneous Factors**

The miscellaneous, or catch-all, category of factors used in the individual method include: General economic conditions in the geographic area (a factor in calculating economic loss); **Whether the insured’s conduct in causing the loss was outrageous** (a factor in calculating compensatory damages); **Whether drinking or drug abuse contributed to the loss (a factor in calculating liability**); The insured’s credibility as a witness (a factor in determining the likelihood of successful lawsuit); The claimant’s credibility as a witness (a factor in determining the likelihood of successful lawsuit).

**Setting the Reserve**

After analyzing the various factors that apply the individual case method, the claim representative list the factor that could increase or decrease the settlement value.

Factors that may influence the value of Sara’s Claim Settlement

|  |  |
| --- | --- |
| **Factors that Increase the Claimant’s Settlement Value** | **Factors that decrease the Claimants Settlement Value** |
| Dependent son: 5 years old | Age 35 |
| Pain and suffering continue 4 months post accident | Occupation: accountant |
| Disruption of lifestyle | Injury not permanent |
| Lost wage may increase beyond 6 months while claimant searches for work in down economy | Future medical bills, if any, expect to be small |
| Claimant represented by an attorney | Batter of diagnostic tests will likely not be needed |
| Attorney has reputation of being competent | Attorney has reputation of being inexperienced |
| Neighbor driver ran a red light in a busy intersection | Drunk driver’s insurer may contribute to settlement, reducing the cost of the settlement to the neighbor driver’s insurer |
| Other driver was drunk and may have had the last clear chance to avoid the accident | General economy s down |
| Claimant was not driving and can have little to no comparative negligence assigned to her. |  |

Aside from potential contribution from the other drivers’ insurers, the initial case reserve of $40,000 appears to be inadequate. The low setting may have been a result of the representative’s poor planning or lack of expertise in estimating claim severity; it could lead to stair stepping, or incremental increase in the reserve, as more bills arrive. Analyzing these factors will help the claim representative determine a dollar range for an adequate reserve.

**3 – Insurer’s Duty to Investigate**

**Objective**: Evaluate the insurer’s duty to investigate in regard to Authority; Reasonableness; Good faith; Promptness; Privacy issues

Insurers want to avoid allegations of breach of contract and bad faith. To help prevent these claims, claim representatives should know how to conduct appropriate claims investigations.

When an insurer receives a claims notice, a claims representative is assigned to determine whether the claim is a covered cause of loss. While a claims representative can fairly easily understand the terms of a policy, the facts of the claim often can be learned only through an investigation. A claims investigation should be handled with the insured’s authority, reasonably, in good faith, promptly, and with an awareness of privacy issues.

**Authority**

**The terms of a policy often give the insurer the authority to investigate the facts of a claim**. ISO uses similar language in several of its policy forms granting this authority.

Examples of Policy language granting authority to investigate

|  |  |
| --- | --- |
| Insurance Services Office, Inc. (ISO) | Policy Language |
| Homeowners 3- Special Form  (H0 00 03 05 11) and personal Umbrella  Personal Liability Policy  (DL 24 01 07 14) | “We may investigate and settle any claim or suite that we decide is appropriate.” |
| Commercial General Liability  Coverage Form (CG 00 02 04 13) | “We may, at our discretion, investigate any ‘occurrence’ and settle any claim or ‘suit’ that may result.” |
| Business Auto Coverage Form  (CA 00 01 010 13) | “We investigate and settle any claim or ‘suit’ as we consider appropriate. |

In the sample provided, **the authority to investigate is phrased as a contractual right but not a duty to investigate. However, state law typically imposes such a duty on the insurer, regardless of the term of the policy.** Policies also frequently require an insured to cooperate with the investigation.

**Reasonableness**

An insurer must perform a reasonable investigation. If an investigation is not reasonable, denying a claim could result in an insurer being held liable for damages beyond a policy’s limits. As an additional challenge for a claims representative, what may be reasonable with one claim may not be reasonable with another claim. Generally, a claims representative should take these actions:

* **Take into account all facts in the insurer’s claims file**
* **Check facts provided by an insured through an independent source prior to rejecting his or her position**

A court, for example, would likely find that an insurer failed to perform a reasonable investigation if it denied a claim event though it had paid two similar claim earlier to the same insured under the same policy and coverage. The reasons the earlier claims were paid should be in the insurer’s claims filed. A reasonable investigation would include reviewing the earlier claims and determining whether a different reason prevented the current claim from being accepted.

**The claim representative should also check the facts stated by an insured before rejecting them. A Court would likely find an insurer’s investigation unreasonable if it failed to confirm or deny and insured’s version of an incident that resulting in injury to a third party. When two conflicting accounts are presented, a claims representative may need to contact other witnesses as independent sources to confirm or deny the insured’s version of the facts**. Example: Ale, a third party, may allege that Elijah, an insured, intentionally injured him – which, if true, would likely cause the claim to be denied. However, Elijah may assert that the injuries were accidental, in which case the claim would likely be covered.

**Good Faith**

Good faith, considering the insured’s interests as equal to the insurer’s, relies on common sense and good judgement. Good faith claims handling involves thorough investigation, documentation, evaluation, negotiation, communication, and pursuit of legal advice when appropriate. The insurer’s management of the claims process is also important to good faith claims handling.

Claims representatives should investigate claims thoroughly and make sure they have sufficient evidence of their good faith efforts before concluding claims. That evidence is helpful in defending bad-faith lawsuits. In addition, claims representatives should seek legal advice when appropriate.

Digital claim files provide a way for claim representatives to have easy access to pertinent information, such as repair estimates, medical bills, photographs, and police reports. When a claims representative receives such information via an app, an email, or a text, it should immediately be included in the claims file. A digital claims process also allows for live updates to the insured about the status of the claim. For this reason, it is important that any information a claim representatives enters is accurate. If an insured receives a text message notification that her damaged roof is being inspected by a claims representative on Monday yet does not hear the result of that inspection until Thursday, it leads to a negative customer experience and diminishes the efficiency of the digital process.

In a thorough investigation, the claim representative is on the alert for new information that may change the course of a claim. Thorough investigation of any new information must be completed. The additional investigation may reveal the claimant who fell on a homeowner’s front porch, may actually have been a resident of the household, or was on the premises as a business customer.

A claims investigation should never be biased, meaning there should be no predisposition to find a particular outcome. Claims representatives should avoid asking misleading questions that slant the answers to a particular outcome, such as “the light was red when you saw it, wasn’t it”? In addition, claims representative should work with service providers that are unbiased and have no conflict of interest. Courts and juries may not look sympathetically on medical providers or repair facilities that always favor insurers. Investigations should seek to discover the facts and consider all aspect of the claims so that decisions are impartial and fair.

**Promptness**

An investigation must be timely. An insured who makes a claim expects prompt contact from the claims representative. Most insurers have guidelines requiring the claims representative to contact the insured and/or claimant within a specific period, such as 24 hours after submission. **Such timely contact benefits the insurer in these ways:**

* **All parties are more likely to remember details of the loss accurately. Memory fades over time; therefore, claims representatives are more likely to get complete, accurate information from the insureds and claimants if they contact them quickly.**
* **Parties are more likely to share information if contacted soon after an incident; prompt contact assures insureds and claimants that their claims are important and makes them less likely to accept the advice of others who may encourage them to retain a lawyer or pursue unnecessary litigation.**

By automating parts of the claims process, artificial intelligence and blockchain technology can further reduce response lag times. For example; using an app, a customer can submit a claim without ever speaking to a claims representative. This is particularly relevant to the auto insurance industry and allows for insurers to quickly assist their insureds. Taking things even further, connected cars could use telematics and blockchain technology to trigger first notice of loss reports for accidents without the insured having to contact the insurer at all.

**Claims representatives should always remember that unnecessary delays in resolving a claim may cause an insured to incur additional, avoidable damages. An investigation should continue only as long as new, relevant facts develop or become available. Claims representatives should obtain the information and documentation necessary to determine liability and damages and should make decisions once they believe they have sufficient information**.

**Privacy Issues**

Because claims representatives handle highly sensitive information, they need to be aware of privacy issues. Many privacy issues are regulated by law, and insurers should also adopt privacy best practices to protect themselves and their insureds.

**State laws that apply to licensing, unfair trade practices, unfair claims settlement practices, and privacy are in place to protect the public. Federal statutes, also designed to ensure the privacy of confidential information include the Health Insurance Portability and Accountability (HIPPA); the Gramm-Leach Bliley Act, which requires financial institutions (including insurers) to explain information-sharing practices and protect sensitive data; The Sarbanes-Oxley Act of 2002 (investor protection, internal controls, and penalties); and the Fair Credit Reporting Act**.

**GDPR Compliance**

**As awareness of cyber risk increases, new regulations have been put into place, such as the European Union’s (EU’s) General Data Protection Regulation (GDPR), which is intended to give consumers control over their personal data. While this regulation applies to countries in the EU, Unites States organizations that conduct business with European countries, including insurers, must also comply with it.** Unlike many other privacy regulations, the GDPR changes both controllers (entities deciding what to do with personal data) and processors (entities collecting, storing, and/or using the personal data but not deciding how it is used) with protecting data.

Most insurers are controllers that sometimes rely on processor handling insureds’ data. Noncompliance with GDPR can have serios results, with high fines for organizations and compensation for victims.

**4 – Insured’s Duty to Cooperate**

**Objective:** Examine the insured’s duty to cooperate with the insurer in regard to: Compliance with a reasonable request; Production of documents and evidence; Examination under oath and other types of statements; Independent medical examination; Consequences of noncooperation.

Many claims representatives will face claims in which an insured doe not fully cooperate. To successfully resolve these claims, a representative should understand the insured’s contractual duties and be familiar with tools that can help enlist the insured’s contractual duties and be familiar with tools that can help enlist an insured’s cooperation.

The terms of most insurance policies make it clear that the insured has a duty to cooperate in the investigation, settlement, and/or defense of a claim under the policy.

**Samples of policy language requiring insured’s cooperation in investigation**

|  |  |
| --- | --- |
| Insurance Services Office, Inc. Policy (ISO) | Policy Language |
| Personal Auto (PP 00 01 09 18)  And Homeowners 3 – Special Form  (HO 00 03 05 11) | “Cooperate with us in the investigation, settlement or defense of any claim or suit.” |
| Commercial General Liability Coverage  Form (CG 00 02 04 13) and Business Auto  Coverage Form (CA 00 01 10 13) | “Cooperate with us in the investigation or settlement of the claim or defense against the ‘suit’.” |

The insured’s duty to cooperate involves several key aspects, include compliance with an insurer’s reasonable request, production of documents and evidence, examination under oath or other types of statements, participation in and independent medical examination, and acceptance of consequences for noncooperation.

**Compliance with a Reasonable Request**

The insured is contractually required to cooperate in a claim investigation and to respond to reasonable requests. **Several questions can be used to determine whether a request for information is reasonable:**

* **Is the information requested relevant to the claim?**
* **Is the request specific and clear? (not too vague)**
* **Is the insured given an ample opportunity to comply?**
* **Is the insured able to provide at least some of the information requested?**

In certain claims, such as when an insurer suspects fraud, the insurer may appear to ask for irrelevant information. For example, an insured named Catherine reports that her truck has been stolen and recovered, but indicators suggest she may have committed claims fraud.

The insurer asks Catherine to provide her income tax returns, bank records, and cell phone records, accordingly. Catherine thinks these requests are irrelevant and refuses the insurer’s multiple request for this information. The insurer, in turn, denies the claim, and Catherine sues for breach of contract and bad faith. The insurer, however, will likely win the case once it presents the circumstances: that the request for information was indeed relevant, that Catherine was provided with a reasonable opportunity to respond, and that Catherine did not comply with the request.

**Production of Documents and Evidence**

Insurance policies that provide coverage for an insured’s property – for example, a homeowners policy – typically allow the insurer to review and copy the insured’s books and records.

**An insured has a “reasonable amount of time” to comply with the insurer’s request for documentation. This standard may depend on the circumstances of the insured after the loss.** A fire loss, for instance, may destroy the insured’s tax returns that an insurer wants to see.

Some delays are considered unreasonable no matter what the circumstances. For example, an insured could not reasonably ignore an insurer’s multiple requests for information only to file suit against the insurer and then provide the requested information during litigation.

**While an insurer is entitled access to adequate records to settle a claim, it is not allowed unlimited access to an insured’s records. All request must be reasonable and specific.**

**Examination Under Oath (EUO) and Other Types of Statements**

Anyone seeking benefits under an insurance policy must be willing to answer the insurer’s questions. An examination under oath (EUO) is a valuable tool to use when an insured is suspected of submitting a fraudulent claim. During an EUO, the insured or claimant is sworn in under oath to give truthful answers as recorded by a court reporter. An attorney hired by the insured usually asks questions to the insured, who may or may not be represented by an attorney.

**An EUO is similar to a deposition. There are, however, two distinct differences between them. First, and EUO may be demanded by an insurer before litigation has begun. Second, an insurer may demand that an EUO be done more than once. (This is rare, generally only occurring if the insured produces information that contradicts the insured’s prior position**.)

In property claims, most representatives prefer asking the insured to submit a sworn proof of loss before asking for an EUO. A proof of loss commits the insured under oath to a specific set of facts, including these:

* Amount of loss
* Records supporting the amount of loss
* Date and cause of loss
* Person asserting a claim under the policy and an interest in the property that was damaged or stolen
* Records of a governmental investigation, such as a police or fire marshal’s report

**Independent Medical Examination**

Claims representatives rely on medical records to evaluate bodily injury damages. If a medical dispute arises, a claims representative may ask a doctor to perform an independent medical examination (IME) to resolve the dispute and determine the amount of damages.

A medical dispute might involve issues such as these:

* Whether the insured will remain totally disabled
* Whether tests that would objectively validate the insured’s claims of pain should be performed
* Whether the insured’s progress or lack thereof with current treatment should be assessed and whether potential treatment alternatives should be reviewed

**Many policies allow an insurer to request than an injured insured submit to an in-person examination. Because such an exam is listed in the policy condition, a claims representative may believe he or she can demand that an insured submit to one. However, because an IME involves in-person physical contact with a doctor chosen by the insurer, an insured may not be required to submit to it. Accordingly, caution should be used in making IME requests**.

Additionally, an IME is not required to deny coverage; a doctor’s review of the insured’s medical records may be sufficient for a denial. A claims representative should be careful not to provide his or her opinion of the insured’s medical condition and rely solely on a medical specialist.

**Consequences of Noncooperation**

An insured that makes a claim typically has firsthand knowledge of that claim. And because the knowledge must be shared with the insurer, most policies require that the insured cooperate in the insurer’s investigation and defense of the claim. For example, the Insurance Services Office, Inc. (ISO), personal auto policy states that the insurer does not have a duty to provide coverage if **the insured’s failure to cooperate in the investigation, settlement, or defense of a claim or suit is prejudicial to the insurer**.

**When determining whether an insured has forfeited the right to coverage for failure to cooperate, courts often assess whether certain factors, such as these apply:**

* **The insured has not cooperated at all or only partially**
* **The insurer’s investigation and/or defense has been compromised**
* **The insurer’s request for cooperation were reasonable**

Let’s take a loss at how these factors could affect a claim. For example, Brett, an insured, suffered a fire loss at his home, and the fire investigator confirmed arson. The claim representative wants to determine whether Brett was involved in the arson.

In an EUO, the insurer asks Brett to provide his income tax returns to determine whether he had financial motive to commit arson. Brett refuses to provide these records, a reaction a could will likely fine unreasonable. Accordingly, the court will likely determine that the insurer should be allowed to deny coverage.

**5 – General Investigative Tools**

**Objective**: Explain when and how each of the following investigative tools is used in a claims investigation.

Conducting a claims investigation is a lot like solving a mystery. Working with unproven evidence about a loss and around a tight timeline for resolution. Claims investigators rely on various tools to make crucial determinations about what actually happened, how the loss occurred, whether the relevant policy applies, and the monetary value of the loss.

**Loss notice Forms**

Generally, losses are reported to insurers on loss notice forms, such as those issued by the Association for Cooperative Operations Research and Development (ACORD). A loss notice form conveys essential information about the insured, the claimant, the type of injury or property damage, and the circumstances of the loss.

But losses aren’t always reported on loss notice forms. An insurer may receive loss reports through phone calls, emails, loss notification apps, legal filings, and other means. These methods may not be as comprehensive as a formal loss notice, though, and require the claims representative to gather basic facts to start the investigation.

**The Loss notice Form and the Investigation Plan**

* **Severity of the accident – losses that can be immediately recognized as sever (fatal injuries, property losses described as a total loss or severe) indicate the need for a very thorough investigation and usually an investigator to visit and photograph the accident scene**
* Questionable cause of loss – property loss after a hurricane requires investigation into whether the damage was caused by wind or flood; and unwitnessed slip or fall usually indicates a need for additional investigation.
* Third-party involvement – an auto accident involving collision with another vehicle or a workplace injury involving a third party usually requires additional investigation
* Minor losses – minor auto damage claims, record-only minor workers compensation injuries, and minor property losses may not require additional investigation beyond the policy review. Investigative resources should be allocated where they have the greatest potential to produce results.

**Policy Information**

Another useful source of investigative information is the policy itself, which should be explicitly reviewed when examining a claim – even if the claim seems simple and routine. If the handling of a claim is challenged in court, a claims representative’s admission that he or she relied on memory to determine policy coverage or exclusion could seriously harm an insurer’s defense. Plus, reviewing the policy may reveal endorsements that change the coverage – for example, by adding or deleting locations or changing limits.

**A preliminary review of the policy should focus on these questions:**

* **Who is covered?**
* **What is covered?**
* **When is coverage in effect?**
* **What causes of loss are covered?**
* **What is excluded?**

After gathering information about the loss from the first report and covering information from the policy review, the claim representative can either conclude the investigation (for minor claims) or continue it using one or more additional investigative tools.

**The Importance of Policy Reviews in Claims Investigations:**

This example illustrates how a review of the policy and underwriting file can provide information that is not initially significant but becomes important later in the investigation.

ABC insurance company insures a property policy to Acme Warehouse. Several months after the policy takes force, Acme Warehouse burns to the ground. The claims representative reviews the policy and learns that in its policy application, Acme stated that is stores only household goods. Several weeks later, the fire investigation indicates that the fire and extensive damage to the building resulted from the storage of a large amount of highly combustible and unstable chemicals used in a special manufacturing process. The claims representative realizes, based on the application, that more investigation into the loss and the policy is needed because of a potential increase in hazard from the storage of the chemical. While the nature of the insured’s business initially did not seem to be an issue, it later became important in determining coverage.

**Statements**

Depending on the type of loss, statements from the insured, the claimant, witnesses, and other interested parties, such as an injured worker’s supervisor, may prove valuable**. Statements are best taken shortly after the loss occurs so that time does not diminish the person’s memory of the event**.

**Diagrams, Photos, and Videos**

Diagrams, photos, and videos can illustrate what the loss scene looked like, how an accident happened, and the extent of the property damage and bodily injuries. These visual exhibits may be gathered by the claim representative, a field adjuster, or an investigator. In cases where the site of ta loss is inaccessible or hazardous, they may instead be recorded by aerial drones or remotely controlled robotic sensors.

**Experts**

During the claim investigation, an expert may be needed to evaluate the cause or value of loss, investigate the possibility of fraud committed by an insured or a third-party claimant, or provide legal advice. Many insurers employ a panel of experts who are impartial, respected in their fields, and credible. Accordingly, when the needs arise for field experts, the claims representative can select a panel member who best fits the investigation’s needs.

**Records and Reports**

**Records and reports can verify the facts of an accident or the nature and extent of damage or injury**, as well as reveal new information. Certain records and reports are common. For example, police and fire reports can be found in both property and liability claims, including some workers compensation claims. Workers compensation claims and liability claims that deal with bodily injury can include medical reports and records, as well as reports that verify income.

Other types of records and reports are exclusive to one type of claim. For example, motor vehicle title and registration records are used to verify the existence and ownership of vehicles in auto claims. In large property claims, claims representative may request income tax records, inventory records, and bank records from the insured to verify the value of inventory involved in a claim.

**Industry Databases**

Determining whether a claim is fraudulent may be difficult when relying only on the facts associated with the claim itself. For example, a claim representative may not realize that someone is filing a claim for damages from a seemingly legitimate car accident has filed suspiciously similar claims in the past. An industry database, however, could reveal such patterns, putting the investigation in a different direction.

Industry databases, such as ISO Claim Search, pool claims information from insurers, third-party administrators (TPAs), and industry organization. Claim representatives can search a database to detect fraud or find data on property, liability, auto, and workers compensation claims.

**Social Networking Sites**

**Social networking sites can be sources of valuable information about claimants and other parties to a loss. For example, a claimant alleging an immobilizing injury may post pictures that clearly contradict this on Facebook**.

Various federal and state privacy laws regulate permissible conduct in investigations of social networking sites. Additionally, rules of evidence and ethical concerns surrounding reviewing individual’s social networking posts.

**Other Investigative Tools**

Insurers and TPAs provide other investigative tools to their claims representatives to ensure consistent quality in claims handling. These tools can be fairly simple, such as programs that use room dimensions to calculate the amount of paint needed to repaint the walls. Others can be complex, such as expert injury evaluation tools that give the claim representative the benefit of many year’s worth of historical data for use n evaluating an injury claim.

**6 -Confirming the Loss Notice Information With The Policy**

**Objective**: Illustrate the critical information in the first notice of loss and how it is reconciled with coverage provided by the policy.

The loss notice provides essential information about a claim. Matching the information on the loss notice to the relevant policy is the first step in confirming coverage.

An insurance claim is typically initiated when the insurer receives notification of a loss, which can come in several form ranging from a phone call to a transmission from an auto’s telematics device.

An internal claims handler often transfers the information to the insurer’s standard first notice of loss (FNOL) form, but sometimes the insured fills out the FNOL. However, the loss notice form is completed it will become the basis for the claim investigation.

**If information obtained later contradicts statements on the loss notice form, additional investigation will be needed. Claims representative should become familiar with the loss notice forms their insurer uses. ACORD forms are the industry’s standard loss notice forms. Fore each line of insurance, claims information is entered into one of several fields, which include these:**

* **Agency**
* **Insured**
* **Loss or occurrence**
* **Policy information and preparer**

**Agency**

**Acord loss notice forms for property, auto and general liability contain a field at the top of the form for information about the insurance agency. If no agency information is provided, the claims representative should review the policy to identify the agent or broker who submitted the application**

The claims representative should investigate any discrepancy between the agency information provided by the loss notice form and the producer who submitted the application.

**Insured**

It is essential for the claims representative to confirm that the insured is correctly listed on any notice of loss. If the name of the insured does not match that on the policy, a thorough investigation must be conducted to determine why.

Although an insured may move or change phone numbers without notifying the insurer, a claims representative must investigate any discrepancies between the address and phone number on the loss notice form and those on the policy. The insured can be questioned about other information from the insurance application to verify that he or she is the same person who filed the claim.

If there is significant mismatch between the insured information on the loss notice form and the application or policy that cannot be easily resolved, the insurer may require an examination under oath, in which the insured provides documentation of his or her identity.

**Loss Or occurrence**

**Information about the loss or occurrence on the loss notice from is the starting point for the claims investigation. Documentation should be obtained to confirm the information provided during the course of the investigation**.

A loss notice may be missing information that an insured has omitted or discovered after completing the loss notice. During the claim representative’s first contact with the insured, it is important to fill in any such missing information. Example, the insured may now have a copy of the police report, or a witness may have been identified.

**Policy Information and Preparer**

**All relevant policy information needs to be verified. For example, the policy number should be confirmed because a mistake could easily be made when entering it on the loss notice form. At the same time that the policy number is verified, the claim representative should also confirm the policy effective date to determine whether the loss or occurrence took place within the policy period.**

**If the person who prepare the loss notice form is not the insured or producer, the relationship of the preparer to the insured should be determined. Although a family member or friend may prepare a loss notice for someone who needs assistance, it is important to follow up directly with the insured to verify the accuracy of the loss notice**.