

## **What does the Claims Department do?**

A Claims Assessor (or Claims Consultant) is the person responsible for processing a claim and deciding whether payment may be made to the beneficiary. A Claims Manager is the head of the claims team and is responsible for managing the day to day running of the department.

Processing claims can be a complex procedure involving considerable investigation in some instances. As this article will explain, the Claims team are required to have a wide range of skills and knowledge in order to conduct their roles.

The Claims Department needs to strike a delicate balance between protecting the company from undue loss (paying claims that can not be substantiated) and ensuring that the clients making claims receive their full and just entitlement (paying out valid claims).

## **How does the Claims Department process claims?**

The first step in any claim is to ensure that the policy is in force. This means checking that the policy premiums are fully paid up to date and that the policy has not lapsed or surrendered, and establishing whether the policy has been transferred or assigned. The second step is to check that the claim being made is consistent with the policy terms and conditions. Essentially this means ensuring that the cause of the event (death, disability or sickness) is not excluded by either the standard policy exclusions or by an endorsement placed on the policy by the insurer.

The next step is to ensure that the person making the claim is legally entitled to the proceeds. In a life insurance claim not held by a superannuation fund ('ordinary policy') this would mean ensuring that the person claiming is the recognised next of kin or beneficiary named in a Will. Where a life insurance policy is held through a superannuation fund, the trustee of the fund is the owner of the policy and there are some rules which must be followed in determining who receives the proceeds of the policy. A Binding Nomination form ensures that the nominated beneficiary receives the policy proceeds. In some instances 'own life' policies may require a grant of probate or a letter of administration so that the proceeds can be paid into the estate.

In most instances, these three steps are sufficient for the Claims Department to authorise payment of the claim.

A Claims Department will normally request authority to access medical records for every claim submitted. This ensures that the Claims Department has the authorities, in the event that it needs to access the medical records. The standard medical records that a Claim Department accesses are the Medicare and Pharmaceutical Benefits Scheme ('PBS'). It can take up to ten weeks to access this type of medical information, so it is important that Claims Departments have the requested authorities as quickly as possible to avoid any further delays.

On other occasions the Claims Department will require additional information in order to process the claim. The most common reasons for needing additional information are:-

- > The financial details need to be verified (in income protection claims)
- > The claim is inconsistent with the medical history
- > There are suspicious circumstances surrounding the claim

### **The financial details need to be verified**

Income protection claims need to be verified regardless of whether they are based on agreed value or indemnity. Some insurers will verify agreed value policies at the time of underwriting, meaning that claims will not require financial investigation in the event of a claim.

Advisers are encouraged to have agreed value income protection policies verified at the time of policy acceptance whenever the product provider offers this service. This not only ensures that claims can be paid promptly, but also provides peace of mind that the agreed value amount on the policy is valid.

The financial sum assureds on income protection policies can be extremely difficult to calculate, especially when they involve income splits, investment income, depreciation and superannuation contributions. Advisers are encouraged to make the time and effort to thoroughly assess agreed income levels and to forward all the necessary documentation to the insurer at the time of application for verification.

All life policies are written in good faith, meaning that some insurers will accept income protections on the basis of figures submitted in the application. However, the term 'agreed value' only means that the value is agreed subject to the figures submitted in the application being accurate and verified.

### **The claim is inconsistent with the medical history**

The Medicare and PBS records only provide information on consultation dates and doctors visited. Sometimes further medical information is needed to substantiate claims. This can be either historical information such as medical records or an assessment of a current condition such as blood tests, x-rays, etc. The Claims Department may want an independent confirmation of the diagnosis.

### **There are suspicious circumstances surrounding the claim**

There are several warning signs that alert Claims Departments to the need for further investigation, these include:-

- > Generally any claims on a new policy (typically in force for less than 3 years)
- > Claims on policies which have been on risk for less than 90 days
- > Evidence of non-disclosure in the application form (pre-existing conditions not disclosed)
- > Claims where the beneficiary appears to be over insured
- > Death claims where the cause of death is unknown or unclear
- > Claims on policies that are not consistent with the 'typical' type of policy submitted by the adviser (for example a death claim on a policy for \$500,000 where the typical average sum assured for the adviser's business is \$100,000)

### **How is the investigation conducted?**

The Claims Department works in conjunction with a variety of third parties to investigate claims. The investigation is conducted so that the Claims Department can obtain more information or seek clarity on some of the information provided. The investigation stage is also an opportunity for the claimant to respond or to support their entitlement to the claim. Depending on the type of claim and the investigation required a Claims Department could contract the following services:-

- > Loss adjustors/Private Investigators.

To conduct interviews, surveillance, etc.

- > Chief Medical Officers ('CMO's)

To obtain support and guidance on medical conditions, symptoms and terminology, etc

- > Medical Practitioners

To conduct additional tests, such as fitness exams, blood tests, x-rays, etc

- > Forensic Accountants

To conduct audits on claims for income protection and calculate income levels

- > Solicitors

For advice and guidance, (particularly when a claim bears similarity to test cases in common law).

The Claims Department is also often involved in any disputes or appeals made on claims which are denied. This usually involves either reporting to or playing a part in the company internal dispute resolution team. The Claims Department may also need to provide reports to external complaints bodies (FICS for life insurance policies and SCT for superannuation policies)

## **What skills do staff in a Claims Department need?**

Personnel in the Claims Department need to have a variety of skills and expertise. Most of their interaction with clients is at the time of a loss. The result is that most of their client contact is with upset clients. Either the bereaved who want a death claim processed, or unwell and injured claimants who are frustrated and anxious. Excellent customer handling skills are vital.

The personnel in the Claims Department also interact with a variety of people such as service providers (advisers, doctors, lawyers), internal departments (underwriting, actuary, etc) and clients (trades people, business owners, young clients, elderly clients, etc). They need to be able to tailor their communication styles to all these different types of people.

In addition to communications skills the Claims personnel need to have and maintain knowledge in a wide range of areas. They need to at least a basic level of medical training to understand medical conditions, symptoms and terminology. They need a good overall understanding of the different types of occupations and what each occupation involves doing. They have to be financially minded and able to read financial reports when dealing with income protection policies. They must understand when and how tax is deducted from payments. They must understand the products that they deal in and the legislative framework in which they work. They need to understand the law and contractual requirements, in particular the requirements of The Insurance Contracts Act and the Privacy Act. They need a good understanding of Wills and Probate.

## **The challenges for the Claims Department**

Apart from dealing with clients who are experiencing very stressful situations and needing to keep up to date with all the knowledge requirements there are other challenges that face the Claims Department.

The Privacy Act provides very strict guidelines for the handling of personal information. Staff must proceed with care when assessing claims, taking into account the variety of people who can be involved in a claim (the claimant, the adviser and the various third parties who might be contracted). This means that it is not always possible to provide advisers with complete updates. This can be a frustrating scenario with the adviser needing an update in order to help the client with having the claim processed, and for the Claims Assessor who is prevented from providing a full update under the requirements of the Privacy Act. By opting in or opting out (depending on the process used by the insurer) a claimant can decide whether the adviser can have access to information regarding the progress of the claim.

The second challenge is in navigating the law. Whilst statute law (written law) sets out the standard conditions for life insurance contracts, common law (recent decisions made by judges in similar cases) sets precedents which must be observed and followed. This means that a Claims Assessor needs to be mindful of any cases considered by courts which

are of a similar nature to the claim being made. The Claims Assessor needs to keep up to date with all changes to the law regarding challenges and appeals on decisions made by other insurers. In addition to the constant changing laws, there is the further complication of the interpretation of legal terminology such as acting in 'good faith', understanding what a 'reasonable person would know' and 'material fact'. These can often be grey areas.

The third challenge is the service standards. An insurance company is often judged on its ability to process claims fairly and quickly. The clock starts ticking every time a Claims Department receives a claim form.

## Summary

The Claims Department needs to strike a delicate balance between protecting the company from undue loss (paying claims that can not be substantiated) and ensure that the clients making claims receive their full and just entitlement (paying out valid claims).

Some claims require investigation which can involve the services of several third parties. Some claims can be complex, particularly in the event of non disclosure. A Claims Assessor must make the best decision possible given the facts before them. There is often a fine line between what might be an oversight on the part of a client in an application and a deliberate fraudulent claim.

Advisers can assist Claims Departments by ensuring that application forms are fully completed at the time of submitting new business. This includes explaining the repercussions of non disclosure and influencing income protection clients to submit financial details for the purposes of verification.

Advisers can speed up the claims process considerably by assisting clients to make claims. Ensuring that all required documents, information and evidence is submitted with the application and that all authorities are completed and signed allows the claims to be processed efficiently.

Advisers should ensure that client records are kept up to date. Advise the Claims Department of any changes of personal details during the claims process. Advisers should also encourage clients to have up to date Wills and Binding Nominations.

Advisers should contact their Business Development Managers for information from insurers on the specific requirements for handling claims. Requirements may vary across insurers.

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