Central Bank of Trinidad & Tobago

# Claims Guideline for Insurers

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# 1. INTRODUCTION

1.1 The insurance sector plays an important role in indemnifying commercial entities and households against losses incurred on specified perils. Commercial and individual policyholders enter into contracts with insurers to mitigate and/or transfer risks. By these means, the policyholders protect the value of their income and assets. Insurers accept these risks in consideration for receiving a premium and, in turn, promise that a valid claim will be paid. Claims management is the process by which insurers fulfill their contractual obligations to policyholders.

1.2 The Insurance Act, 2018 (the Act)[1] and the Motor Vehicles Insurance (Third-Party Risks) Act, Chapter 48:51 set out the legal requirements for insurance companies with respect to the settlement of claims.

1.3 The purpose of this Guideline is to provide the Board of Directors and management of insurers, brokerages or agencies with a framework for the establishment of policies and procedures for effective claims management.

1.4 The Central Bank of Trinidad and Tobago ('Central Bank') considers that the internal policies and procedures of insurers, brokerages or agencies should facilitate prompt and fair settlement of claims to policyholders. These policies and procedures should address the interaction between insurer and policyholder or claimant, as well as the insurer's ability to pay claims.

[1] Section 28(1) (g) of the Act requires that a company shall not be registered in respect of any class of insurance business unless the Central Bank is satisfied that the policy and practice of the company in dealing with claims are conducive to the fair, efficient and speedy settlement thereof.

Section 34(1)(n) provides that the Board of the Central Bank may revoke the registration of a company where the Board is satisfied the policy and practice of the insurer in dealing with claims are unfair or that there is unreasonable delay in settlement of claims payable under policies issued by it.

Section 34(1)(q) provides that the Board of the Central Bank may revoke the registration of a company where a final judgement obtained against the insurer in any court and in relation to which there is no stay of execution and the judgment remains unsatisfied for at least forty business days.

Section 155(2) requires that the powers of intervention conferred by Section 155(1) shall be exercisable where the Inspector is satisfied that there has been unreasonable delay in the settlement of claims under policies issued by the company.

## 2. PURPOSE OF THE GUIDELINE

2.1 This Guideline seeks to promote greater fairness and transparency between policyholders and insurers. Strong market conduct ethics serve to reduce mistrust that may exist between clients and insurers, and enhanced mutual confidence improves market efficiency. Conversely, weak market conduct ethics are usually the major reason for the poor development of an insurance market.

2.2 In Trinidad and Tobago, although the majority of consumer complaints relate to motor vehicle claims, the concerns raised by consumers are not confined to this class of business. Consequently, this Guideline requires each insurer to develop, document and implement claims management policies and procedures for all of its lines of business.

2.3 This Guideline takes into consideration international standards and best practice[2] and addresses three inter-related aspects of the claims management function:

- **Market conduct**: the ways in which the insurer communicates and interacts with the consumer;
- **Claims reserving**: the primary means of ensuring that there are sufficient funds to meet claims obligations; and
- **Internal controls**: the means to ensure that the preceding functions work effectively.

2.4 This Guideline and the documented claims policies and procedures of an insurer will be taken into account in assessing unfairness or an unreasonable delay in the settlement of claims by such insurer for purposes of the Act[3]. The timelines given in this Guideline are intended for motor claims settlement. However, each insurer should include as part of its policies and procedures, settlement timelines for claims for all types of business and should ensure that these timelines reflect the principles of good market conduct.

[2] See Guidance papers published by the Australian Prudential Regulation Authority (APRA), Financial Services Authority (FSA) UK, International Association of Insurance Supervisors (IAIS), Organization for Economic Cooperation and Development (OECD).

[3] Sections 28, 34(1)(n) and 266 of the Act

## 3. DEFINITIONS

3.1 An "adjuster" means any person who receives compensation for investigating or negotiating settlement of claims arising under insurance contracts on behalf of the insurer, the insured or any third party affected under the policy, but does not include:

(a) a salaried employee of an insurer while acting on behalf of such insurer in the adjustment of losses; or

(b) an agent of an insurer[4].

3.2 An "agency" means any company appointed by an insurer and registered under the Act to carry on the business of an insurance agency.

3.3 An "agent" means an individual employed by an agency to solicit applications for insurance or negotiate insurance business on behalf of the agency.

3.4 A "brokerage" means any company registered under the Act to carry on the business of an insurance brokerage.

3.5 A "broker" means any individual employed by a brokerage to solicit, negotiate or procure in any manner insurance or the renewal or continuance thereof or the settlement of any claims on behalf of existing or prospective policyholders, or reinsurance on behalf of insurers[5].

3.6 The "business of an insurance agency" means the solicitation of applications for insurance or negotiation of insurance business on behalf of an insurer and, where authorized to do so by the insurer, the effectuation and countersigning of contracts of insurance.

3.7 The "business of an insurance brokerage" means the business as an independent contractor of soliciting, negotiating or procuring in any manner insurance or the renewal or continuance thereof or the settlement of any claims on behalf of existing or prospective policyholders, or reinsurance on behalf of insurers.

3.8 A "claimant" means a person who makes a claim for an incurred loss under a policy.

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[4] Definition as contained in the interpretation section of the Act.

[5] Definition as contained in the interpretation section of the Act.

3.9 A "claim reported but not yet admitted" means a claim in respect of which an insurer has been notified, but for which the insurer has not yet made a decision to either admit or decline liability.

3.10 A "complex claim" means a claim for an incurred loss under a policy that meets the criteria stipulated in the insurer's Claims Policy, which is not simple to analyze or understand and which can lead to a lengthy and complicated claims settlement process.

3.11 A "foreign adjuster" means a person who is registered in another jurisdiction to carry on the business of an adjuster and is permitted under the Act to act as an adjuster during periods of catastrophe or where there is a complex claim or major loss.[6]

3.12 "Inspector" means the Inspector of Financial Institutions appointed pursuant to section 7 of the Financial Institutions Act and includes any person appointed to act temporarily in his place by the Governor.

3.13 An "insurer" means a local company[7] registered to carry on insurance business in Trinidad and Tobago and includes an association of underwriters.

3.14 A "major loss" means a loss that exceeds the insurer's established materiality threshold having regard to the insurer's business profile, capacity and criteria stipulated in the insurer's Claims Policy.

3.15 A "policyholder" means the person who, for the time being, has the legal title to the policy issued by an insurer, including any person to whom a policy is assigned and may include, in the case of long-term insurance business, a life insured.

3.16 "subrogation" means the right of an insurer, following payment of a claim, to be put in the place of the policyholder so that it can recover payment from the third party responsible for the loss. Subrogation has three elements (1) the right to proceeds of recovery; (2) the right to commence litigation; and (3) the right to control the conduct of litigation.

[6] Section 140(1) of the Act.

[7] Under section 4 of the Act, a "local company" is a company incorporated under the Companies Act or any other written laws of Trinidad and Tobago.

## 4. GENERAL REQUIREMENTS

4.1 Insurance policies, product literature, policy summary or marketing material should be clearly worded in easily understandable language and should define any words likely to be unfamiliar to the policyholder or claimant or capable of misinterpretation.

4.2 A document containing the terms and conditions of the policy should be prepared by the insurer and should be used as a basis of discussion with the prospective policyholder. A copy of the policy summary document should be given to the policyholder. At a minimum, such document should also contain all exclusions or exceptions and implied conditions[8]. All the features of a product must be clearly and fairly reflected in any policy summary and marketing material in language which should be easily understandable by the policyholder or claimant.

4.3 The insurer should ensure that the claims settlement process is handled fairly, promptly and efficiently and in accordance with the terms of the insurance contract and company policy. The insurer, brokerage or agency should have documented internal policies and procedures for the fair, prompt and efficient handling of claims in accordance with the terms of the insurance contract and company policy. Such policies and procedures should be approved by the Board of Directors and reviewed and updated periodically. The insurer, brokerage or agency should ensure that staff are aware of and adhere to these procedures.

4.4 Timely and accurate information should be provided to the policyholder or claimant at all times.

## 5. CLAIMS NOTIFICATION

5.1 The notification of a claim should be effected through a written document, the telephone, email or face to face contact and subsequently a claim form should be completed in keeping with the policy conditions.

[8] Implied conditions are those implied by common law or implied based on an interpretation of the wording of the policy.

5.2 When a policyholder or claimant reports a loss, the insurer, brokerage or agency should make available an appropriate claim form for the class of business, with clear instructions as to how the form should be completed. This should be done within two business days of receiving notification of a claim.

5.3 When a loss is reported, the insurer, brokerage or agency should inform the policyholder or claimant to co-operate in the investigation by providing the insurer with all relevant information to ensure timely processing of the transaction.

5.4 If the insurer requires specific documents from policyholders or claimants when a claim is filed, such as copies of official documents regarding the loss or any other relevant form of evidence, the insurer, brokerage or agency should provide a listing of these requirements with the claim form.

5.5 If a brokerage or agency is the initial contact for the policyholder or claimant, the brokerage or agency should forward the completed claim form to the insurer's claim department within three business days of the date of receipt of the completed claim form.

5.6 An insurer should respond promptly to notification of a claim. The insurer must acknowledge receipt of the claim form within four business days.

5.7 The insurer must indicate to the policyholder or claimant the relevant department or contact person to whom all information or enquiries must be channeled. The insurer's claim department, the brokerage or agency should be easily accessible.

5.8 The insurer should maintain a checklist for all relevant documents needed. This should be completed and dated for all legitimate claims.

5.9 The insurer should advise the policyholder or claimant of the consequences of submitting a false or incomplete statement (which may include criminal prosecution).

5.10 If a claim involves more than one insurer, the lead insurer or brokerage where applicable, should contact the other insurer(s) within two business days of the initial notification.

5.11 The insurer should inform the policyholder or claimant if an adjuster will be engaged to conduct a survey and/or an assessment. Where the insurer uses

claims adjusters or other intermediaries, the insurer must be satisfied as to their competence and qualifications and should use only persons who are registered under the Act[9] for these purposes. In the case of a catastrophe or where there is a complex claim or a major loss, the insurer may retain the services of a foreign adjuster who is in good standing with his governing body and regulatory authority[10].

5.12 The insurer should hire the adjuster within two business days from the date of receipt of the completed claim form accompanied by all relevant documentation. In the case of a catastrophe or where there is a complex claim or a major loss, the insurer, brokerage or adjuster should hire the foreign adjuster within ten business days.

5.13 The adjuster should submit the assessment of damage report within five business days of receiving the instructions from the insurer. In the case of a catastrophe or where there is a complex claim or a major loss, the foreign adjuster should submit the assessment of damage report to the insurer, brokerage or adjuster within twenty business days after having received from the insurer, brokerage or adjuster written instructions and written proof of authority to represent the insurer, brokerage or adjuster. The foreign adjuster must, upon demand, provide such proof of authority along with a photo ID to the policyholder or claimant.

5.14 The Inspector may extend the period of time for the submission of the assessment of damage report by the foreign adjuster to the insurer, brokerage or adjuster as he sees fit, based on a written request prior to the end of the twenty business day period, including justification, by the insurer.

5.15 Within two business days of receipt of the assessment of damage report, the insurer should notify the policyholder or claimant as to the sum of the offer, and if accepted, as to when the claim will be paid.

5.16 In instances where the insurer does not engage the services of an adjuster or a foreign adjuster for a complex claim or major loss, the insurer should conduct the investigation into the reported loss within ten business days of receipt of a claim form accompanied by all relevant documentation.

[9] Refer to Sections 110 to 116 of the Act.

[10] Refer to Section 140(2) of the Act.

## 6. CLAIMS PROCESSING

6.1 On receipt of a claim, the insurer should establish a claim file which at a minimum should contain the following information:

- Policy number;
- Name of policyholder or claimant;
- Information on claimants;
- Description of the loss;
- Claim file number;
- Claim form;
- Checklist of all relevant documents;
- Progress report schedule;
- Opening date of the file;
- Initial value of the claim reserve and any subsequent changes;
- Reporting date;
- Request for an adjuster or investigator;
- Date on which the adjuster's report is received;
- Electronic and/or paper copy of the adjustors' and investigators' reports where applicable;
- Dates and amounts of payments;
- Date of denial of claim, if applicable;
- Reasons for denial or reduced settlement;
- Name of broker or agent, if applicable;
- Documents recording contacts with the policyholder;
- Documented evidence of agreements or settlements;
- Claims discharge form and/or acceptance form;
- Date of file closure;
- A record of all communications whether formal or informal; and
- Any other information pertinent to the claim.

6.2 The insurer should update the claim file as necessary, and document all actions taken as part of the claims management process in order to be able to address questions that may arise concerning the handling and settlement of the claim.

6.3 If it is determined that the claim is not covered by the insurance policy or denied, the insurer should notify the policyholder or claimant in writing stating the policy provisions, conditions or exclusions on which the claim is being denied. This should be done within two business days of the date of determining the invalidity of the claim.

6.4 The insurer should not dissuade policyholders or claimants from obtaining the services of an attorney, adjuster or the Financial Services Ombudsman.

6.5 The insurer should not deny a claim without reasonable and comprehensive investigation.

6.6 The insurer should keep the policyholder or claimant informed of the status of the claim and should provide explanations for any delays.

6.7 The insurer should inform the policyholder or claimant when it decides to appoint an independent expert (for example, loss adjusters, attorneys-at-law, surveyors) and explain the reasons and role of these persons in the assessment of the claim.

6.8 The insurer should implement a management reporting system to track the timeliness of claims settlement and other pertinent information. Management should receive and review periodic reports which at a minimum should include:

- The aging of outstanding claims;
- Claims reported but not yet admitted;
- Claims reported but not yet paid; and
- Adequacy of case reserving.

## 7. CLAIMS SETTLEMENT

7.1 When an insurer makes an offer of settlement, the insurer should disclose to the policyholder or claimant the basis used for the offer of settlement.

7.2 The insurer should not settle a claim for less than the amount to which the policyholder or claimant would be entitled to receive under the terms of the insurance contract.

7.3 After an agreement has been reached between the insurer and the policyholder or claimant on the amount of the claim, the insurer should effect

the payment within three business days.

7.4 In instances where the insurer cannot settle the claim within three business days of the date of the agreement, the insurer should notify the policyholder or claimant in writing, stating the reasons for delay and indicating the earliest timeframe in which the claim will be paid.

7.5 In the case of claims settlement procedures involving other insurers, the claim should be settled with the policyholder or claimant in an appropriate time period while potential disputes with respect to subrogation between insurers are resolved.

7.6 The insurer should ensure that once an agreement has been reached and payment effected, a copy of the release signed by the policyholder or claimant should be retained on the policyholder's or claimant's file.

## 8. COMPLAINTS AND DISPUTE RESOLUTION

8.1 Each insurer should establish well-documented procedures for complaint and dispute management to ensure, as far as possible, that such situations are resolved promptly and fairly. As a minimum, the procedures should include:

- Acknowledgement of receipt of the complaint within an established period of time;
- Details of how the policyholders or complainants will be kept informed of the status of their complaint;
- Information to complainants on how and when to access the services of the Financial Services Ombudsman as an alternative dispute resolution mechanism; and
- Establishment of the time period for sending a final response in writing to the complainant.

## 9. CLAIMS RESERVING METHODS AND DOCUMENTATION

9.1 Insurers should have appropriate claims reserving policies and procedures approved by its Board of Directors, which should be reviewed at regular periodic intervals. At a minimum, such policies should include the following:

- The date on which the reserve should be initiated;
- The process to be followed to adjust the initial reserve amount;

- The measurement method to be used (case estimates and or any triangulation estimate); and
- Authorization limits to adjust reserves.

9.2 An insurer carrying on general insurance business should have documented methods for quantifying claim reserves determined pursuant to the requirements of section 212 of the Act. The reserve should be:

- Established upon the notification of a claim;
- Updated when additional information is received to ensure that it reflects the anticipated extent of the liability; and
- Reviewed on an on-going basis.

The insurer should therefore develop a proper procedure for the coding and statistical processing of losses using their information technology systems. This would involve the use of claims reserving methods such as case estimates and/or triangulation estimates per class of business.

## 10. INTERNAL CONTROLS

10.1 There should be a complete record of each claims transaction which evidences adherence to this Guideline.

10.2 The insurer should have documented internal policies and procedures for the fair, prompt and efficient handling of claims, including complex claims and claims for major losses. These internal policies and procedures for claims should also include criteria for determining a complex claim or major loss. Such policies should be approved by the Board of Directors of the insurer and reviewed at regular periodic intervals. The insurer should ensure that its staff are aware of and adhere to these procedures. An officer of the insurer should be responsible for the maintenance of the manual of policies and procedures and should ensure that additions or amendments are made when necessary.

10.3 Information to be detailed in the manual of policies and procedures should at a minimum include:

- Clearly defined levels of authority;
- Claims settlement procedures, including loss estimation and investigation procedures;

- Procedure for rejecting claims;
- Dispute resolution procedures;
- Method for monitoring compliance with claims management processes and procedures; and
- Segregation of duties in the claims department.

10.4 All staff involved in the claims handling process should possess suitable qualifications and/or experience. The insurer, brokerage or agency should provide training on an ongoing basis for its claims staff.

10.5 The insurer should ensure that the work programme of the internal auditor includes a review of the claims settlement process and reserving for claims.

10.6 The insurer should establish, implement and update a statistical database to track how long they take to settle claims as well as the trends in settlements and expenses. Senior management should receive periodic reports on the time taken to process claims and appropriate action taken where necessary. The Board of Directors of the insurer should also receive reports on a periodic basis on claims management.

10.7 The insurer should have written internal policies and procedures for identifying and treating with fraud associated with claims. These procedures will serve to minimize the incidence of fraudulent claims and the resulting rise in premiums.

10.8 The insurer should ensure that members of staff in their claims department are aware of, and follow the company's internal policies and procedures on fraud and are adequately trained to recognize the early warning indicators.

10.9 The insurer should ensure that regular periodic reviews are done on the claims assessment process. This should include revisiting the valuation and assessment basis for certain types of claims on an ongoing basis and having the internal audit department conduct examinations on the process.