

فراخوان ترجمه کتاب



پژوهشکده بیمه، به منظور کمک به گسترش دانش بیمه‌ای، ترجمه کتاب

Insurance claims handling WCE

را در دستور کار خود قرار داده است. لذا از کلیه اساتید، پژوهشگران، صاحب‌نظران و کارشناسان دعوت می‌شود که در صورت تمایل به ترجمه کتاب مذکور، کاربرگ درخواست ترجمه پیوست را به همراه سوابق علمی و اجرایی خود و ترجمه صفحات ذکر شده با ذکر عنوان کتاب، حداکثر تا تاریخ ۱۴۰۵/۰۳/۲۰ به آدرس ایمیل nashr@irc.ac.ir ارسال فرمایند.

کاربرگ درخواست ترجمه کتاب

Insurance claims handling WCE

عنوان کتاب:

سال نشر: ۲۰۲۵

ناشر: Chartered Insurance Institute (CII)

الف - اطلاعات عمومی

نام و نام خانوادگی	
شغل و سمت فعلی	
مرتبه علمی (ویژه اعضای هیات علمی)	
آخرین مدرک تحصیلی و رشته	
آدرس	
شماره تماس ثابت	
شماره تماس همراه	
پست الکترونیک	

ب - سابقه تألیف/ترجمه (حداقل ۳ عنوان از آثار خود را اعلام بفرمائید)

ردیف	عنوان کتاب/ترجمه	سال انتشار	ناشر

ج - سابقه اجرایی

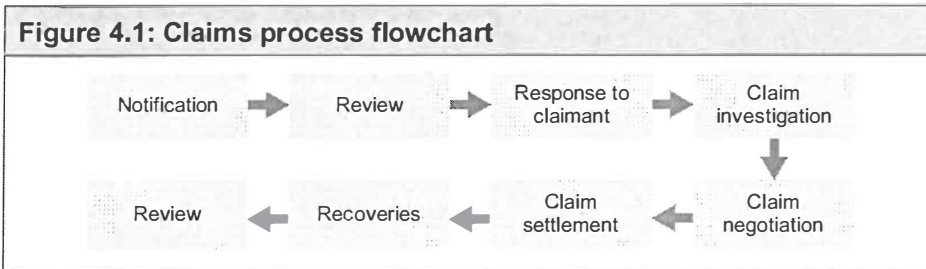
ردیف	محل خدمت	مدت زمان خدمت

Introduction

Chapter 2 detailed the various classes of insurance and the cover available for each class. This chapter will deal with class-specific claims matters to provide an insight into the varying characteristics of the claims processes.

We will demonstrate that each class of business will result in claims being notified, but each will call for a different response from the insurer. For example, a minor rear-end collision motor claim in which no-one was injured. This could be settled in a few days if the insurer were proactive. Compare this to a fatal accident under a liability policy, which may take years to resolve and would require a different level of sophistication and expertise.

The claims process can be summarised using the following flowchart.



The chapter will be split into:

- personal lines (i.e. insurance of the person and their belongings); and
- commercial lines (i.e. insurance of businesses).



Key terms

This chapter features explanations of the following ideas:

Authorised repairers	Claims-made basis	Losses-occurring basis	Risk control
Uninsured loss recovery			

For reference only

A Personal insurance

We will deal here with:

- private motor claims – cars and motor cycles;
- health – personal accident and sickness;
- household – contents and buildings;
- travel; and
- extended warranties.

A1 Private motor claims – cars and motor cycles

The considerations for both cars and motor cycles will be the same, subject to certain policy differences. We outlined these in chapter 2.

There are seven aspects to the claims process.

1.	The insured is bound by the claims notification policy condition to report all accidents. This applies whether or not they intend to claim or expect a third party to claim against them.
2.	At notification, the insured may be required to complete an accident report form (ARF) which could be done over the telephone or internet.
3.	When the insurer has received the necessary information, it will set up a file. In practice, this is likely to be electronic and no longer a physical paper file.

4.	If a claim is to be made, the insurer will firstly establish whether a policy is in force and whether the insured is entitled to an indemnity. Depending on the nature and size of the claim it may be investigated. This could be done as a desktop exercise by the insurer or else a claims investigator or loss adjuster may interview the drivers and witnesses, as well as visit the accident scene. If there is a valid claim, repairs to the insured's vehicle will take priority. The repairs are often carried out at the insurer's own authorised repair centres.
5.	If there are claims under other sections of the policy (for example, for property in the vehicle that was damaged in the accident), these are reviewed as necessary.
6.	A third party may claim for damage to their vehicle or there may be damage to other property, such as a boundary fence or hedge. The third party will generally be required to submit estimates for the repair or replacement of the damaged items, which the insurer will consider and either approve or renegotiate. It will establish who was at fault or ascertain the degree of negligence by each party. If the insured is at fault, the insurers may offer to proactively handle the third party claim as a way of controlling costs.
7.	If a third party is injured in the accident, claims can be complex and costly to settle. The degree of negligence must be established before consideration is given to the extent of the injury, the medical prognosis, and other relevant considerations (e.g. whether the claimant was unable to work, or had required care whilst incapacitated). A claims handler must be able to analyse this information and place an accurate valuation against the injuries in line with current damages awards made by the courts in order to negotiate settlement of the claim. Considering the complexities and the amount involved, opinion of Orthosurgeon or respective speciality can be taken to confirm the diagnosis, nature (temporary/permanent) and the extent of the disability.

Where the insured has non-comprehensive cover (i.e. third party, fire and theft or third party only), they must still report the incident to their insurer as one of the claims conditions. However, the insurer will take no further action in respect of any damage to the policyholder's own property, because they have no cover for this. The insurer would only deal with third party claims, subject to liability. The insured would have to make a claim against the responsible party or their insurer where they would be dealt with as the 'third party' as discussed above.

Refer to

Subrogation is covered in *Recovery* on page 6/6

Where an insured has comprehensive cover and has a claim against a liable third party, their insurer would utilise the subrogation condition in the policy to recover the costs they have incurred.

Consider this...

What rights does the subrogation clause give the insurer?



For reference only

A2 Health claims

Health claims are those regarding personal accident and sickness policies. The handling of such claims is vastly different from those under indemnity policies. This is because they are benefit policies and the settlement figure has already been agreed at policy inception.

When a health claim is submitted, the insurer will check that a valid contract was in force and that the policy conditions have been met. The appropriate supporting evidence must be provided and this includes the following. If the insured:

- has died as a result of an accident or sickness, there may be a coroner's inquest and a post-mortem examination, and a death certificate must be provided;
- suffered the loss of a limb or limbs, sufficient proof must be provided; and
- is temporarily or permanently disabled, they must provide a medical certificate and be in the care of a registered doctor.

The insurer may wish to involve its own investigators to confirm the extent of any illness or disablement.



Question 4.1

Why are personal accident and sickness policies always benefit policies rather than indemnity policies?

- a. Because insurers want to pay the minimum amount possible.
- b. Because the loss of a limb or health is something it is impossible to put a financial value on.

A3 Household claims

A3A Contents

Household contents are divided into two categories:

1.	Durable goods	Things like household furniture, refrigerators and freezers etc.
2.	Consumer goods	Less durable items that are likely to wear out more quickly, such as curtains, towels and clothing

Most insurers will state in their policy wordings that claims for durable goods are generally settled on a 'new for old' basis. This means that damaged goods will be replaced by new items, rather than the claim being settled on an indemnity basis.

Claims for consumer goods are generally settled as new for old or on the basis of the cost of replacement, less wear and tear, according to their age. A claims settlement on this latter basis is more likely to lead to disagreements between the insurer and the policyholder, unless the policyholder's expectations are well managed.

A3B Buildings

Claims under the buildings section of the household policy are usually settled by repairing the buildings. Practically speaking, the indemnity sum for the loss or damage to the buildings has been calculated as the cost of repair or reinstatement at the time of loss **less** an allowance for betterment. Usually a loss adjuster is used to provide an expert's opinion as to any substantial damage.

Betterment arises when certain aspects of the repaired property are in a better condition than they were before the loss (for example, the installation of new wiring) or the repaired/ replaced article is better than the original one was when new, e.g. double glazing replacing an old single-glazed window.



Consider this...

Think back to the definition of 'indemnity'. Why is an allowance for betterment subtracted from the indemnity sum?

The principle of indemnity states that the insured must be placed in the same financial position after a loss as they enjoyed before the loss. Such improvements to their property would increase the value of the property leaving the insured better off than before the loss. This is against the principle of indemnity.

For reference only

A4 Travel claims

The processing of travel claims will depend on which section of the policy the claim is covered. Claims for:

- **personal accident or sickness benefits.** The considerations that apply to health claims will generally apply;
- **travel interruption or delay.** The insurer can make its own enquiries with the travel authorities or ask that the insured obtains the necessary proof;
- **medical and associated expenses.** Usually authorised prior to treatment so that costs can be controlled, and emergency medical expenses claimed after treatment are scrutinised prior to payment: and

- **baggage, personal effects and money.** The insurer will usually request proof of purchase for the items claimed for, together with confirmation that the loss has been reported to the necessary authorities.

A5 Extended warranties

Claims under extended warranty policies are unlike those we have already discussed. A claims 'settlement' would result in the covered appliance being repaired or replaced. Because there is no cash incentive to be gained, these policies are not subject to fraudulent claims as frequently as other lines, like household or motor insurance.

It is very seldom that a claim form is even required, and a telephone call to the issuing company is usually the only action required by an insured. The issuing company will then instruct a repairer to attend the insured's premises and carry out the necessary repairs, which can sometimes be subject to an excess.

A6 Creditor insurance

Creditor insurance provides protection to the policyholder in the event that they are unable to repay a loan due to their death, disability or losing their job. Before settling any claims on a creditor insurance policy the insurer will require:

- proof that the insured is not working; and
- evidence of the payments that the insured needs to make.

B Commercial insurances

This section will cover:

- property claims – fire and special perils, all risks, theft, glass and money;
- pecuniary claims – legal expenses and business interruption;
- liability claims – employers', public, products and professional indemnity; and
- commercial vehicle claims.

B1 Property claims

B1A Fire and special perils

In the event of loss or damage, the insured has a duty to:

- notify the insurer immediately;
- mitigate their losses, i.e. carry out, or permit to be carried out, any reasonably practical action to prevent further damage;
- deliver to the insurer full information about the property lost, destroyed or damaged and the amount of damage, in writing; and
- provide proof of loss (e.g. a builder's estimate for repair) and, if required, complete a statutory declaration of the truth of the claim.

The insurer would then establish the following.

1.	Whether the policy is in force
2.	Whether the claim is valid (i.e. an insured peril caused the loss)
3.	Whether the policy covers the loss

If the claim is large, the insurer will usually appoint an independent loss adjuster. The loss adjuster investigates the loss and prepares a report recommending the amount payable under the terms of the policy. They investigate the cause of the loss as well as its extent, and check that the insured has complied with any related endorsements or warranties. The loss adjuster also advises on any recovery prospects.

The insured may appoint a loss assessor to act on their behalf and negotiate with the adjuster and/or the insurers.

Sometimes, a monetary payment is made. Otherwise, the insurer may exercise its options by reinstating the building or replacing, repairing or restoring the property, as appropriate.

B1B All risks claims

The procedure for claims here is the same as that described for fire and special perils insurance. For larger claims, an insurer usually appoints a loss adjuster who will ensure that the claim is valid and negotiate settlement on the insurer's behalf.

B1C Theft claims

For theft claims, the insurer requires the insured to notify the appropriate authorities (i.e. the police) of the theft. Insurers often request a copy of the police report and, especially with larger claims, appoint a loss adjuster or, if fraud is suspected, a specialist claims investigator. The insurers then usually liaise with the police so that if the stolen goods are recovered, the insurer can claim them as salvage.

B1D Glass claims

It is usual for insurers to have approved repairers for these claims. As there is little financial incentive to be gained and claims can rarely be 'overstated', when the insurer has satisfied itself that the claim is covered, repairs will usually be authorised. The invoice from the repairer will be sent directly to the insurer. Glass claims are usually subject to an excess to avoid small claims.

B1E Money

When the insurer has completed its standard investigations in respect of cover, it will request proof of loss, including:

- proof that the money, cheques or stamps etc. were on the premises;
- details of the occurrence; and
- confirmation that the matter has been reported to the authorities.

There is great scope for abuse here, and insurers will want assurance that there is no fraud involved. If necessary, specialist investigators will be enlisted to assist their enquiries.

B2 Pecuniary insurance

B2A Legal expenses

Claims under such policies are different from other claims. This is because an insurer can assess its potential liability before the claim commences. The insured has an obligation to notify their insurers before action is commenced and the insurer can then take any steps it deems appropriate. This includes things such as appointing its own solicitors and, if appropriate, co-operating with the insured in attempting to reach a settlement before the court action starts.

B2B Business interruption (BI)

Business interruption insurance covers the insured's loss of profits following damage to their property caused by the action of an insured peril.

Consequently, there is always a property damage proviso in a business interruption policy, i.e. the underlying property must be insured before an interruption policy is issued. Both policies are usually with the same insurer and the BI claim will be run in conjunction with the property damage claim.

BI claims are unique, in that at the proposal stage questions are asked about how the proposer will react in the event of a claim. Examples of such questions would be:

- have they got alternative premises;
- how soon can they get up and running; and
- is there a detailed disaster recovery plan?

The insurer can 'participate' in the claim here because, unlike any other type of claim, the indemnity period selected (usually 12, 24 or 36 months) represents the maximum length of the claim. The insurer can, and often does, have representation to minimise the loss.

B3 Liability claims

Liability losses are claims arising out of legal liability for incidents involving injury to third parties (including employees) or damage to their property.

Employers' liability insurance covers indemnity against bodily injury or disease sustained by the insured's employees arising out of, and in the course of, their employment. It is common for this policy to be combined with a public liability policy. Employers' liability claims are a particular concern in industries with a high incidence of accidents or disease, e.g. mining.

Public liability policies cover loss of or damage to third party property and/or third party injury caused by the insured's negligence or breach of statutory duty. This is often combined with product liability insurance, which provides the same cover, but for losses arising out of the sale or supply of the insured's product.

Professional indemnity policies protect the insured against their legal liability towards third parties for injury, loss or damage arising from their own professional negligence, or that of their employees. Liability usually arises from breach of contract, though it can also arise from negligent misstatements or a breach of the duty of care.

It should be noted that professional indemnity insurance is generally written on a *claims-made basis*. This means that, provided a claim is made during the period of insurance, it does not matter when the event leading to the loss took place. For this reason, it is important for professional indemnity claims adjusters to consider whether the policy was in force at the time the claim was made against the insured. The exact claims notification required depends on the policy terms.

It is also common for product liability policies to be written on a claims-made basis, though it can be written on an occurrence basis too. Public and employers' liability policies are usually written on a **losses-occurring basis**.

Example 4.1

Jose is a solicitor. He has the following insurance history:

- In 2016 he had professional indemnity (PI) insurance with XYZ Insurance and public liability (PL) insurance with the same company;
- In January 2017 he moved both his PI and PL insurance to ABC Insurance.

His PL policy is written on a losses-occurring basis and his PI policy is on a claims-made basis.

In October 2016, two incidents occur:

- a client, Julia, trips over a loose carpet tile in his office, badly injuring her knee; and
- as a result of his bad advice another client, Roberto, loses a lot of money.

In March 2017 two claims land on Jose's desk: one from Julia desiring compensation for her injury and one from Roberto demanding compensation for his loss. Jose takes the following action:

- because his PL policy is on a losses-occurring basis he contacts XYZ Insurance as its policy was providing cover at the time the incident leading to the loss took place; and
- because his PI policy is on a claims-made basis he contacts ABC Insurance as this is the policy in force at the time the claim is made.

Simply put, the issue is as follows.

For policies written on a <i>claims-made basis</i> the questions are:	When was the claim made?
	Was it in accordance with the policy terms notified to the insurer?
	Did insurance cover exist at that time?
For policies written on a <i>losses-occurring basis</i> , the questions are:	When did the loss occur?
	Did insurance cover exist at that time?



For reference only

Once the insurer is satisfied that the loss is covered within the policy period a full investigation will be carried out. This will include:

- investigating what work was being carried out and whether it was included within the business description on the policy schedule;
- obtaining all relevant documentation; and
- interviewing any witnesses.

In practice, the insurer negotiates directly with the third party or their representative. The insured **must** immediately pass any claim made against them to their insurer, in accordance with the policy terms.

For third party property damage, insurers investigate the facts of the case and reach a decision on liability. This includes:

- a request for a written report of the negligence alleged against the insured;
- evidence to support the amount of the claim; and
- if required, an inspection of the damaged property.

Claims involving personal injury usually come from the third party's solicitors, who will obtain a medical report on the injury. Damages are paid to the claimant under two headings as follows.

Special damages	General damages
Those losses that can be quantified (e.g. medical expenses, future loss of earnings)	Less tangible losses, such as compensation for pain, suffering and loss of amenity (PSLA) and loss of use of vehicle

Some cases proceed to court. Once in court, a judge may:

- make a decision that allows for a reassessment after a period of time;
- award a single lump sum payment;
- allow a structured settlement, which provides an income to the claimant over a period of time; or
- allow a periodic payment which provides pre-determined sums at certain dates in the future.

For reference only

B4 Commercial vehicles

Refer to

Private motor claims discussed in *Private motor claims – cars and motor cycles* on page 4/2

The claims considerations here are essentially the same as for private motor vehicles. However, the insured will often arrange and pay for the repairs and then submit the invoice to their insurers for settlement, net of the excess. Many commercial vehicles require specialist repair, which may not be available at the insurer's authorised repairer.

C Related claims services

There are a variety of services that can be utilised in the claims handling and settlement procedures. In this section, we will deal with the following and their impact on the procedures:

- legal helplines;
- authorised repairers;
- uninsured loss recovery services;
- legal costs service;
- risk control/advice; and
- rehabilitation.

C1 Legal helplines and advice

A legal helpline is an advisory and/or assistance service provided by telephone. They are usually free to the user, and often operate 24 hours a day. The emphasis is on immediate practical action, which has the benefit of meeting customer expectations.

Helplines offer two main services:

- advice and assistance in respect of potential claims. This is especially relevant to the legal advice services offered in conjunction with legal expenses insurance; and
- advice only (usually legal advice).

Advisers will guide a policyholder through the legal process in a practical way. Calls may be made on common legal issues (such as boundary disputes) or more complex contractual implications and obligations. The helpline can help the insured pursue or defend a claim.

The three main elements in the majority of cases are as follows:

- Does the party in question have the basis of a claim in law?
- What legal rights are involved?
- What is the best way to enforce such legal rights if pursuing a claim?

Legal helplines often act as the first notification of loss (FNOL) stage for claims under legal expenses insurance policies. This is because advisers will have an understanding of the cover provided and whether there is a claim which can be settled by the insurer.

Refer to

Outsourcing considered in *Outsourcing companies* on page 5/8

Helplines are often outsourced to specialist providers because of their experience, economies of scale and IT specialisation.

C2 Authorised repairers

Insurers will often negotiate with various suppliers and/or repairers to provide services at a discounted rate, and at an agreed standard. This benefits the provider, the insured and the insurer.

Example 4.2

Mo has a household policy covering breakage of windows. A window is broken in an accident. Mo notifies the insurer, which has an agreement with a glazing service. The insurer confirms that the claim is valid and so a glazier visits Mo's premises and repairs the window. The glazier submits the invoice directly to Mo's insurer.



Such contractors or suppliers are termed **approved** or **authorised repairers**.

Motor insurance has the most prevalent use of approved repairers. Private motor insurers have a panel of authorised repairers and, when a claim is reported, insurers usually provide their insured with the details of such repairers in their area.

Consider this...

What are the principal benefits of a panel of approved repairers to motor insurers?



The main benefits of using approved repairers are:

- convenience;
- cost (a price reduction on labour and parts will normally be negotiated); and
- competence (as mentioned, approved repairers are vetted first and continuing quality control and monitoring takes place).

Tow-ins may also be arranged through approved repairers if a vehicle is not driveable. The use of equipment such as digital cameras mean that an insurer's engineer need not attend the repairer's premises to 'inspect' each vehicle and authorise repairs. The repairer will email