Standard Operating Procedures

CIB/CLM/SOP-NON MOT NEG VAL/Version 20/07/2018

NON MOTOR VALIDATION / NEGOTIATION

PRÉCIS

1. The validation procedures and criteria include evaluation of all circumstances on claims

PURPOSE OF THE PROCESS

2. Validation of a claim is performed to ensure claims costs are kept to a minimum and to ensure that only valid claims are paid

STAKEHOLDERS

3. Broker, Policy Holder, CIB (PTY) Ltd and Insurer

GENERAL

Validation / negotiation of a claim is performed to ensure the validity of the claims being submitted. If the validation of a claim is performed effectively it can contribute to reduce claims costs and ensure only valid claims are paid. The Claims Specialist must validate the claim in accordance with the SOP and in conjunction with the Claims Manual.

The Claims Specialist must ensure that throughout the validation / negotiation process that the claims activity is updated each and every time the claim is accessed or an action on the claim is performed. In additional reserves must be updated as and when new information is received to ensure that they remain current and sufficient (as outlined in the reserving methodology)

The Claims Specialist must apply the necessary due care and skill when validating the loss. The Claims Specialist must ensure they thoroughly check the claim form and ensure that they validate the questions and answers given in respect of information which is significant to the loss.

The Claims Specialist must establish whether any of the answers indicate a red flag, and if so proceed with appointing an internal assessor as outlined in the appointing of a specialist SOP.

The Claims Specialist must always read ALL documentation in conjunction with each other and identify any discrepancies all documentation refers to the claim form, supporting documents, the policy wording, the policy schedule and annexure.

Failure to do so could result in invalid claims being paid, and increased claims costs. Any outstanding information/documentation relevant to the claim must be followed up by the Claims Specialist via e-mail with the Broker (The Claims Specialist must apply logic and refer to the list of documentation required outlined in the claims manual, as failure to do so may impact turnaround times and lead to Broker/Client complaints

CLAIMS RULES IN RESPECT OF PREMIUM PAYMENT:

- If the premium reflects as unpaid, the Claims Specialist must request confirmation from Finance as to the non-payment.

- If the policy is a brand new policy and the first premium (inception premium) is returned - then claim must not be authorised

- If the policy is an existing policy and it is the first unpaid on the clients policy then the claim may be authorised if Finance confirms that the premium is due to be received

- If the policy is an existing policy and a double debit is being collected, and the double debit is unmet then authorisation must wait until premium confirmation has been received from the insured

- If CIB does not receive the insured's premium by the due date, as shown in the Schedule of Insurance, the insured shall be entitled to a grace period of 15 (fifteen) days after the due date (except in the first month) in which to pay his/her premium. If a claim happens after the 15 (fifteen) day grace period has lapsed and the premium was not paid within the 15 (fifteen) days, the claim will not be paid.

- While waiting for confirmation of premium payment, the Claims Specialist must proceed with the validation of the claim to avoid unnecessary delay's but may not authorize the claim until such time as the requested premium confirmation has been received.

- Should the premium payment be in arrears, the Claims Specialist must ensure that the broker submits a copy of the policy schedule and proof of payment

ACTION	RISK	CONTROL	STANDARD	MEASUREMENT
Once a claim has been registered on System A (as outlined in the Registrations SOP), the Claims Specialist must perform various **standard validation checks** as outlined below: 1) That the claim form has been received and it is fully completed and signed by the relevant parties 2) That the documentation required for the specific claim has been received / requested (refer to list of documentation required as outlined in the Claims Manual). 3) A full description of the loss has been received together with the details relating to the damages/loss 4) That insurable interest has been established 5) That the item being claimed for reflected on the policy closings / proposal form is in line with the insured item on the policy and the cover is in line with the insured's request 6) That the date of notification is in line with the policy wording. If the claim is reported late (in excess of 30 days) then an explanation as to why is to be provided which must be refer as per the delegation of authority. 7) Whether the claim occurred during the first 90 days of inception and there are Red Flagging indicators. **Claims which occurred during the first 90 days of inception with red flagging indicators must be referred as per the delegation of authority**	* Inability to make an informed liability decision in the absence of the required information /documentation /standard validations * Possible payment of invalid claims if standard validation checks are not performed * Payment of claims where no premium has been received * Failure to check claims history could result in anomalies going undetected and possible duplication of claims * Failure to update claims activity TAB could result in a lack of record keeping of checks performed	**Process Controls** * Check by Claims Specialist * List of documentation outlined in the claims manual * Validation/negotiation SOP (in terms of what validations are required to be performed) **System Controls** None **Reporting Controls** None	Once a claim has been registered on System A (as outlined in the Registrations SOP), the Claims Specialist must perform various standard validation check The Claims Specialist must apply the necessary due care and skill when validating the loss. Failure to do so could result in invalid claims being paid and increased claims costs / leakage.	* Ad hoc claims audits performed by the Team Leaders

8) Confirm payment of premium - the previous three months transaction history available on the system is required to be checked (Refer to premium payment business rules outlined in the claims manual) 9) Gain an understanding of the relevant endorsements and limitations in the cover in respect of the item /section being claimed for 10) Review the previous claims history to determine whether any patterns exists that may have an influence on the claim being submitted 11) The policy confidential comments must be checked for any relevant underwriting notes referring to the claimed item. **12) The Claims Specialist must make clear notes under the claim activity TAB as to what validations were performed in respect of the above** The purpose of the notes, whether it be via User note or email correspondence format is to provide proof / confirmation that the necessary validation checks were done.				
On completion of the above mentioned standard validation checks the Claims Specialist must determine whether there are any **Red Flag Indicators** present (as outlined in the claims manual) If the claim warrants the Appointment an Assessor according to the Red Flag Indicators, the Claims Specialist must follow the procedure as outlined in the Appointment of a Specialist SOP by sending a user note to Stephen Sales and Pieter Van Der Walt in order for the claim to be allocated to the correct Assessor. Make sure the following is attached to System A for the Assessor. * Claim Form * Full policy schedule * Proposal form / Closings – if applicable If the claim warrants the Appointment of a surveyor to conduct a Value at Risk Report, the Claims Specialist must complete the Value at Risk Request in full taking special precaution to note what section must be valued according to the claim. The request must be sent to risksurvey@cib.co.za	* Possible payment of invalid claims if the necessary specialist is not appointed * Possible payment of invalid claims if red flags are not identified	**Process Controls** * Red Flag indicators as outlined in the claims manual * Validation/negotiation SOP * appointment of a specialist SOP **System Controls** None **Reporting Controls** None	On completion of the above mentioned validation checks the Claims Specialist must determine whether there are any red flag indicators (as outlined in the claim manual) present. If there are, then the Claims Specialist will appoint a specialist as outlined in the appointment of a specialist SOP and the Claims Manual.	* Ad hoc claims audits performed by the Team Leaders

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<tr><td>Please note that the only time average cannot be applied to a claim or where a Value at Risk should not be conducted is when the claim is a total loss.</td><td></td><td></td><td></td><td></td></tr>
<tr><td>The Claims Specialist must ensure that should the claim fall under any of the following sections, the validation of the claim must be handled in accordance with the Validation SOP, the relevant specific SOP for the type of claim received and the Claims Manual. It is important to note this specific claim individually due to specific reporting and notification procedures involved for these types of claims.

1) Any claim where there is Facultative Reinsurance attached to the policy
2) Claims in excess of R50 000.00
3) SASRIA Claims
4) Catastrophe Claims
5) Liability Claims
6) Home Assist
7) Fast Track Claims
8) Any possible rejections
9) Any possible ex gratia claims
10) Any staff claims</td><td>* Failure to identify policies specific types of policies could result in CIB breaching the agreements and requirements with the Insurer
* Incorrect validation of specific types of claims could result in inaccurate reports being drawn and / or incorrect decisions being made
* Incorrect reserves being held
* Invalid claims being paid</td><td><u>System</u>
The system will flag the user if the reserve is raised above R50k.
<u>Reporting</u>
None
<u>Other</u>
* Self-management of Claims Specialist
* Policy schedule and excess annexures
* FAC RI + Large Losses SOP
* Reserving Methodology
* Over R50k SOP
* SASRIA SOP
* Liability SOP (Legal)
* Fast Track Methodology and SOP
* Rejection SOP
* SASRIA SOP
* Validations SOP
* Claims Manual</td><td>Adherence to the applicable SOPS</td><td>* Ad hoc claims audits performed</td></tr>
<tr><td colspan="5">NO COVER</td></tr>
<tr><td colspan="5">If once the standard validation checks have been completed and it has been established that there is no cover in terms of the policy either due to the cover or extension not requested then the Claims Specialist must proceed with the no cover process.

The Claims Specialist must discuss the claim with the relevant Manager, when in agreement the claims must be presented to the Rejection Committee.

The Letter will be sent to the Non Motor Claims Manager / General Manager to ensure all the information and format is correct. Once the confirmation was received, the letter must be sent to the broker.

Once the letter has been sent the documentation must be uploading onto Doc Man system A. The Claims Specialist will then change the status under the claims detail on system A to "No cover/Rejection" and provide full reasons in the claims description section of the screen. The estimate must then be reduced to NIL as outlined in the Claims Manual.</td></tr>
<tr><td colspan="5">WHEN A SPECIALIST IS NOT APPOINTED AND THE CLAIM IS VALIDATED BY THE CLAIMS SPECIALIST</td></tr>
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The following validation checks must then be done by the Claims Specialist in order to validate the actual loss: * It is important to pay special attention to the description of loss because this is the client's disclosure of how the loss occurred. The description will confirm the proximate cause and you will then be able to ensure that this cause is a peril in terms of the policy wording. For Example: When I returned home from work, I found the front door had been damaged and my contents stolen. The above description confirms that the claim is for theft under the contents section of the policy. * Now that you understand how the loss occurred and under what section the loss occurred, refer to the Documentation Required Listing in the Claims Manual to ensure that the correct documentation required for the claim to be validated is requested from the broker / client if not already received. * Ensure that the relevant quotations, damage reports, proof of ownership, proof of quantum, proof of forcible entry, if so required according to the Claims Manual, is received and once received must be checked to ensure that this is in line with the details submitted on the claim form, policy schedule and Claims Settlement Philosophy. * Ensure that the relevant section of the policy wording is checked and that the proximate cause is covered in terms of the wording and check if any exclusion noted under this section are applicable to the claim. * Ensure that the relevant section of the policy schedule and annexures are checked and any endorsements or specific exclusions noted under this section are applicable to the claim. * Check the excess annexure in order to ensure that the correct excess is applied according to the claim. * Check the sum insured according to the quotations received to ensure that the repair or replacement quotations do not exceed the sum insured of the item.	* Inability to determine liability decision in the absence of the required information * Possible payment of invalid claims if basic validation checks are not performed * Non adherence to turnaround times of the claim procedure * Claims leakage * Not obtaining the relevant amount of quotations * Not validating the claim correctly and in its entirety	**System** None **Reporting** None **Other** * Self-Management by Claims Technician * Adherence to the Validation SOP * Adherence to the Claims Manual	The Claims Specialist must perform various validation checks (applicable to each and every claim)	* Ad hoc claims audits performed by the Team Leaders

It is important to remember that the Claims Specialist must ensure that the correct validation procedure is followed as outlined in the Claims Manual and Claims Settlement Philosophy for the specific type of claim being handled. The Claims Specialist must ensure that the quantum of the loss can be determined. If the item is to be repaired/replaced then the Claims Specialist must request a minimum of two quotations per item from the relevant Supplier Listing, by utilizing the relevant Request for Quote Form found on the Intranet. On receipt of the quotations from the suppliers the Claims Specialist must compare the pricing, make and models or full break down of repairs quoted for to ensure that the correct replacement or repair can be done on a "like for like" basis. In cases where the make and model of the item has been discontinued the Claims Specialist must advise the broker /insured of the suggested replacement make and model prior to authorization in order for the broker / insured to accept this replacement. In cases where the item is stolen, the Claims Specialist must ensure that the relevant proof of ownership is received if the item is less than 12 months old. In cases where there is a theft and forcible / violent entry is a requirement, the Claims Specialist must ensure that acceptable proof of this is received. The Claims Specialist must authorise replacement / repair with the cheapest quote based on a "like for like" basis.	* Increase claim costs if procurement initiatives are not utilised * Non adherence to turnaround times * Time delays in the claim process * Claim leakage * Inability to request quotes on a "like for like" basis * Broker/ Insured complaints if the repairs / replacement are note authorised timeously. * Non adherence to turnaround times * Time delay in the claims process * Not following up with the supplier on authorised item * Not updating the broker/ Insured on status of claim	**System** * Claims Activity TAB **Reporting** * Detailed Claims Report to be monitored by the Claims Team Leader and actioned by the Claims Specialist **Other** * Self-management by Claims Technician * Turnaround times * List of documentation required * Procurement Non Motor Supplier Listing * Internal Audits	Once a liability decision has been made the Claims Technician must endeavour to settle the insured's claim within the required turnaround times (as per the departmental Service Level agreement in place) The Claims Technician must ensure that the quantum of the loss can be determined. **If the item is to be repaired/replaced then the Claims Technician must request 2 quotations per item from the relevant CIB preferred Supplier using the relevant quotation request form which can be found on Common on H (Common on H/Claims/Procurement/Request for quotation)** **If the insured provides a quotation in respect of the item then the Claims Specialist will request a comparative quotation from a CIB supplier.**	* Ad hoc claims audits performed by the Team Leaders

WHEN A SPECIALIST IS APPOINTED AND THE REPORT MUST BE VALIDATED BY THE CLAIMS SPECIALIST

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<td>On receipt of the Specialists report, the Claims Specialist must ensure that the report contains the following information AND the following checks are done:

* A detailed description of the Value at Risk, to establish whether the insured is adequately insured.
* Details about the risk, e.g. address, construction of the house and roof, any other material information about the risk.
* Circumstances surrounding the loss. Does this correspond with the description on the claim form?
* Description of loss
* Is the loss covered in terms of the policy? Was it caused by an insured event?
* Costing in terms of the claim. The specialist has to confirm that the quote is a fair quote and that the quote is comprehensive.
* The correct amount of quotes have been requested and received by the Specialist and attached to the report in accordance with the Documentation Required Listing.
* Photographs depicting the loss
* Remedial action to be taken by the Insured should the claim be rejected.
* Previous insurance check has been done.
* Dual insurance check has been done.
* Has the correct excess been applied to the settlement calculations
* Is the report a preliminary or final report
* Is there any information that is required by the Specialist which is impacting on the finalisation of the report, if so this must be attended to immediately
* If the Specialist recommends any risk improvements /corrective action be instituted on the policy the Claims Specialist must complete an underwriting notification form and refer it to the Underwriting Department for the required action to be considered.</td>
<td>* Possible payment of invalid claims
* Inability to make an informed decision in the absence of all the required information (which will be gathered by a non-motor assessor)</td>
<td><u>System</u>
* Claims Activity TAB
<u>Reporting</u>
* Detailed Claims Report to be monitored by the Claims Team Leader and actioned by the Claims Specialist
<u>Other</u>
* Self-management by Claims Technician
* Turnaround times
* List of documentation required
* Procurement Non Motor Supplier Listing
* Internal Audits</td>
<td>The Claims Specialist must perform various validation checks (applicable to each and every claim)</td>
<td>* Ad hoc claims audits performed by the Team Leaders</td>
</tr>
<tr>
<td colspan="5">Once the Claims Technician has considered all the information relevant to the loss (basic validation checks, specific validations checks, non-motor assessor/investigators findings), the Claims Technician must determine whether liability in respect of the claim will be accepted.</td>
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<tr>
<td colspan="5">If the Loss is in excess of the Claims Technician's mandate as outlined in the Delegation of authority the Claims Technician must refer the claims via mail for authorisation</td>
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If any of the items to be replaced are salvageable the Claims Specialist must complete a **Non-Motor Salvage Upliftment Form** which can be found on the intranet and must proceed with the process as outlined in the Non Motor Salvage SOP. The notification form containing the following information must be sent to the Salvage Co-ordinator so that they may arrange upliftment of the items/s from the insured: * Claim number * Insured's details * Detailed list to items to be collected with values	* Salvage upliftment not arranged * Details of items incorrect * Increased claims costs - claims leakage if non motor salvage process not initiated	* Salvage Upliftment Instruction sheet * Non motor salvage SOP	If any of the items to be replaced are salvageable the Claim Technician must complete a Non-Motor Salvage notification form which can be found on Common on H (Salvages/Non-Motor Salvages/ Non-Motor Salvage Notification Form). The notification form containing the following information must be sent to the Salvage Co-ordinator so that they may arrange upliftment of the items/s from the insured: * Claim number * Insured's details * Detailed list to items to be collected with values	* All Risk Checklist * Weekly Outstanding Report

ACCEPTANCE OF LIABILITY

Once a claim has been validated and a liability decision has been made, the Claims Specialist must endeavour to settle the insured's claim within the required turnaround times as outlined in the Claims Manual.

The following Acceptance of Liability options are available at our sole discretion:
*** Repair**
*** Replace**
*** Indemnify;**
Or a combination of all of the above but always subject to the limit of indemnity stated in the Policy Schedule

Payment of any amount authorized by us is conditional upon the clients signature of an Agreement of Loss or acceptance from broker on Fast Track claims.

We may apportion payment or offer part payment of a claim in circumstances where the client may be enriched by full settlement which is known as Betterment

We will not be liable under more than one section of the policy in respect of liability, loss or damage arising from the same event in respect of the same liability, loss or damage

In the event of a claim where we provide indemnity under any section of the policy for the maximum limit of indemnity, we are not obliged by law, or otherwise, to refund premium, for the unexpired period of insurance

REPAIR OR REPLACEMENT:

Claims Technician will send an email to the contractor / supplier to inform them to proceed with the quoted work, the following should be included in the mail:

* Insured's name
* Insured's contact number
* Insured's address
* Claim Number
* Approved quote
* Agreed Amount
* Excess payable by client
* Additional excess that may be applicable
* Total (VAT Included)

CASH IN LIEU SETTLEMENTS:

On acceptance of a valid claim in terms of the policy, a cash settlement can be considered as a last resort of indemnification and must be approved by Management. Only exceptional circumstances will be approved:
* Where the client has already replaced the item / effected the repairs and can provide an invoice as proof in this regard and the invoice has been validated according to the above validation procedure.
* Where the client has a specialised item (minimal providers are available)
* Where Average is applicable

The Claims Specialist must complete the **Agreement of Loss Form** found on the Intranet which must include the following information:
* Insured's name
* Policy Number
* Claim Number
* Description of Loss
* Section where claim is being paid under
* Name of supplier
* Item being claimed for
* Agreed Amount
* Excess payable by client
* Total (VAT Included)

Each and every Agreement of Loss must be authorized and signed according to the Delegation of Authority found in the Claims Manual.

What is an agreement of loss?

An agreement of loss is the document drafted for the offer on the total claim calculated in full and final settlement. This must be signed / approved by the policy holder prior to authorisation or payment being made.

When drafting the Agreement of Loss the Claims Specialist must ensure that the proposed settlement is the full and final agreed figures as duly calculated per their own adjustments or the proposed settlement by the assessor/loss adjuster for the claim. The Claims Specialist must ensure they utilize only one agreement of loss per claim stating full breakdowns of the indemnity per section or item.

FINALISATION OF CLAIM:

While the claim is in progress, the Claims Specialist must follow-up with the service provider / supplier (if applicable) and the broker in line with agreed turnaround times in the SLA.

On completion of the above procedure, the Claims Specialist must make clear notes under the claim activity TAB as to the following:
* What validations were performed on the claim
* How the settlement was agreed upon
* Who authorized the settlement
* That the Settlement documentation was sent to the relevant parties
* Confirmation of receipt of the settlement documentation by the relevant parties

A Diary note must be made by the Claims Specialist to ensure that the follow up is done on the progress of the authorized claim in line with the Claims Turnaround Times as noted in the Claims Manual.

All settlement authorization documentation and relevant correspondence documentation must be uploaded onto Doc Man (System A) for record purposes.

On receipt of the suppliers invoice /signed agreement of loss the Claims Specialist will process the payment within the SLA turnaround times.

AUTHORISATION

In authorisation whereof this **'Non Motor Negotiations/Validations Standard Operating Procedure'** has been executed on this 12th day of July, 2018, for implementation with effect from 13 July 2018.

SIGNED by Executive head of Claims and Legal

Elsa Jordaan

SIGNED by Non Motor Claim Manager

Nadia Du Toit

SIGNED by General Manager

Michelle McSorley

SIGNED by Portfolio Manager

Amanda Leon

SIGNED by Technical Claims Specialist

Christel Coetzee