

**OECD Guidelines for Good Practice
for Insurance Claim Management**

These Guidelines, prepared by the OECD Insurance Committee, were adopted by the OECD Council on 24 November 2004.

INTRODUCTION

Insurance claim management is a core issue for the protection of insurance policyholders and hence a priority concern for the OECD Insurance Committee. From the insurance company viewpoint, claim management is a key element in the competition between insurance providers and for the improvement of industry's public image.

To date, however, there has been no international guidance on claim management, and very little comparative information at the international level to allow the sharing of experience between countries in this key area of insurance activity. This is a matter of concern since most policyholder complaints focus on claim management, suggesting there is room for improvement in this area of client service.

The Insurance Committee therefore decided in June 2000 to launch a project on claim management in OECD countries designed to collect information on Member country claim management practices and to explore the scope for international co-operation to improve the quality of claim management processes. On the basis of a survey on Member countries' regulations and practices related to claims handling by insurance companies, the Committee's Working Party of Governmental Experts on Insurance developed a set of good practices to guide both public authorities and insurance companies.

These good practices address every step of the insurance claim management process that Working Party experts had identified as particularly important: adequate information and assistance to the policyholder for claim reporting; efficient claim filing methods; operational fraud detection and prevention measures; adequate, fair and transparent claim assessment and processing; expeditious claim settlement; effective complaint and dispute settlement procedures; and appropriate supervision of claims-related services.

The OECD good practices on claim management are neither binding nor exhaustive, but meant as a "checklist" to assist insurance companies in handling claims. Other appropriate ways to manage claims may exist and may already be reflected in a country's national laws and regulation and/or in company or industry codes of conduct. Insurance companies could also go further, for instance through the launch of public awareness programmes on claims management issues.

**RECOMMENDATION OF THE COUNCIL
ON GOOD PRACTICES FOR INSURANCE CLAIM MANAGEMENT**

THE COUNCIL,

Having regard to Article 5b) of the Convention on the Organisation for Economic Cooperation and Development of 14 December 1960;

Considering that insurance claim management is a core issue for the protection of insurance policyholders;

Considering the need for enhanced efficiency, transparency and disclosure of information to policyholders during the claim management process,

Considering that claim management is a key element in the competition between insurance companies and for the improvement of industry's public image;

Considering that such good practices are expected to fill a gap at the international level by providing further guidance for the benefit of the insured and that their implementation would further the quality of the service provided by insurance companies; noting that the companies could also go further, for instance through the launch of public awareness programmes on claims management issues;

Considering that the good practices presented hereafter are neither binding nor exhaustive;

Considering that such good practices provide a checklist which can be recommended to insurance companies and public authorities in the field of insurance claim management, while other appropriate ways to handle claims management may exist and may already be reflected in a country's national laws and regulation and/or in company or industry codes of conduct.

Noting that these practices do not cover the management of major claims arising from natural or man-made catastrophe;

Recognising that innovations may occur in the claim handling process, which may require future updating of these good practices;

On the proposal of the Insurance Committee:

RECOMMENDS that Member countries invite public authorities and insurance companies to ensure the efficient and fair management of insurance claims, having regard to the contents of the Annex to this Recommendation of which it forms an integral part.

INVITES non-Members to take account of the terms of this Recommendation.

ANNEX

Good practice 1: Claims reporting

The insurance company writes insurance policies in easily understandable language. Policies spell out what is covered and what is not covered. If necessary, plain language explanations could be an addendum to the legal language.

The insurance company draws the attention of the policyholder/claimant/beneficiary¹ both when he/she signs a policy (for policyholders only) and when he/she reports a loss on his/her duties related to claim reporting which include:

- To try to minimise losses;
- To report claims in a timely fashion;
- To co-operate in the investigation by providing the company with all relevant information and, in particular, copies of official documents regarding the damage (accident, loss, etc.);
- To authorise the company to handle necessary inspections and assess the extent of the damage prior to any repairs or replacement;

To ensure that the claims reporting phase proceeds as smoothly as possible, the insurance company sends to the policyholder/claimant/beneficiary within a reasonable period of time (beginning from when the loss is reported):

- An appropriate claim form (when the loss reporting is made in writing) for the type of policy - prepared either by an individual insurance company or at the national level by companies or the supervisory authorities together with instructions and useful information on how to comply with the terms of the policy and the legitimate requirements of the company;
- The information necessary to help them to report the claim.

Good practice 2: Receipt of claims by the company

- The company claim department and/or the intermediary (if applicable) are as accessible as possible for the claimant. If an intermediary is an initial contact for claimants, claims should be sent to the company claim department within an appropriate time period.
- The insurance company contacts the policyholder/claimant/beneficiary or sends an acknowledgement of receipt as soon as the claim is received.

¹ Depending on the context, one or all of these potential counterparts may be relevant.

- Subsequently, if it appears that the claim cannot be settled rapidly, the company notifies the policyholder/claimant/beneficiary and indicates that he/she will be re-contacted within a reasonable time limit.
- When it is necessary for the policyholder/claimant/beneficiary to provide specific documents when filing a claim, the company sends him/her the list of these documents as soon as possible. In addition, a specific notification listing the elements to be provided when another insurance company is involved is sent to the policyholder/claimant/beneficiary.
- If it appears that the claim is not covered by the insurance policy, the company sends a notification as soon as possible to the policyholder/claimant/beneficiary, explaining why it is not covered.
- When the claimant is not the policyholder, the company sends him/her information on his/her rights and duties when relevant.
- When appropriate, the insurance company notifies the policyholder of his/her right of subrogation and informs him/her of the main principles governing the subrogation procedure.

Good practice 3: Claims files and procedures

Once a claim has been filed and, when applicable, after any additional documents that are required to process the claim have been received, the file established by a company contains the following documents:

- Claim filing number;
- Policy number;
- Name of the policyholder/claimant/beneficiary;
- Summary sheet showing development / review of the claim;
- Type of insurance concerned;
- Opening date of the file;
- Date of loss;
- Reporting date;
- Description of the claim;
- Information on claimants;
- Assessment date;
- Electronic and/or paper copy of the adjustors' and investigators' reports where applicable;
- Identity of the adjuster;
- Estimated cost of damage;
- Dates and amounts of payments;
- Date of denial, if applicable;
- Name of intermediary, if applicable;
- Date of file closure;
- Documents recording contacts with the policyholder/claimant/beneficiary.

Good practice 4: Fraud detection and prevention

In order to curb the growth of fraudulent claims and the rise in premium costs that results from them, companies take the following steps:

- They establish compliance programs for combating fraud and money laundering appropriate to their exposure and vulnerabilities.
- In the claim filing phase, they discourage fraudulent practices by making the policyholder/claimant/beneficiary aware of the consequences of submitting a false statement (which in particular could be liable to prosecution) and/or an incomplete statement. To this end, insurance companies place a notification on their claims forms referring to the appropriate law, statute or insurance regulation that addresses the filing of fraudulent or incomplete claims.
- Where legally possible, companies participate in relevant databases where claims susceptible to be fraudulent would be reported. Moreover, public authorities may encourage or take steps to initiate the creation of a public or private bureau of insurance fraud.
- Besides, companies provide their claims department staff with adequate training on fraud indicators.

Good practice 5: Claims assessment

General issues:

- Any method of taking into account specific factors such as depreciation, discounting or negligence on the part of the victim is clearly outlined in the claim file.
- Any loss evaluation methods used by the company are reasonable and coherent.
- The insurance company uses internal methods for assessing claim values based on the applicable law of the jurisdiction.

The role of claims adjusters:

- Companies that use claims adjusters or intermediaries will need to ascertain their competence qualifications. Moreover, if these claims adjusters/intermediaries were to commit any errors or misappropriation of funds affecting their policyholders, claimants or beneficiaries within the framework of the contract² with the insurance company, the latter would be held responsible. Consequently, companies may decide to limit the scope of action of claims adjusters and intermediaries (for example, by setting ceilings on the number of claims they can handle).
- Companies notify policyholders/claimants/beneficiaries whenever they use independent claims adjusters or intermediaries.

Information to policyholders:

² Including employment contracts

When the damage is assessed through a written estimate made on behalf of the insurer, the insurer sends the policyholder/claimant/beneficiary a copy of the document used to set the amount of compensation.

Good practice 6: Claim processing

General issues:

- A company’s claim procedures are gathered together in a manual for internal use. At least, one staff member should be responsible for ensuring that the manual is kept up to date and additions/amendments are made when necessary.
- Companies’ claims department staff possess proper qualifications. To this end, companies encourage ongoing internal or external training of their claim staff.
- Regular internal audits are carried out for all claims not settled in their entirety. Internal audits apply to all stages of the claims management process. Peer reviews (where the claims department staff review each others’ files) could also be carried out.
- In case of claim settlement procedures involving several insurance companies, policyholder indemnification is a priority: the claim should be compensated in an appropriate time period while potential disputes between insurers are resolved at a later stage. For the most common insurance claims (related to motor insurance, for instance), specific agreements are concluded between insurers to accelerate and simplify claims settlement procedures involving several insured parties.
- Insurance companies do not:
 - Conceal policy coverage provisions of any insurance policy when they are pertinent to a claim.
 - Dissuade policyholders/claimants/beneficiaries from obtaining the services of an attorney or adjustor.
 - Attempt to settle claims for less than the amount to which the claimant would be entitled to receive according to any written or printed advertising material accompanying the application forms. However, insurers may take legal action against any intermediary that has made irresponsible promises.
 - Deny a claim without reasonable investigation.
 - Transfer responsibility for the claim to others, except as may be expressly provided for by policy conditions.

Provision of information to policyholders:

- The company keeps policyholders/claimants/beneficiaries informed of the progress during the claims process. The company provides information on when payments, repairs or replacements are expected to be made, and, if necessary, explains why additional time is required.

- When the company decides to call on outside parties (i.e. loss adjusters, solicitors, surveyors, etc.), it informs policyholders/claimants/beneficiaries of this fact, gives the reasons for this decision and explains the role that these outside parties will play in processing the claim.
- When a final payment or offer of settlement is made, the company explains to policyholders/claimants/beneficiaries what the payment or settlement is for and the basis used for the payment/settlement.
- The insurance company documents their claim files in order to be able to address questions that may arise concerning the handling and payment of the claim.

Cases of no/partial payment claims:

- If the claim is denied, the insurance company states explicitly to the policyholder/claimant/beneficiary the policy provision, conditions or exclusion on which the denial is based.
- If the amount offered is different from the amount claimed, the insurance company explains the reason for this to the policyholder/claimant/beneficiary.
- When the insurance company is not responsible (by virtue of policy clauses) for meeting all or any part of the claim, it notifies the policyholder/claimant/beneficiary of this fact and explains why.

Good practice 7: Timely claim processing

- In accordance with applicable insurance law, companies may specify in the contract the most likely period of time for responding to correspondence from policyholders/claimants/beneficiaries.
- Once policyholders/claimants/beneficiaries have filed a claim:
 - They are informed of the acceptance or denial of the claim within a reasonable amount of time after the receipt of the notification.
 - The insurance company contacts any other company that is involved in the claim within a reasonable amount of time, and resolves inter-company claim disputes as quickly as possible.
- The insurance company endeavours to settle the claim as soon as possible and advises in writing the policyholder/claimant/beneficiary on the reasons for any delay.
- Quick claims settlement as well as high-quality and punctual information provided to the policyholder/claimant/beneficiary are key competition features for insurance companies.
- After an agreement has been reached between the company and the policyholder/claimant/beneficiary on the amount of compensation, the payment is effected within a reasonable amount of time.
- Insurance companies implement and update their own statistical database tracing their performance in the timely settlement of claims as well as in trends in settlements and expenses. A proper procedure for the coding and statistical processing of losses is developed for this purpose.

Good practice 8: Complaints and dispute settlement

Complaints/Disputes:

- When the policyholder/claimant/beneficiary files a complaint, the company:
 - Acknowledges receipt of the complaint within a reasonable period of time;
 - Provides policyholders/claimants/beneficiaries with explanations on how their complaints will be handled and on the procedures to be followed;
 - Provides information to policyholders/claimants/beneficiaries on internal and external dispute settlement procedures;
 - Processes complaints promptly and fairly;
 - Keeps policyholders/claimants/beneficiaries regularly informed of how their complaints are progressing;
 - Provides a final response in writing within a reasonable period of time.
- If the policyholder/claimant/beneficiary is dissatisfied with the final response that he/she has been sent by the company, he/she can activate an internal appeals process. He/she can also appeal to the dispute settlement procedures available outside the company (for example, the handling of complaints by the supervisory authorities). In case of a dispute, the insured/claimant/beneficiary should be informed by the company of the existence of these appeal procedures.

Good practice 9: Supervision of claims-related services

The insurance supervisory authorities may conduct examinations on claims management services especially where problems are suspected.

In these cases, the following elements are taken into account:

- Possible access to non-confidential claims data for all open and closed files within a specified time frame (e.g. for the current year and the two preceding years);
- Maintenance of sufficient and appropriate information on claims files;
- Use of the appropriate type of claim form for the type of insurance;
- Proper qualification of the claims department's employees based *inter alia* on the applicable insurance code;
- Valuation of claims payments according to company procedures;
- Appropriate tracking of the nature and number of complaints related to claim management process;
- Monitoring of the proportion of claims that result in litigation;

- Compliance with procedures for combating fraud and money laundering;
- Regular internal audit practices on claims files;
- Appropriate internal claims procedure manuals;
- Proper procedure for coding and statistical reporting of losses;
- Performance in terms of the speed of claim settlements (as assessed according to the statistical database implemented by virtue of item 7).

Good practice 10: Market practices

The public authorities promote the implementation of a benchmark exercise regarding the claims process or a specific part of this process (i.e. handling of complaints).

The terms of remuneration of insurance company employees or other services in charge of claim management do not give incentives to disadvantageous treatment of policyholders/claimants/beneficiaries, as regards the handling or the outcome of claims.