



IRA

**GUIDELINES ON CLAIMS MANAGEMENT
FOR THE INSURANCE INDUSTRY**

JUNE 2012

**TO: ALL REINSURANCE COMPANIES
ALL INSURANCE COMPANIES
ALL INSURANCE INTERMEDIARIES**

**RE: GUIDELINES ON CLAIMS MANAGEMENT FOR THE INSURANCE
INDUSTRY**

These Guidelines on Claims Management are issued pursuant to Section 3A of the Insurance Act for observance by insurance companies, reinsurance companies, intermediaries and insurance service providers.

These guidelines aim to enhance efficiency, transparency, disclosure of information to policyholders during claims processing and increase consumer satisfaction.

The Authority envisages that an efficient claims management process will result in improved service delivery to the public which will in turn create confidence hence improving the image of the industry.

To this end, the Insurance Regulatory Authority hereby issues these Guidelines on Claims Management to be effected from 1st July 2012.

A handwritten signature in black ink, appearing to read 'Sammy M. Makove', is written over a light-colored, irregularly shaped background that resembles a stamp or a piece of paper.

**SAMMY M. MAKOVE
COMMISSIONER OF INSURANCE & CHIEF EXECUTIVE OFFICER**

THE INSURANCE ACT (CAP 487)
CLAIMS MANAGEMENT GUIDELINES

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1.0 Authorization

IN EXERCISE of the powers conferred by sections 3A (a), (b) and (g) of the Insurance Act, the Insurance Regulatory Authority issues the Guidelines set out here below, for observance by insurance and reinsurance companies in Kenya (herein referred to as the insurers), intermediaries and service providers licensed under the Act , in order to enhance claims management in the industry.

2.0 General Introduction

The Insurance Regulatory Authority (herein referred to as the Authority) has a mandate to formulate and enforce supervisory standards for the conduct of insurance business in Kenya as well as to protect the interests of policy holders and insurance beneficiaries in any insurance contract.

The insurance industry has been faced with challenges in claims management which has contributed to poor image of the industry and low penetration of the insurance services. Most insurance complaints relate to claims management suggesting room for improvement in this area of client service.

The Authority has developed this set of claims management guidelines in order to enhance efficiency, transparency, disclosure of information to policyholders during the claims processing, and increase consumer satisfaction. These guidelines are also expected to enhance compliance with the provisions of Section 203 of the Insurance Act by the industry.

The Authority envisages that an efficient claims management process will result to improved service delivery to the public which will in turn create confidence hence improving the image of the industry and eventually lead to a deeper penetration level of insurance service.

The Board of Directors is ultimately accountable and responsible for the performance and conduct of the Insurer in respect to claims management. Delegating Authority to board committees or management does not in any way mitigate or dissipate the discharge by the Board of Directors of its duties and responsibilities.

3.0 Definitions

“Authority” means Insurance Regulatory Authority established under section 3 of the Insurance Act CAP 487 Laws of Kenya.

“Licensee” means any person that holds a license from the Authority or any other person where the approval of the commissioner is required and shall include the insurers, insurance intermediaries and service providers as licensed by the Authority.

“Claimant” means a person who has a right to a settlement arising from a contract of insurance.

“Complaint” means any communication that expresses dissatisfaction about an action or omission of a service and calls for a remedial action.

“Enquiry” means any communication from a customer for the primary purpose of seeking information about a company or services.

“Policyholder” means the person who for the time being is the legal holder of the policy for securing the contract with the insurer.

“Service Provider” means any person appointed to provide a service in facilitating a claim process.

4.0 Pre-loss information

4.0. The Insurer shall issue the insurance policy and provide instructions on what a claimant should do when a loss occurs.

4.1. Notwithstanding the generality of clause 4.1, the instructions shall provide information to the policyholders on the following;

- i. Loss minimization.
- ii. Reporting of the claim in a timely manner as provided for in the policy. The insured has an obligation to notify the insurer of the loss as soon as it occurs or as soon as reasonably possible. It should be emphasized to the insured that prompt reporting of the loss is important for preserving evidence that may be critical in determining admissibility and quantum of the claim.

- iii. The need for policyholders to cooperate in the investigations by providing the company with all facts & information and in particular official documents regarding the loss.
- iv. The need to allow the company to handle inspection and assessment of damage prior to settlement.
- v. The need to understand that they may be required to surrender their rights to the insurer for recovery after settlement of the claim under the principle of subrogation.

5.0 Loss notification & acknowledgement

- 5.1 Notification of the claim may be done as per the policy provided that the claimant shall use any fast means of communication to the insurer's designated contact person or department or through the intermediary by;
- (a) Direct reporting
 - (b) Telephone call
 - (c) Text message
 - (d) E-mail
 - (e) Fax
 - (f) Letter
 - (g) Use of social sites or websites
 - (h) Any other form of technology of wide usage.

Provided that where the mode of communication used lacks written evidence, the insurer shall inform the claimant of the need to follow up such communication with a letter and/or completion of the appropriate claim form.

- 5.2 Where loss notification is received by an insurance intermediary, such notification shall immediately be transmitted to the insurer, provided that an intermediary who contravenes the provision of this clause shall be liable for any of the enforcement mechanisms specified in clause 4.3 of the Guidelines on Market Conduct for Intermediaries.
- 5.3 Upon receipt of claim notification, the insurer shall take the following action immediately but not later than seven (7) working days;
- (a) Acknowledge the notification.

- (b) Avail an appropriate claim form and if specific documents are required when filing a claim, the insurer will provide a list of these documents.
- (c) Provide any additional information/advice that will assist in dealing with the claim.
- (d) Where applicable contact any other insurer that is involved in the claim within a reasonable time and resolve inter-insurance claim disputes as quickly as possible.
- (e) Appoint a service provider(s) as necessary.

6.0 Receipts of claims by the company

6.1 The insurer upon receipt of all the documents in clause 4.3 (b) shall;

- i. Acknowledge receipt of the documents within 7 days. The date of acknowledgement of the full documentation shall be construed to be the date of reporting of the claim within the meaning of section 203 (1).
- ii. If a claim is admissible and can be settled immediately without any further assessment, the insurer shall effect the settlement of the claim expeditiously.
- iii. If the claim is admissible but further assessment by a service provider is necessary to quantify the loss, the insurer shall promptly appoint a service provider and advise the claimant or the intermediary on the action being taken. The insurer shall upon receipt of the assessment report make an offer to settle the claim.
- iv. Where further investigation is necessary to determine admissibility of the loss under the policy, the insurer shall notify the claimant of this requirement, explain and emphasize to the claimant the need to cooperate with the investigators. Upon receipt of the investigation report, the insurer shall within seven days make an offer or communicate declinature and the reasons thereof.
- v. An admission of liability contemplated in section 203(1) shall be construed to mean performance of an act by an insurer that is consistent with the settlement of the claim and shall include but not

limited to making of an offer, issue of a discharge voucher, authorizing repair and replacements.

- vi. If in the opinion of the insurer the loss is not covered by the insurance policy, the insurer shall after exhausting their internal mechanisms on declining a claim, immediately send a notification to the claimant and/or the intermediary explaining the reasons for the declination.
- vii. If the amount offered is different from the amount claimed, the insurer shall explain the reason for this to the claimant.
- viii. Where the insurer is not responsible for any part of the claim, the insurer shall promptly notify the claimant of this fact and explain the reasons.

6.2 A claim that is reported late should not be repudiated without establishing reasons for the late notification.

7.0 Claims Handling

- 7.1. Every insurer shall develop and maintain a manual on their claims handling procedures which shall include all steps from claim intimation to settlement for different classes of insurance business. The manual shall provide expected timeframes in each of the steps, provided that the insurer shall, while setting the time frames take into consideration the provisions of Section 203 of the Insurance Act.
- 7.2. Every insurer while formulating the manual in clause 7.1 shall put in place clearly defined control and reporting systems surrounding the claims management process.
- 7.3. Every Insurer shall file with the Authority the manual in clause 7.1 above. Any changes to such a manual shall be notified to the Authority before implementation.
- 7.4. The insurer shall inform the claimants about their procedures, formalities and common time frames for claims settlement.

- 7.5. The insurer shall give information about the status of the claim to the claimant or the intermediary in a timely and fair manner.
- 7.6. The insurer shall explain to the claimant in simple language claim conditions such as depreciation, average, pre-loss value, reinstatement, excess/deductibles among others.
- 7.7. Where an assessment of a claim has been carried out, a copy of the assessment report shall be made available to the claimant upon request.
- 7.8. Every insurer upon recovering through subrogation shall promptly refund the excess or deductible to the insured. The insurer shall set the procedures for recoveries in the manual under clause 7.1.
- 7.9. An insurer shall develop procedure for declining claims, provided that such procedures shall ensure reasonableness in the decision to decline.
- 7.10. An insurer shall not decline a claim on the grounds of:-
 - (a) non-disclosure of material facts which a policyholder will not reasonably be expected to have known.
 - (b) misrepresentation unless it is fraudulent or negligent misrepresentation of material facts.
 - (c) breach of warranty or condition where the circumstances of the loss are unconnected with the breach.
 - (d) late reporting without establishing and considering the reasons for the late notification.
 - (e) expiry of a driving license at the time of the accident provided that the driver was not disqualified from holding such a license at the time of the accident and has not contravened the requirements of the Traffic Act CAP 403 as far as validity of the driving license applies.
- 7.11. Every insurer shall maintain competent staff with appropriate skills in claims handling.
- 7.12. Every Insurer shall carry out regular internal audit of all claims lodged with them. Internal audit shall apply to all stages of the claims management process.

8.0 Fraud detection and prevention

- 8.1. In order to curb the growth of fraudulent claims, every insurer shall take the following steps;
- (a) Establish systems and controls for detecting and identifying fraud appropriate to their exposures and vulnerability.
 - (b) Discourage fraudulent practices by making the claimant aware of the consequences of submitting false statements in the claims filing phase. To this end the insurer may place a notification on their claim forms referring to the consequences of lodging fraudulent claims.
 - (c) Establish a database where claims suspected to be fraudulent would be reported.
 - (d) The staff handling claims shall be trained to scrutinize claim documents in order detect falsehood and possible fraud.
- 8.2. Where in the opinion of the insurer any claim lodged is fraudulent the insurer shall;
- (a) Apply and exhaust its internal mechanisms for detecting, identifying and verifying the fraud.
 - (b) Where necessary report the matter to the Insurance Fraud investigation Unit (IFIU).
 - (c) Provide relevant evidence that forms the basis of suspicion that a claim is fraudulent.
 - (d) Not disclose or perform anything that is likely to prejudice the criminal investigations and prosecution of the suspects.

9.0 Specific issues affecting Motor Claims

9.1 Valuation of motor vehicles at inception of cover.

In order to minimize complaints in respect of pre-accident values of motor vehicles after a loss, valuations of insured vehicles shall be carried out at inception and/or renewal of cover.

9.2. Contribution for Motor Vehicle repairs.

An insured will only be called upon to contribute towards repairs where:

- (a) Components in the vehicle are subject to continuous wear and tear. Such components include but are not limited to;

- (i) Tyres and tubes
 - (iii) Batteries
 - (iv) Engine overhaul parts
 - (v) Gear box, transmission and transfer cases.
- (b) The vehicle requires rebranding after repairs.
- (c) The repair requires a set of similar items to be replaced whilst only one of the items was damaged in the accident.

9.3. Repair for accident vehicles.

- 9.3.1. Accident vehicles will be repaired by a repairer of the insured's choice selected from the insurer's panel of repairers, provided that where the insured chooses one outside the panel, the insurer shall ascertain that the repairer is competent to carry out such repairs and has complied with all statutory requirements to carry out such business.
- 9.3.2. It will be a requirement that such a repairer shall be a registered member of a body or association recognized by the Authority.
- 9.3.3. A copy of assessment report referred to in clause 7.7 containing a list of parts to be repaired and replaced shall be made available to the claimant.
- 9.3.4. Upon receipt of the assessment report and establishing that a vehicle is repairable, the insurer shall authorize repairers to commence on the vehicle without delay.
- 9.3.5. The claimant shall be informed by the insurer about the coverage for towing and storage services and the extent of coverage if any, for a replacement rental vehicle while the damaged one is under repair.

9.4. Write-off

A motor vehicle will be considered a write-off when the repair estimate expressed as a percentage of the pre-accident value as contained on the assessment report exceeds an economical level. The insurer shall accord the claimant the opportunity to contest the basis of valuation leading to the write-off.

9.5. Disposal of salvages

- 9.5.1. Where the vehicle is a write-off but repairable, the insured shall be accorded an opportunity to retain the salvage or forfeit the salvage to the insurer and be indemnified on the basis of the pre-accident value established in the assessment report.
- 9.5.2. No insurer shall dispose of salvage before the insured is indemnified.
- 9.5.3. Where the insured chooses to retain the damaged/written-off vehicle, the insurer after determining salvage value may deduct the amount from the settlement amount based on the assessment report.

9.6. Duty Free Vehicles

9.6.1. Market value basis

Where a duty free vehicle is insured at market value there will be no contribution for repairs provided in case of write off or theft, the insured shall be required to clear with the Kenya Revenue Authority before compensation. Where the insured wishes to keep the salvage, its value will be determined on a market value and this may be deducted from the total loss amount.

9.6.2. Duty free basis

Where a vehicle is insured on duty free basis, liability of the insurer for repairs will be limited to the proportion that the duty free value of the vehicle bears to its market value. In case of a write off, the insured will be indemnified on duty free basis and will retain the salvage.

Where the vehicle is lost and not recovered, settlement will be on the duty free basis. The insured will clear with the Kenya Revenue Authority to obtain a transferable document to submit to the insurer for the claim to be settled.

10.0 Customer care Desk

- 10.1 Every insurer will establish a customer service desk where queries and complaints will be lodged and resolved.
- 10.2 To maximize customer satisfaction, the desk will be used to lodge, route enquiries and complaints. The desk shall be equipped with competent officers with skills in complaints handling.
- 10.3 Every insurer shall have a documented system and procedure for receiving, registering and disposing of complaints in each of its offices. This will include a system to receive and deal with all kinds complaints lodged with them.
- 10.4 Every insurer shall have in place details of Turn Around Times (TAT) for complaints resolution which shall be set out in the manual of procedures under clause 7.1. These will include but not limited to;
 - i. Acknowledgement of complaints.
 - ii. Provision to the complainant with explanations on how their complaint will be handled and the procedures to be followed.
 - iii. Provision of information on internal and external complaints settlement procedures.
 - iv. Processing of complaints promptly and fairly.
 - v. Updating the complainant regularly on the progress of the claim.
 - vi. Provision of a final response in writing within a reasonable period of time.
 - vii. If complainant is dissatisfied with the final response sent by the insurer, provision of advice on the external complaint settlement procedures available, including reporting to the Authority.
- 10.5 A complaint will be considered as disposed off and closed when;
 - i. The company has acceded to the request of the complainant fully.
 - ii. Where all parties to the complaint have been satisfied and the matter marked as closed.

11.0 Submission of Returns

Every Insurer shall file with the Authority monthly and annual returns in a prescribed form as provided under section 203 as read together with Principal Regulation 48 of the Insurance Act.

12.0 Enforcement of the Guidelines

- 12.1. The Insurance Regulatory Authority shall enforce these guidelines against the insurance companies, reinsurance companies, insurance intermediaries and insurance service providers.
- 12.2. The Authority shall enforce compliance to these guidelines by exercising its powers to any person who contravenes the guidelines or take any other measure as prescribed in the Insurance Act.

13.0 Effective Date

1st July 2012

14.0 Enquiry

Enquiries on any aspect of these guidelines shall be referred to;

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