Certified Claims Manager
Sample Material

V-Skills Certifications

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V-Skills

1. INSURANCE

Insurance is the equitable transfer of the risk of a loss, from one entity to another in exchange for payment. It is a form of risk management primarily used to hedge against the risk of a contingent, uncertain loss. An insurer, or insurance carrier, is a company selling the insurance; the insured, or policyholder, is the person or entity buying the insurance policy. The amount of money to be charged for a certain amount of insurance coverage is called the premium. Risk management, the practice of appraising and controlling risk, has evolved as a discrete field of study and practice.

The transaction involves the insured assuming a guaranteed and known relatively small loss in the form of payment to the insurer in exchange for the insurer's promise to compensate (indemnify) the insured in the case of a financial (personal) loss. The insured receives a contract, called the insurance policy, which details the conditions and circumstances under which the insured will be financially compensated.

1.1. History

Early Methods

Methods for transferring or distributing risk were practiced by Chinese and Babylonian traders as long ago as the 3rd and 2nd millennia BC, respectively. Chinese merchants travelling treacherous river rapids would redistribute their wares across many vessels to limit the loss due to any single vessel's capsizing. The Babylonians developed a system which was recorded in the famous Code of Hammurabi, c. 1750 BC, and practiced by early Mediterranean sailing merchants. If a merchant received a loan to fund his shipment, he would pay the lender an additional sum in exchange for the lender's guarantee to cancel the loan should the shipment be stolen or lost at sea.

At some point in the 1st millennium BC, the inhabitants of Rhodes created the 'general average'. This allowed groups of merchants to pay to insure their goods being shipped together. The collected premiums would be used to reimburse any merchant whose goods were jettisoned during transport, whether to storm or sinkage.

Separate insurance contracts (i.e., insurance policies not bundled with loans or other kinds of contracts) were invented in Genoa in the 14th century, as were insurance pools backed by pledges of landed estates. The first known insurance contract dates from Genoa in 1347, and in the next century maritime insurance developed widely and premiums were intuitively varied with risks. These new insurance contracts allowed insurance to be separated from investment, a separation of roles that first proved useful in marine insurance.

Modern Insurance

Insurance became far more sophisticated in Enlightenment era Europe, and specialized varieties developed.

Property insurance as we know it today can be traced to the Great Fire of London, which in 1666 devoured more than 13,000 houses. The devastating effects of the fire converted the development of insurance "from a matter of convenience into one of urgency, a change of opinion reflected in Sir Christopher Wren's inclusion of a site for 'the Insurance Office' in his new plan for London in 1667". A number of attempted fire insurance schemes came to nothing, but in 1681, economist

Nicholas Barbon and eleven associates established the first fire insurance company, the "Insurance Office for Houses", at the back of the Royal Exchange to insure brick and frame homes. Initially, 5,000 homes were insured by his Insurance Office.

At the same time, the first insurance schemes for the underwriting of business ventures became available. By the end of the seventeenth century, London's growing importance as a centre for trade was increasing demand for marine insurance. In the late 1680s, Edward Lloyd opened a coffee house, which became the meeting place for parties in the shipping industry wishing to insure cargoes and ships, and those willing to underwrite such ventures. These informal beginnings led to the establishment of the insurance market Lloyd's of London and several related shipping and insurance businesses.

The first life insurance policies were taken out in the early 18th century. The first company to offer life insurance was the Amicable Society for a Perpetual Assurance Office, founded in London in 1706 by William Talbot and Sir Thomas Allen. Edward Rowe Mores established the Society for Equitable Assurances on Lives and Survivorship in 1762.

It was the world's first mutual insurer and it pioneered age based premiums based on mortality rate laying "the framework for scientific insurance practice and development" and "the basis of modern life assurance upon which all life assurance schemes were subsequently based".

In the late 19th century, "accident insurance" began to become available. This operated much like modern disability insurance. The first company to offer accident insurance was the Railway Passengers Assurance Company, formed in 1848 in England to insure against the rising number of fatalities on the nascent railway system.

By the late 19th century, governments began to initiate national insurance programs against sickness and old age. Germany built on a tradition of welfare programs in Prussia and Saxony that began as early as in the 1840s. In the 1880s Chancellor Otto von Bismarck introduced old age pensions, accident insurance and medical care that formed the basis for Germany's welfare state. In Britain more extensive legislation was introduced by the Liberal government in the 1911 National Insurance Act. This gave the British working classes the first contributory system of insurance against illness and unemployment. This system was greatly expanded after the Second World War under the influence of the Beveridge Report, to form the first modern welfare state.

1.2. Principles Of Insurance

The business of insurance aims to protect the economic value of assets or life of a person. Through a contract of insurance the insurer agrees to make good any loss on the insured property or loss of life (as the case may be) that may occur in course of time in consideration for a small premium to be paid by the insured.

Apart from the above essentials of a valid contract, insurance contracts are subject to additional principles. These are

Principle of Utmost Good Faith

Both the parties i.e. the insured and the insurer should have a good faith towards each other. The insurer must provide the insured complete, correct and clear information of subject matter. The insurer must provide the insured complete, correct and clear information regarding terms and conditions of the contract. This principle is applicable to all contracts of insurance i.e. life, fire and marine insurance.

Principle of Insurable interest

The insured must have insurable interest n the subject matter of insurance. In life insurance it refers to the life insured. In marine insurance it is enough if the insurable interest exists only at the time of occurrence of the loss. In fire and general insurance it must be present at the time of taking policy and also at the time of the occurrence of loss. The owner of the party is said to have insurable interest as long as he is the owner of it. It is applicable to all contracts of insurance.

Principle of Indemnity

Indemnity means guarantee or assurance to put the insured in the same position in which he was immediately prior to the happening of the uncertain event. The insurer undertakes to make good the loss. It is applicable to fire, marine and other general insurance. Under this the insurer agreed to compensate the insured for the actual loss suffered.

Principle of Subrogation

As per this principle after the insured is compensated for the loss due to damage to property insured, then the right of ownership of such property passes to the insurer. This principle is corollary of the principle of indemnity and is applicable to all contracts of indemnity.

Principle of Contribution

The principle is corollary of the principle of indemnity. It is applicable to all contracts of indemnity. Under this principle the insured can claim the compensation only to the extent of actual loss either from any one insurer or all the insurers.

Principle of Proximate Cause

The loss of insured property can be caused by more than one cause in succession to another. The property may be insured against some causes and not against all causes. In such an instance, the proximate cause or nearest cause of loss is to be found out. If the proximate cause is the one which is insured against, the insurance company is bound to pay the compensation and vice versa.

Principle of Loss of Minimization

Under this principle it is the duty of the insured to take all possible steps to minimize the loss to the insured property on the happening of uncertain event.

1.3. Disclosure

The principle of Utmost good faith applies to all types of insurance contracts and is a very basic and primary principle of insurance. According to this principle, the insurance contract must be signed by both parties (i.e insurer and insured) in absolute good faith or belief or trust.

The person getting insured must willingly disclose and surrender to the insurer all relevant complete true information regarding the subject matter of insurance. The insurer's liability is voidable (i.e legally revoked or cancelled) if any facts, about the subject matter of insurance are either omitted, hidden, falsified or presented in a wrong manner by the insured.

The principle forbids either party to an insurance contract, by non-disclosure or mis-representation of a material fact, which he knows or ought to know, to draw the other into the bargain, from his ignorance of that fact and his believing the contrary. The duty of the utmost good faith is implied in insurance contracts because they are entered into by parties who have not the same access to relevant information. In this, they differ from contracts of sale to which the maxim caveat emptor (let the buyer beware) applies.

1.4. Material Facts

Material fact is every circumstance or information, which would influence the judgment of a prudent insurer in assessing the risk or those circumstances which influence the insurer's decision to accept or refuse the risk or which affect the fixing of the premium or the terms and conditions of the contract, must be disclosed.

A material fact is one which would have influenced the judgment of a prudent insurer in deciding whether he would accept the risk in whole or in part and, if so, at what amount of premium. The materiality of a fact depends upon the application of this test to the particular circumstances of the case as at the date that the fact should have been communicated.

1.5. Methods of insurance

In accordance with study books of The Chartered Insurance Institute, there are the following types of insurance:

- ✓ Co-insurance – risks shared between insurers
- ✓ Dual insurance – risks having two or more policies with same coverage
- ✓ Self-insurance – situations where risk is not transferred to insurance companies and solely retained by the entities or individuals themselves
- ✓ Reinsurance – situations when Insurer passes some part of or all risks to another Insurer called Reinsurer

1.6. Insurer's Business Model

Underwriting and Investing

The business model is to collect more in premium and investment income than is paid out in losses, and to also offer a competitive price which consumers will accept. Profit can be reduced to a simple equation:

Profit = earned premium + investment income – incurred loss – underwriting expenses.

Insurers make money in two ways

- ✓ Through underwriting, the process by which insurers select the risks to insure and decide how much in premiums to charge for accepting those risks
- ✓ By investing the premiums they collect from insured parties

The most complicated aspect of the insurance business is the actuarial science of ratemaking (price-setting) of policies, which uses statistics and probability to approximate the rate of future claims based on a given risk. After producing rates, the insurer will use discretion to reject or accept risks through the underwriting process.

At the most basic level, initial ratemaking involves looking at the frequency and severity of insured perils and the expected average payout resulting from these perils. Thereafter an insurance company will collect historical loss data, bring the loss data to present value, and compare these prior losses to the premium collected in order to assess rate adequacy. Loss ratios and expense loads are also used. Rating for different risk characteristics involves at the most basic level comparing the losses with "loss relativities"—a policy with twice as many losses would therefore be charged twice as much. More complex multivariate analyses are sometimes used when multiple characteristics are involved and a univariate analysis could produce confounded results. Other statistical methods may be used in assessing the probability of future losses.

Upon termination of a given policy, the amount of premium collected minus the amount paid out in claims is the insurer's underwriting profit on that policy. Underwriting performance is measured by something called the "combined ratio", which is the ratio of expenses/losses to premiums. A combined ratio of less than 100% indicates an underwriting profit, while anything over 100 indicates an underwriting loss. A company with a combined ratio over 100% may nevertheless remain profitable due to investment earnings.

Insurance companies earn investment profits on "float". Float, or available reserve, is the amount of money on hand at any given moment that an insurer has collected in insurance premiums but has not paid out in claims. Insurers start investing insurance premiums as soon as they are collected and continue to earn interest or other income on them until claims are paid out. The Association of British Insurers (gathering 400 insurance companies and 94% of UK insurance services) has almost 20% of the investments in the London Stock Exchange.

In the United States, the underwriting loss of property and casualty insurance companies was $142.3 billion in the five years ending 2003. But overall profit for the same period was $68.4 billion, as the result of float. Some insurance industry insiders, most notably Hank Greenberg, do not believe that it is forever possible to sustain a profit from float without an underwriting profit as well, but this opinion is not universally held.

Naturally, the float method is difficult to carry out in an economically depressed period. Bear markets do cause insurers to shift away from investments and to toughen up their underwriting standards, so a poor economy generally means high insurance premiums. This tendency to swing between profitable and unprofitable periods over time is commonly known as the underwriting, or insurance, cycle.

Claims

Claims and loss handling is the materialized utility of insurance; it is the actual "product" paid for. Claims may be filed by insureds directly with the insurer or through brokers or agents. The insurer may require that the claim be filed on its own proprietary forms, or may accept claims on a standard industry form, such as those produced by ACORD.

Insurance company claims departments employ a large number of claims adjusters supported by a staff of records management and data entry clerks. Incoming claims are classified based on severity and are assigned to adjusters whose settlement authority varies with their knowledge and experience. The adjuster undertakes an investigation of each claim, usually in close cooperation with the insured, determines if coverage is available under the terms of the insurance contract, and if so, the reasonable monetary value of the claim, and authorizes payment.

The policyholder may hire their own public adjuster to negotiate the settlement with the insurance company on their behalf. For policies that are complicated, where claims may be complex, the insured may take out a separate insurance policy add on, called loss recovery insurance, which covers the cost of a public adjuster in the case of a claim.

Adjusting liability insurance claims is particularly difficult because there is a third party involved, the plaintiff, who is under no contractual obligation to cooperate with the insurer and may in fact regard the insurer as a deep pocket. The adjuster must obtain legal counsel for the insured (either inside "house" counsel or outside "panel" counsel), monitor litigation that may take years to complete, and appear in person or over the telephone with settlement authority at a mandatory settlement conference when requested by the judge.

If a claims adjuster suspects under-insurance, the condition of average may come into play to limit the insurance company's exposure.

In managing the claims handling function, insurers seek to balance the elements of customer satisfaction, administrative handling expenses, and claims overpayment leakages. As part of this balancing act, fraudulent insurance practices are a major business risk that must be managed and overcome. Disputes between insurers and insureds over the validity of claims or claims handling practices occasionally escalate into litigation (see insurance bad faith).

Marketing

Insurers will often use insurance agents to initially market or underwrite their customers. Agents can be captive, meaning they write only for one company, or independent, meaning that they can issue policies from several companies. The existence and success of companies using insurance agents is likely due to improved and personalized service.

1.7. Types of Insurance

Life Insurance

Life insurance is an insurance coverage that pays out a certain amount of money to the insured or their specified beneficiaries upon a certain event such as death of the individual who is insured. This protection is also offered in a Family plan, to protecting individual and their family.

The coverage period for life insurance is usually more than a year. So this requires periodic premium payments, either monthly, quarterly or annually. The risks that are covered by life insurance are

- ✓ Premature death
- ✓ Income during retirement
- ✓ Illness

The main products of life insurance include

- ✓ Whole life
- ✓ Endowment
- ✓ Term
- ✓ Investment-linked
- ✓ Life annuity plan
- ✓ Medical and health

General Insurance

General insurance is basically an insurance policy that protects you against losses and damages other than those covered by life insurance. For more comprehensive coverage, it is vital for you to know about the risks covered to ensure that you and your family are protected from unforeseen losses. The coverage period for most general insurance policies and plans is usually one year, whereby premiums are normally paid on a one-time basis. The risks that are covered by general insurance are:

- ✓ Property loss, for example, stolen car or burnt house
- ✓ Liability arising from damage caused by yourself to a third party
- ✓ Accidental death or injury

The main products of general insurance include

- ✓ Motor insurance
- ✓ Fire/ Houseowners/ Householders insurance
- ✓ Personal accident insurance
- ✓ Medical and health insurance
- ✓ Travel insurance

1.8. Insurance Policy

In insurance, the insurance policy is a contract (generally a standard form contract) between the insurer and the insured, known as the policyholder, which determines the claims which the insurer is legally required to pay. In exchange for an initial payment, known as the premium, the insurer promises to pay for loss caused by perils covered under the policy language.

Insurance contracts are designed to meet specific needs and thus have many features not found in many other types of contracts. Since insurance policies are standard forms, they feature boilerplate language which is similar across a wide variety of different types of insurance policies.

The insurance policy is generally an integrated contract, meaning that it includes all forms associated with the agreement between the insured and insurer. In some cases, however, supplementary writings such as letters sent after the final agreement can make the insurance policy a non-integrated contract. One insurance textbook states that generally "courts consider all prior negotiations or agreements ... every contractual term in the policy at the time of delivery, as well as those written afterwards as policy riders and endorsements ... with both parties' consent, are part of written policy". The textbook also states that the policy must refer to all papers which are part of the policy. Oral agreements are subject to the parol evidence rule, and may not be considered part of the policy if the contract appears to be whole. Advertising materials and circulars are typically not part of a policy. Oral contracts pending the issuance of a written policy can occur.

A contract of insurance is an agreement whereby one party, called the insurer, undertakes, in return for an agreed consideration, called the premium, to pay the other party, namely the insured, a sum of money or its equivalent in kind, upon the occurrence of a specified event resulting in a loss to him. The policy is a document which is an evidence of the contract of insurance. As per Anson, a contract is an agreement enforceable at law made between two or more persons by which rights are acquired by one more persons to certain acts or forbearance on the part of other or others.

The Indian Contract Act, 1872, sets forth the basic requirements of a Contract. As per Section 10 of the Act

“All agreements are contracts if they are made by the free consent of parties competent to contract, for a lawful consideration and with a lawful object, and are not hereby expressly declared to be void.....”.

An Insurance policy is also a contract entered into between two parties, viz., the Insurance Company and the Policyholder and fulfills the requirements enshrined in the Indian Contract Act.

General Features

The insurance contract or agreement is a contract whereby the insurer will pay the insured (the person whom benefits would be paid to, or on behalf of), if certain defined events occur. Subject to the "fortuity principle", the event must be uncertain. The uncertainty can be either as to when the event will happen (e.g. in a life insurance policy, the time of the insured's death is uncertain) or as to if it will happen at all (e.g. in a fire insurance policy, whether or not a fire will occur at all).

Insurance contracts are generally considered contracts of adhesion because the insurer draws up the contract and the insured has little or no ability to make material changes to it. This is interpreted to mean that the insurer bears the burden if there is any ambiguity in any terms of the contract. Insurance policies are sold without the policyholder even seeing a copy of the contract. In 1970 Robert Keeton suggested that many courts were actually applying 'reasonable expectations' rather than interpreting ambiguities, which he called the 'reasonable expectations doctrine'. This doctrine has been controversial, with some courts adopting it and others explicitly rejecting it. In several jurisdictions, including California, Wyoming, and Pennsylvania, the insured is bound by clear and conspicuous terms in the contract even if the evidence suggests that the insured did not read or understand them.

Insurance contracts are aleatory in that the amounts exchanged by the insured and insurer are unequal and depend upon uncertain future events. In contrast, ordinary non-insurance contracts are commutative in that the amounts (or values) exchanged are usually intended by the parties to be roughly equal. This distinction is particularly important in the context of exotic products like finite risk insurance which contain "commutation" provisions.

Insurance contracts are unilateral, meaning that only the insurer makes legally enforceable promises in the contract. The insured is not required to pay the premiums, but the insurer is required to pay the benefits under the contract if the insured has paid the premiums and met certain other basic provisions.

Insurance contracts are governed by the principle of utmost good faith (uberrima fides) which requires both parties of the insurance contract to deal in good faith and in particular it imparts on the insured a duty to disclose all material facts which relate to the risk to be covered. This contrasts with the legal doctrine that covers most other types of contracts, caveat emptor (let the buyer beware). In the United States, the insured can sue an insurer in tort for acting in bad faith.

Parts of an insurance contract

- ✓ Declarations - identifies who is an insured, the insured's address, the insuring company, what risks or property are covered, the policy limits (amount of insurance), any applicable deductibles, the policy period and premium amount. These are usually provided on a form that is filled out by the insurer based on the insured's application and attached on top of or inserted within the first few pages of the standard policy form.
- ✓ Definitions - define important terms used in the policy language.
- ✓ Insuring agreement - describes the covered perils, or risks assumed, or nature of coverage, or makes some reference to the contractual agreement between insurer and insured. It summarizes the major promises of the insurance company, as well as stating what is covered.
- ✓ Exclusions - take coverage away from the Insuring Agreement by describing property, perils, hazards or losses arising from specific causes which are not covered by the policy.
- ✓ Conditions - provisions, rules of conduct, duties and obligations required for coverage. If policy conditions are not met, the insurer can deny the claim.
- ✓ Endorsements - additional forms attached to the policy form that modify it in some way, either unconditionally or upon the existence of some condition. Endorsements can make policies difficult to read for nonlawyers; they may modify or delete clauses located several pages earlier in the standard insuring agreement, or even modify each other. Because it is very risky to allow nonlawyer underwriters to directly rewrite core policy language with word processors, insurers usually direct underwriters to modify standard forms by attaching endorsements preapproved by counsel for various common modifications.
- ✓ Policy riders - A policy rider is used to convey the terms of a policy amendment and the amendment thereby becomes part of the policy. Riders are dated and numbered so that both insurer and policyholder can determine provisions and the benefit level. Common riders to group medical plans involve name changes, change to eligible classes of employees, change in level of benefits, or the addition of a managed care arrangement such as an Health Maintenance Organization or Preferred Provider Organization (PPO).