# ASSESSMENT OF CLAIMS MANAGEMENT PRACTICES IN THE CASE OF AFRICA INSURANCE SHARE COMPANY

**DEPARTMENT OF BUSINESS ADMINSTRATION**

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# Declaration

This is my original Thesis work and has not been presented for award of a degree in any other university or any other institution of higher learning for examination.

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# Certification

We certify that this Thesis *Assessment of Claims Management Practices in the case of Africa Insurance share Company* was undertaken and finalized by **Temesgen Abay** and that the thesis work is supervised by us and submitted to the department of MBA Program.

Zemenu A. (Assistance professor) _____ _____

Name of advisor Signature Date

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# Acronyms/Abbreviations

| | |
|---|---|
| AIC | Africa Insurance Company (S.C.) |
| AEI | Association of Ethiopian Insurers |
| PAB | Personal Accident Benefit |
| PAMB | Personal Accident Medical Benefit |
| PLL | Passenger Legal Liability |
| COMESA | Common Market for Eastern and South Africa |
| BS | Bandits and *Shifta* |
| BSG | Bandits, *Shifta* and Guerrillas |
| P&C | Property & Causality customer |
| CSAT | satisfaction |
| ADR | Alternative Dispute Resolution |
| NBE | National Bank of Ethiopia |
| MTPL | Motor Third Party Liability Insurance |
| MBA | Masters of Business Administration |
| EIC | Ethiopian Insurance Company |
| SMU | St Mary's University |
| UNCTAD | United Nations Conference on Trade and Development |
| GNPI | Gross National Premium Income |
| VIATPR | Vehicle Insurance Against Third Party Risks |
| IFAA | Insurance Fund Administration Agency |
| CII | Chartered Insurance Institute |
| TP | Third Party |
| TP&F&T | Third Party and Fire and Theft |

# Abstract

*The purpose of this study is to* assessment of claims management practices *in case of AIC. The research's particular emphasis was given to non-life /general insurance business of the company. The study tried to answer the questions that; what are the main factors of claims settlement dalliance in AIC, how claims management practices are source of customer compliance, how efficient is the claims management practice in AIC and what are the main reasons of claims rejection in Africa insurance company. The general objective of the study is to investigate claims management processes and practices of claims management. The study employed cross-sectional survey design in which 315 external customers selected randomly and 88 internal customers (i.e., staffs) involved in the claim process were the subject of the study by administering specially designed questionnaires. The results obtained suggest that the prevailing claims handling process is a major problem area affecting customers' satisfaction that need to be overhauled. The clients of AIC believed that lack of updated and clear claims management manuals and procedures, lack of skilled, knowledgeable, experienced and committed claim staff and in claims service are the key challenges in AIC. More importantly, centralized claims management, external and internal effects of immoral behavior of the clients, surveyors, garages, spare part dealers, and internal employees along with sluggish interdepartmental/work units/ communications towards claims management were the major issues in the company. Poor compliant handling system of the company, delay of claims management from notification up to settlement to claimants, lack of intensive standard training for claims staff, and lack of work standard for internal employees, external surveyors and garages decelerates the rate at which quality service is delivered in the company. Thus, it's recommended based on the finding that the AIC should create an effective, transparent and customer-oriented means to standardize the services, educate the customers, decentralize the claim unit and make use of the standard monitoring mechanism as per the strategies and policies of the company so as to maximize the level of satisfaction of motor claimants. The study suggests that to solve the claims settlement problems should begin from underwriting and the policies should be have an Amharic version and the management should also solve the problems of claims department centralization and dalliance problems. In addition the company should provide timely response for its customers and the investigation process should do in good cooperation with in claims department.*



**Keywords: -** Challenges, Clients, claims management, Satisfaction

# CHAPTER ONE

# INTRODUCTION

## 1.1 Background of the study

Insurance is a risk transfer mechanism and its purpose is to compensate or indemnify the victim for the financial losses suffered as a result of the risks but it does not eliminate the risk and cannot stop the disaster or misfortune from happening. Insurance is basically a service business that exists in order to ensure the success and survival of other businesses, by providing security in the form of cover and making available funds for investment. In this regard insurance, being an area of investment, has a critical linkage to all sectors of the national economy (Rejda and McNamara, 2014).

The development of insurance is associated with the early days of human civilizations. For example, marine insurance was practice around 1,000 BC, some 2000 year ago, in Roman time a form of life assurance was practice by burial societies (Fisher and Marshall, 1999). However there is no unanimous evidence as to when and how the modern insurance began. Nonetheless, the $19^{th}$ and $20^{th}$ centuries have been marked with the hastening of insurance services all over the world (Getensh, 2007).

Modern insurance service in Ethiopia traces its origin back to 1905 when the Bank of Abyssinia began to underwrite fire and marine insurance policies as an agent to a foreign insurance company. According to Tsegaye (2009) in 1951about 31 foreign insurance companies were transacting insurance business in Ethiopia that started with opening of a single company in 1905. The success of foreign companies became seed for the establishment of first domestic insurer known as Imperial Insurance Company, by foreign nationals with the ruling aristocracy and royal families in 1951; and was followed by National Insurance Company of Ethiopia. In the subsequent years fifteen privately owned insurance companies were operational in the Ethiopian insurance market until 1975 (Getensh, 2007).

The heart of any insurance company is the claims management process. The better the process the more likely the insurer will be successful in retaining and winning new customers and thereby growing revenue and profits (KPMG, 2012).Claims management means and includes all the managerial decisions and processes concerning the settlement and payment of claims in

accordance with the terms of insurance contract. It includes carrying out the entire claims process with a particular emphasis on monitoring and lowering the claims costs (Jitesh, 2012).

An insurance claim is the actual application for benefits provided by an insurance company. Policy holders must first file an insurance claim before any money can be disbursed to the hospital or repair shop or other contracted service. The insurance company may or may not approve the claim, based on their own assessment of the circumstances (Jitesh, 2012).

Africa Insurance Company is one of the private insurance companies incorporated in Ethiopia. Like other insurance companies, Africa Insurance Company has its own claim management department.

The claims department is one of the key departments in an insurance company. The claims department has the sole responsibility of managing claims. Claims management by far is the most complex issue in an insurance company. The people in the claim department should have good interpersonal skills.

A new and comprehensive law to regulate the licensing operation and supervision of insurance business has been promulgated under proclamation no 86/1994 on February 1, 1994(EIBI, 1996) which led to the establishment of privately owned insurance companies (Getensh, 2007). Between February 1994 and June 30, 2015, the total number of insurance companies operating in Ethiopia, including governmentally owned Ethiopian Insurance Company, is 17(seventeen); and Africa Insurance Company (S.C.) is one of the leading operators in the market. The industry has registered the following records: - birr 5.9 billion worth of total assets, birr 1.5 billion of capital, birr 4.5 billion of gross premium (out of which 51% is accounted to motor insurance) and birr 576.9 million of net income in general or non-life insurance business (NBE, 2014) and operate nationwide by using 377 branch offices (NBE, 2015).

Africa Insurance Company S.C. was established on 8, December 1994, with the main objective of transacting general and long-term Insurance Business, in accordance with the licensing and supervision of Insurance Business Proclamation No.86/1994 and the Commercial Code of Ethiopia. The company was set up with subscribed capital of birr 30 million and paid up capital of 15 million. Currently the companys paid up capital risen to birr 145.7 million as at June 30, 2015; and registered a total gross premium income of 327.4 million of which 64% is accounted for motor insurance (AIC Annual Report, 2014/15).

## 1.2 Statement of the problem

Nowadays in Ethiopia insurance companies are increasing in number from time to time; one governmental and 23 private insurance companies. The customers have many opportunities to purchase insurance policies from those insurance companies. So, to be competitive and profitable in this sector, it is important that the claims management system is efficient and is staffed by competent and professional claims personnel (handling (Tsegaye, 2009; and Getenesh, 2007)

Even the number of company's increases in number their services including the claims management service is not efficient in satisfies the need of their customers. The claims management services of insurance companies are full of wasteful procedures, unnecessary practices and more centralized decision making processes. The claims management services of insurance companies are full of wasteful procedures, unnecessary practices and more centralized decision making processes. These leads to claims payment dalliances and be sources of customer dissatisfaction. In general underwriting and claims handling are the two most important aspect of the functioning of or delivering insurance service by an insurance company. Qaiser (2015) argues that the customer expects adequate insurance coverage, timely delivery of defect free policy documents with relevant endorsements; and quick settlement to his satisfaction. The claim settlements in general insurance thus have their own peculiarities and therefore need proper handling (Tsegaye, 2009; and Getenesh, 2007). Most policyholders had appreciated it for great importance. The services being rendered will determine the attitude of the customers (Qaiser, 2015).

Though it is dominant contributor to Gross National Premium Income (GNPI), by providing half of the total market premium, very few studies have been conducted on claims service. The studies so far conducted on general claims handling reveal varying results ranging from 19% to 76% satisfaction level of customers (AIC Annual Report, 2016). As indicated under previous sections insurance business takes major share of the market and 64% of AIC's total premium income, thereby dominating other classes (AIC Annual Report, 2016). Assessment and identification of challenges encountered and customers perception of the standard of claims service delivery in insurance by AIC and resultant effect of achieving its strategic objective as envisaged on vision and mission statement have not been researched.

There are various problems claims management practices, customer satisfaction on the response claims, fairness of claim settlement, timeliness of payments, and sources of insured satisfaction in claims in Africa insurance share company.

## 1.3. Research Questions

- What are the main reasons of claims management in the company?
- What are the claims management practices to identify sources of customer compliance
- What are the efficiencies of claims management department of the company
- What are the expected benefits derived from implementing proper claims management in AIC?

## 1.4 Objective of the study

### 1.4.1. General objective

The general objective this study is to investigate claims management practices in AIC.

### 1.4.2. Specific objectives

The specific objectives of this study are:

- To identify the main reasons of claims management in the company
- To examine the claims management practices and identify sources of customer compliance
- To examine the efficiency of claims management department of the company
- To assess the expected benefits derived from implementing proper claims management in AIC?

## 1.5 The significance of the study

This study was provided important outcome both to the insurer (Africa Insurance Company) and the insured (Africa insurance company policy holder). Because it will indicate the problems in claims management and then give recommendation (solution for identified or researched problems). This helps the insurer to easily solve customer service problems. It enables to create

high customer satisfaction and this leads to increase the goodwill of the company, which in the future will be the big asset to the company.

## 1.6 Scope of the study

Methodological scope; First of all, this research was employed by using the quantitative research approach only with structured close-ended questionnaires which can make respondents to answer what is written in the questionnaire only which can limit respondents to provide their own ideas, opinions and feelings. **Conceptually** limited to claims management practices such as time delay in claims management process; sources of customer compliance; benefits derived from implementing proper claims management. **Geographically** the study was conduct at Africa insurance company claims department at head office situated in Addis Ababa where all the regional claim settlement service is centralized. It was cross-sectional study from 2021-2023.

## 1.7 Limitation of the study

The time given to conduct the research not big enough to conduct in-depth study on the subject matter of the study and to include more insurance companies in the study. The researcher was tried to study in-depth as much as possible on the subject matter of the study and tried to focus mainly only in Africa insurance company.

## 1.8 Organization of the study

This research divided into five chapters. The study's background, statement of the problem, research questions, and research objectives, as well as the study's significance, scope, and limitations, would all be included in chapter one. The review of literature in the field of will be discussed in Chapter 2. The methods section had explored in the third chapter. The study's analysis and interpretation would be detailed in Chapter 4. Finally, in Chapter 5, the conclusion and recommendations as well as suggestions for other insight researchers would be offered, followed by the references and questionnaires that were used in the study.

# CHAPTER TWO

# REVIEW OF RELATED LITRATURE

This chapter presents the summary of literature on insurance claims management in general and processes and practices in detail. The literature review will describe and define words related to claims management, contains different topics related to claims management and related to the objective of the study. It is collected from books on insurance and risk management and related books written by different authors, from manuals prepared to train insurance company workers and from Webpages that contains relevant document for the study. This literature has theoretical and empirical part of literature.

## 2.1. Theoretical Literature

### 2.1.1. Insurance

Insurance is the pooling of fortuitous losses by transfer of such risks to insurers, who agree to indemnity insurers for such losses, to provide other pecuniary benefit on their occurrence, or to render services (Rejda, 2003,p-19).

Tekle-georgis (2004, p62-63) defines "Insurance" from two points of views: From an individual point of view, insurance is an economic device where by the individual substitutes a small certain cost (the premium) for a large uncertain functional loss (the contingency insured against) would exist if it were not for the insurance. From the social point of view, insurance is an economic device for reducing and eliminating risk through the process of combining a sufficient number of homogeneous exposures into a group to make the losses predictable for the group as a whole.

#### 2.1.2. Insurance in Ethiopia

Insurance is the financial arrangement that redistributes the cost of unexpected loss. From the dawn of civilization man has been engaged in an unending pursuit of security. Whether in battling the elements of nature or developing social formations, the need to control human destiny and reduce uncertainty has been as the core of human endeavor (Kutty, 2008). As a result

risk management was among the foundation of human endeavor to mitigate the outcomes of such uncertainties in life since time immemorial. Insurance is the financial arrangement that redistributes the cost of unexpected losses. The roots of insurance might be traced to Babylonia (in Iraq), and its evolvement in its present form started at the beginning of the 20$^{th}$ Century.

In Ethiopia, local support systems were practiced among the community members in establishments called *Idiris, Equib* and *Debo* since time immemorial. However, modern insurance services in its present form started in the beginning of the 20th century, through the agents of foreign insurer. However, modern insurance left its birth-mark in Ethiopia1905 during the reign of Menelik II. Sources indicate that it was the Habesha Bank (Bank of Abyssinia) (Tsegaye, 2009) a branch of the Bank of Egypt, began to transact fire and marine insurance acting as an agent of a foreign insurance company (Eyessus, 2007).

The history of the development of insurance in Ethiopia can be demarcated in to four. The "Period of Agents" is the first one that runs from early 1900 to early 1950's. This period is characterized by operation of insurance in a laissez-faire environment on loose agency agreement between the domestic operator and insurance companies established and operating in foreign countries. The second one is the Middle Period, running from early 1950' to 1974; which is characterized by the end of the period of agents and emergency of indigenous companies and also among others, the coming of the Civil Code and Commercial Codes of Ethiopia 1960. The third period is the Period of Monopoly covering the years running between 1974 and 1994, where EIC alone had an insurance monopoly for almost two decades, after the nationalization of thirteen privately owned insurance companies in 1974. The last is, the Current Period that defines the time from 1994 onwards (Getensh, 2007). Between February 1994 & June 2016, including the government owned EIC, the total number of insurance companies operating in Ethiopia as at June 30, 2015 is 17(seventeen), and Africa Insurance Company is one of the main operators in the market.

Africa Insurance Company S.C. has been established on 8, December 1994, to find its own place among private insurance companies, with the main objective of transacting General and longterm Insurance Business, in accordance with the licensing and supervision of Insurance Business Proclamation No.86/1994 and the Commercial Code of Ethiopia. The company was set up with subscribed capital of birr 30 million and paid up capital of 15 million. Currently the

company's paid up capital has risen to birr 145.7 million as at June 30, 2015; and a total gross premium income of 327.4 million of which 64% is accounted for motor insurance (AIC Annual Report, 2014/15).

### 2.1.3. Claim

A claim is a request to be compensated filed by the insured and addressed to the insurer. Williams, Smith and Young (1998) noted that a claim is an assertion of right to payment, as when a customer notifies a manufacturer of an injury from a defective product and expresses a belief that the injury justifies compensation. A reported claimis a claim for which the potentially responsible party has received notifications; otherwise the claim is unreported. A closed claim is a claim for which the liability for payment has been resolved and full payment has been made. When liability for payment has not been resolved, the claim is an open claim and the estimated amount of payment is called reserve (p.218).

Loss

A loss is the occurrence of an insured event, such as a fire, which results in financial disadvantage for the insured. According to Harington and Niehaus (2003), Loss control refers to that reduces expected losses effect of insurance on loss control. Since purchasing insurance coverage and loss control are alternative risk management tools.

### 2.1.4. Claims management

According to Codjia (2013)Claims management consists of the departmental stipulations, corporate policies and industry practices that insurance firms use to validate policyholder payment or reimbursement requests. Claims management is also a business practice that allows an insurer to abide by state and local regulations.

Lewis (2013) noted that claims management is a second topic of discussion and concern for insurance management professionals. How an insurance company handles claims can affect its reputation and the ability of the company to retain clients for long-term business. Claims administration is the process by which insurance companies do this, and this topic is one of several that might be discussed within the larger topic of claims management.

## 2.1.5. Claims Management in General Insurance

Underwriting and claims settlement are the two most important aspect of the functioning of an insurance company. Out of any insurance contract, the customer has the following expectations (Qaiser, 2011):

**i.** Adequate insurance coverage, which does not leave him high and dry in time of need, with right pricing.

**ii.** Timely delivery of defect free policy documents with relevant endorsements /warranties / conditions / guidelines.

**iii.** Should a claim happen, quick settlement to his satisfaction?

The insurance companies have hitherto been handling the claim rather than managing them.

Typically this process involves

**i.** As soon as a claim is reported, the insurance company checks as to whether the cover was in force at the time of loss and whether the peril is covered under the policy.

**ii.** A surveyor is appointed who visits the spot, does the assessment and submits the report.

**iii.** Insurance company examines the report, calls for relevant supporting documents.

**iv.** On receipt of survey report and documents, the same are examined. The claim file is processed and settlement is offered.

The claims handling is thus more process oriented and does not pay adequate attention to the monitoring and claims cost aspect as also to the service parameters.

In the present liberalized scenario, with cut-throat competition being the order of the day, the insurance companies have to go much beyond the handling of claims.

## 2.1.6. The Claims management Process

The claims department of insurance have the responsibility of ascertaining the validity of written proof of loss, interpreting and applying the terms of policy loss situations, and finally approving

payment of claim. These functions are more extensive in property liability insurance than in life insurance because of the higher frequency of losses, the predominance of partial losses, and the uncertainty of the amount of loss in individual cases (Greene, 1997).

It should be noted that the actual procedure for handling claims varies according to the class of business, the type of cover, the amount of claim and whether it is a personal or commercial risk insured (Maqsood, 2008).

## 2.1.7. Claim Notification

After a loss, the insured must notify the insurance company this notice represents a claim for payment (Skipper & Kwon, 2007). Usually the claims condition will instruct the policy holder to notify the insurer, in writing, of any incident likely to give rise to a claim immediately, and to supply full details, at their own expense, within the period of time the insurers agree to.
It is a condition precedent to liability. Conditions are classified into three divisions by the time at which they operate.

Conditions precedent to the contract: Those that operate before the contract is formed. This mainly means the implied conditions. Conditions subsequent to the contract: Those that operate after the contract is made, Such as those relating to taking care, cancellation, alterations. Conditions precedent to liability: Those which must be complied with if the insurer is to be liable to pay claims; this includes conditions such as claims procedures, subrogation and contribution.

Claims notification serves several purposes:

It enables the company to take steps to investigate claims (or occurrences which might give rise to claims) in order to minimize its exposure under the policy.It enables loss adjuster and lawyers to be appointed so that detailed evidence is not lost .It generally allows the circumstances to be investigated so that detailed evidence is not lost. It gives the company the opportunity of investigating possible recoveries from third parties.

**Claim form** is the main means by which insurers receive notification of claims.

The claim form will ask for details such as:

- Name, address and policy number.

- Date of the incident (allows a check as to whether it occurred within the period of insurance)
- Cause of the incident (allows a check as to whether the incident is insured).
- Details of the damage property and the policy holders relationship to it (allows a check on policy coverage and insurable interest)
- Details of person(s) injured or property damaged, and the injuries and damage (allows an idea of what claims to expect from third parties)
- Details of person causing the incident (allows exercise of subrogation's right if desired)
- Details of driver & driving license (allows a check on the validity of driving license)
- Details of other policies covering the same incident (allows exercise of contribution tights if desired)

### 2.1.8. Core Insurance Business processes

Underwriting and claims settlement are the two most important aspect of the functioning of an insurance company or core insurance business processes. According to Qaiser (2015) out of any insurance contract, the customer has the following expectations: - (i) adequate insurance coverage, which does not leave him high and dry in time of need, with right pricing; (ii) timely delivery of defect free policy documents with relevant endorsements / warranties / conditions / guidelines; and most of all, (iii) should a claim happen, quick settlement to his satisfaction.

For the purpose of this study, we shall be concentrating on (iii), as (i) and (ii) relate to underwriting, though proper underwriting facilitates claim settlement. Unlike life insurance, where all policies necessarily result in claims either at maturity or by death in general insurance not all policies result in claim. Approximately around 15% policies in general insurance result in claim. The claim settlements in general insurance thus have their own peculiarities and therefore need proper handling. Also how 15% policy holders are attended is of great importance. The services being rendered will determine the attitude of the customers. How the service being rendered is perceived by the customer? That also needs to be kept in mind. Do we have a mechanism to find out the same?(R. Qaiser, 2015).

Defective underwriting may saddle the companies with unwanted claims (Quasier, 2015) but to all intents and purposes, the claim department can be seen as the "shop window" of the insurance company. It does not matter how cheap an insurance company's premium is, or how efficiently

they conduct their underwriting administration if a claim is not properly and fairly dealt with. This is where an insurer was judged. (Roff, 2004). In the present liberalized scenario, with cutthroat competition being the order of the day, the insurance companies have to go much beyond the handling of claims have to manage it (Tefera, 2010). General insurance especially motor insurance being a market driven service industry, the customer has to be kept satisfied. With so many options available, a customer once lost is most likely a loss forever. Buying insurance is all about receiving compensation at the time of happening of an insured event; the benefits of providing adequate, equitable, fair and prompt claims service cannot be overemphasized in changing the fortune of insurer in the short and long run, not to forget increase in the market size of the insurer (Teferi, 2016). Therefore, claim settlement can be used as a marketing tool; by retaining existing customers and ensuring inflow of new business. It has to be noted that brining in a new customer is much more costly than retaining the existing ones, thus insurers objective shall mainly be directed in satisfying customers by the service especially claims service they provide.

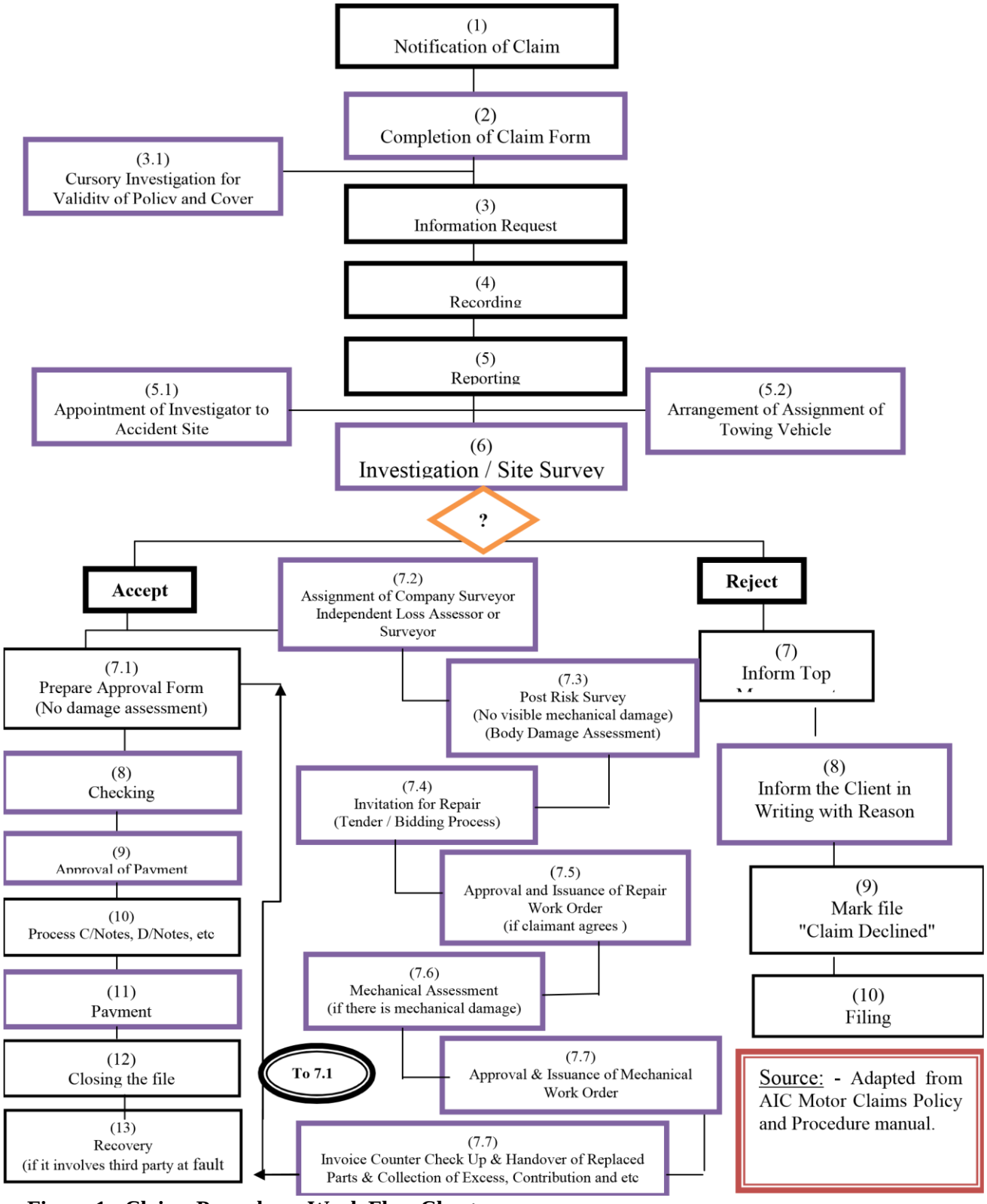



**Figure 1: Claims Procedure -Work Flow Chart**

### 2.1.9. Claim Review

This involves the analysis of the claim by the insurer in light of such things as: The appropriateness of the amounts claimed, the proposal forms e.g. whether the claim contradicts earlier statements. The exact terms of the policy, which are often open to interpretation, Legal requirements, Economic considerations and Market Practice.

### 2.1.10. Response to claimant

The initial response from the company to the insured may be only an acknowledgement or a request for further information. Depending up on this further information the insurer must then convey their claim decision which can be one of three choices:

Payment, i.e. acceptance of the claim in broad terms during the period of insurance(or any subsequent period of time for which the insurer accepts a renewal premium) the insurer will pay to the insured the value of the property at the time of its loss or destruction or the amount of the damage or at the insurers option reinstate or replace such property or any part of it (Gamlen and Francis, 1991, p42);Negotiation, i.e. the offer of a lower amount than that claimed or an offer to enter into negotiation with the insured with no amount initially named, In this situation liability is accepted by the company and the quantum of the claim is the only point in dispute. Rejection, i.e. liability is not accepted by the company. This is the area where insured disputes can arise.

### 2.1.11. Claim investigation

In many cases, such as accidents, the insurer will not be in a position to make a claim decision before the full facts surrounding the claim are available.

All types of claim may need expert advice at times:

Fire and similar claims may need the use of a loss adjuster. Motor engineers may be called in to investigate motor claims. Consulting engineers may need to be employed in engineering claims. Accountants are used in business interruption claims. Solicitors, medical experts may play a part in legal liability cases. Consulting forensic scientists may be used where there are suspicious circumstances suggestive of fraud.

In summary there must be a general move in the claims process towards early investigation, early decision and early settlement which is a further development in the evolution of claims handling.

## 2.1.12. Service Quality and Claims Service Quality

In order to be able to manage quality, it is essential to define exactly what **'**quality' means. Quality can be defined as the totality of features and characteristics of a product or services that bear on its ability to satisfy stated or implied needs (Kotler et al., 2002, p. 831). It is evident that quality is also related to the value of an offer, which could evoke satisfaction or dissatisfaction on the part of the user.

The concept of quality applicable to the context of quality management is: 'conforming exactly to the agreed documented specification. Therefore, quality management can be defined in the claims management context as: The introduction and use of a set of documented and defined service standards and procedures which have been systematically and independently assessed and audited by experienced and qualified assessors (Wedge and Handley, 2005).

Research identifies many characteristics that are associated with service quality. Business researchers Benjamin Schneider and David Bowen assert that service organizations must meet three key customer needs to deliver service excellence: security, esteem, and justice (Schneider and Bowen, 1995). Research identifies an array of service quality factors that are important for customers, including: timeliness and convenience, personal attention, reliability and dependability, employee competence and professionalism, empathy, responsiveness, assurance, availability, and tangibles such as physical facilities and equipment and the appearance of the personnel (Center for the Study of Social Policy, 2007).

However, the insurance product is unique in that its quality can only be judged when something goes wrong. For this reason, the way in which a claim is handled will have important marketing repercussions for insurers. Therefore it is important that the claims operation is adequately managed. The procedure for handling claims varies according to the type of cover, the amount of the claim, and whether it is a personal or commercial claim (Wedge and Handley, 2005).

Unlike the situations in developing countries, the increase in the purchase of motor vehicles in developing countries represent more a real growth in the rate of motorization, rather than vehicle

replacement. Therefore, motor insurance line is extremely important in developing countries. It represents for them the major source of premium income (UNCTAD, 1987). The same source also emphasizes that issues associated with motor insurance as complex, by involving not only to a particular insurer but also affecting interests of all players in the insurance market, motor vehicle operators and owners, victims of motor accidents, and the public at large.

### 2.1.13. Claim Negotiation

Armed with the full facts of the case, the company may decide that a lesser amount should be offered than originally claimed, Ex, Market Value Vs Sum Insured. Oftentimes, negotiations with the claims department are the only direct contact that the insurance buyer has with the insurer (Greene, 1997, p.142).

### 2.1.14. Claim Settlement

This stage in the financial settlement of the claim by the insurer for accepted claims. The company may agree to settle the claim on an ex-gratia basis (literally payments out of grace) which is not based on any contractual obligation.

Such payments are made where:

The application of the exclusion was unclear. There was genuine oversight by the insured, such as an administrative error. Hardship may be created for the insured or a third party claimant. The company wishes to avoid a court battle. The company wishes to avoid the possibility of souring good business relationships. The company wants to avoid possible adverse publicity Ex-gratia payments do not create a precedent (i.e. they cannot be cited in court in subsequent court cases in similar circumstances).

The increased speed of settlement has implication for the following;

- More senior staff will be needed at an earlier point in the life of a claim.
- Transaction costs-which are likely to be reduced
- Increasing customer satisfaction.
- Further claims.

- Paying claims quickly may become an open invitation to other claims.
- Cash flow of the company.
- The investment policies of the company since they may need more liquid assets.

## 2.2.Claims recoveries

Following payment of the claim it is often the case that the company will be able to recover all or part of the outlay from other sources.

- Third parties considered liable
- Subrogation rights may exist
- Re-insurance protections.

## 2.3.Review of performance

This will only be carried out in respect of a sample of claims, plus any large or particularly problematic claims. The idea is to ensure that: Standards of service are being maintained. Internal decisions were correctly made. Any reserves (provisions) still attaching to claims reflect the current position of the claim in line with the corporate reserving policy. To see if anything can be learned from the experience. In particular, any lessons should be incorporated in to the existing policies & procedures manuals etc**.**

## 2.4.Claims Settlement

Maqsood (2008) describes four ways in which a claim could be settled:

- Payment of Money-easiest and most common form.
- Paying for repairs-This is common with motor vehicles.
- Replacement-glass, mobile phones, machinery etc.(new for old)
- Reinstatement-buildings etc.

Replacement and reinstatements only apply if stated in the policy.

An insurance company to the insured to settle an insurance claim according the guidelines stipulated in the insurance policy defines claims settlement as the payment of proceeds. The information furnished in the proposal form of an insurance contract is proved correct only at the time of claim. If after inspection of the property, the claim appears to be misinterpreting or false, then the insurance company can decline the claim or avoid the policy or in certain instances the reduced amount of the claim is paid. The points to be covered in case of a claim settlement procedure are: The loss or damage is to be intimated to the insurance company immediately or as soon as possible. On intimation, the insurance company is to forward a claim form. The completed claim form must have an estimation of all the items suffered loss. A licensed surveyor is arranged, if the loss incurred is major. The insured needs to provide the required documents to support the loss.

- To establish the cause of loss, the insured should prove that the loss has occurred because of an insured peril.

Claim settlement usually refers to the financial payment of a sum of money to the insured. From the insured point of view, it represents the final stage in the claims procedure. The claim has been notified, all parties have carried out their respective duties and all that remains is for the claim to be settled. It should be borne in mind that where claims are rejected and not subsequently successfully appealed by the insured, there would be no claims settlement.

In most cases, the claims settlement process follows on from the establishment of liability under the policy.

Once an insurer is convinced that a claim is valid (i.e. falling within the scope of the contract) the size of the payment must next be assessed.

The size of the claim payment is known as the quantum of the claim. It should be noted that the question of quantum does not arise unless liability is established or admitted. According to Africa Insurance Company claims management manual, the type and amount of the settlement depend upon:-

- The nature of the cover, the adequacy of the cover and the application of any condition which limit the amount payable.

The nature of the cover determines the amount that insurers have agreed to pay in the event of a claim. The contract can be:-

- On an indemnity basis E.g. motor policy
- On a reinstatement basis - new for old E.g. insurance of machineries
- A valued policy - that is a contract where the amount to be paid in the event of a total loss is agreed in advance and known as the agreed value.
- An agreement to pay a specified sum (as in life and personal accident insurances).e.g. life assurance.

Africa Insurance Company claims management manual also explains the contract of indemnity the contract of reinstatement and ex-gratia payments as follow:

## 2.4.1. Contract of indemnity

Jeanty (2008) noted that a contract of indemnity also known as a "hold harmless" clause provides a method for transferring financial risk to a third party using a written contract. A contract of indemnity lists the parties involved, the types of situations covered, and the party or parties responsible for shouldering the risk. In effect, a company that "indemnifies" another company agrees to pay for liability related to a particular product or service. Indemnity clauses appear in commercial and legal contracts, some of which include loan agreements, supply agreements, leases and licensing agreements.

The size of a claim payment under a contract of indemnity should be just sufficient to place the insured in the same financial position after the loss as they were in before. As a value cannot be placed on a person's life or limbs, life assurance and personal accident policies are not contracts of indemnity; however, property and liability policies are contracts of indemnity.

## 2.4.2. Contract of reinstatement

The size of a claim payment under a contract of reinstatement depends on the cost of reinstatement. This is a form of new for old offering reinstatement a voids much of the difficulty in ascertaining the value of loss under an indemnity contracts.

**Ex-gratia payments**

Admin (2011) defines the word ex gratia payment as Ex gratia is Latin for from favor and an ex gratia payment may be made by an insurance company to an insured even if the company feels

they are not really required to do so. In some cases, the company may feel there has been a mistake or a misunderstanding, and they may pay a claim although they do not appear liable.

The insurer may agree to settle the claim on an ex-gratia basis literally payments out of grace which are not based on any contractual obligation. Such payments are made where:-

- The application of the exclusion was unclear,
- There was genuine oversight by the insured, such as an administrative error,
- Hardship may be created for the insured or a third party claimant
- The insurer wishes to avoid a court battle,
- The insurer wishes to avoid the possibility of souring good business relationships.
- The insurer wants to avoid possible adverse publicity.

Ex-gratia payments are made without prejudice to the insurers position (i.e. they cannot be cited in court in subsequent court cases in similar circumstance.) In other words, they do not create a precedent.

When a claim occurs, this is the first contact a customer will have with the company since the inception of the policy. Perceptions of a company gained at this point are very difficult to eradicate even if a claim has been paid in full, customers can be dissatisfied it the experience has been anything less than they were expecting. Claims provide insurance companies with the opportunity to deliver real value to their customers, whose experience of the companys service in this situation is critical in determining whether they renew or take out future new business. New sources of business emanate from satisfied customers recommendations.

## 2.5.General factors affecting claims settlement

According to Jitesh (2012) the factors that affect claim settlement are:

The policy should be in force on the date of the event. The risk and cause of event should be covered by the policy. The cause of loss or the event should be directly related to the loss. A remote cause has no place in the settlement. The loss should not have been caused with an intention to gain from the situation. The preconditions or warranties have to be compiled with. When conditions to be fulfilled before affecting the cover of the policy, are not performed, the cover of insurance will not come into effect even though the premium is paid and accepted by the insurance company. Presence of insurable interest, in case of the property insurances, at least

at the time of happening of event or loss sufferings. Without having the insurable interest in the subject matter, no person can get benefit or compensation. The assured should suffer loss, actual or constructive, to get compensation. The assured should riot make benefits or gains out of the insurance contract as the insurance contract is of indemnity in nature. It only makes good the loss suffered by the assured and is not a source of gains. Sufficient documentary evidence of loss should be presented along with the application form. Multiple claims and reciprocal claims will be settled as per the terms of the contract of insurance.Right to appeal or file a petition with the tribunal or the courts cannot be withdrawn. If the terms of the policy insist upon arbitration, it is not the end of justice for the insurer or the assured.

## 2.6.Time element in the claims payment

The time value for the settlement of a claim is of importance. All claim papers have to be submitted within a limited period mentioned in the policy document or otherwise stated in the Act. In some cases, the death of a person or the accident of vehicle has to be intimated immediately either orally or in person, either by the policyholder or the claimant or by the representative of the claimant (Jitesh, 2012).

According to www.scribd.com (2010) the reasons for the delay in claims settlement are stated and explained in detail as follows:

Late submission of claim form: The claim forms may be submitted late because of the ignorance or lack of knowledge of the existence of the insurance policies against the lives of the persons who face the event or no information is given to the beneficiaries or no nominations are made to the policy. Innocence and illiteracy of the assured: The assured or the claimant may fail to file the papers due to lack of knowledge, to file the insurance claims within a certain period or of the claims procedure. Not submitting the claims forms in full: If the claim forms are not properly filled, they will fail to provide the required information to settle the claims and as a result the claim settlement will be delayed for want of information. If sufficient proof or supporting documents are not submitted along with the claim form to facilitate claim assessor to know the date of the event or the cause of the event, claim settlement may be delayed. The insurer may not get the cooperation of the insured or the claimant to finalize the claim or arrive at some compromise. Destroying the evidences, with or without intention that could have otherwise

facilitated the estimation of the loss payable under the claim. Not providing information about the changes in the constitution of the organization or the changed address of the insured or the claimant or any other information required to make a claim settlement. The delay on the part of the insurer may be intentional or due to the pressure of work. Lack of motivation, lack of knowledge of importance of the claims settlement, lack of awareness among the staff of the organizations or defective supervision or organizational structure.

The delay in submission of claims or settlements can be avoided by making the assured aware of the facts and importance of the insurance and procedure of claims. The insurers can take the help of the agent or local staff to arrive at a compromise with the claimants when the cases are of complex nature. The organization should be so designed to avoid holding of papers at one or two places. The staff should be trained and the importance of the claims management should be driven into their minds. Use of latest technology to assess the losses and recruitment of able staff will speed up claims settlement

## 2.7.Importance of Claims Management

Settling insurance claims can be a complicated process. In addition to the competitive environment in which insurance companies operate, these businesses are challenged by more stringent compliance with government regulations and increasing expectations on the part of consumers. Efficient claims management is vital to the success of both large and small companies working within the insurance industry. Major components of the claims handling process include developing strategies to cut costs and reduce fraud while keeping customers satisfied. Small companies in particular can benefit from claims management tools and technology. Keefer (2013) states four importance of claims management:

### 2.7.1. Settling Claims

Settling insurance claims is just one aspect of the claims management process. The time it takes to process a claim involves several stages beginning with a person filing a claim. The stages that follow determine if a claim has merit as well as how much the insurance company will pay. Insurance customers expect a company to settle claims quickly and to their satisfaction. Because high customer satisfaction levels can give a company a competitive edge, reducing the time it

takes to settle insurance claims is one way to decrease the number of customer complaints and improve service. The use of claims management system software that speeds the process and minimizes costs offers a practical solution. Simplifying the claims process through automation helps reduce expenses for smaller companies that operate with smaller budgets.

### 2.7.2. Detecting Fraud

Paying fraudulent claims costs insurance companies money- a cost the insurance industry then passes on to its customers. Consequently, underwriting guidelines become tougher and the insurance premiums consumers pay increase. Software tools designed to examine payment history and evaluate trends in claim payoffs can help insurance companies detect fraud, according to Wipro, a global IT business. For example, how often the same individual files an insurance claim can be a warning that a person might be filing a fraudulent claim. Unfortunately, settling claims too quickly increases a company's chance of paying out on a greater number of fraudulent claims. Unlike large companies that can absorb some losses as a part of doing business, small companies quickly suffer the negative effect on net earnings when paying fraudulent claims. Then again, processing insurance claims too slowly increases the risk of losing dissatisfied customers. In a highly competitive insurance market, small companies can't afford to lose customers.

### 2.7.3. Lowering Costs

Monitoring costs throughout the claims management process determines how much of a customer's premium rate goes toward paying for the insurance company's administrative costs. Generally speaking, when settling a claim is delayed, it costs the insurance company more money. The higher claim costs reduce profitability. For small and large insurance companies alike, automation of some of the claims management process can help decrease a company's operating costs. One example is the increased cost of investigating a claim manually. Information technology systems, though, improve efficiency by decreasing the number of claim errors, detecting fraud early and reducing the time it takes to process and settle a claim - all factors that cut an insurance company's costs and increase profitability. Even in a healthy economy, running a small business can be tough. Other essential functions of the claims

management process that can reduce costs include developing programs directed at preventing claims before they occur and avoiding future claims.

### 2.7.4. Avoiding Litigation

In most cases involving insurance claim disputes, the insurance company eventually agrees to pay an equitable amount if a customer has a legitimate claim and can present evidence supporting it. Although quickly settling a claim can avoid the chances for litigation, accurate liability assessment is crucial to achieving a quick resolution in a claim dispute. Insurers work to evade litigation because it substantially increases the company's cost of settling a claim. For instance, one-time cases where a person misrepresents information he provides on an insurance application can be expensive for an insurance company to prove legally. Causing a company financial loss is another reason to avoid litigation. Small insurance companies are not immune but rather are increasingly exposed to potential litigation involving claim disputes.

## 2.8.Cost of Claims Management

Singapore College of Insurance deals about cost of claims management by defining "cost" refers firstly to the cost of running the claims operation, and secondly, to the cost of settling the claims by the claims department. Managing the cost means controlling the amount of money expended over a defined period of time.

The operating costs are:

- ✓ The cost of running the claims department itself, such as the staff remuneration of the claims department;
- ✓ Costs allocated to the department from costs of running the entire operation, i.e. costs incurred running the insurance company as a whole, such as IT, office space, and other department staff members; and
- ✓ External costs, i.e. the cost of engaging service suppliers and vendors.

The claims manager cannot analyze the management of the operational costs of the claims department in isolation: any reduction in the operational costs can have an impact on how well it operates. The claims manager needs to balance the cost of the operation against the desired level of service. A company can gain a competitive advantage by having the most efficient expense

ratios. An efficient expense ratio gets the balance between cost and loss of expertise right. Many insurers prefer a lower initial cost base at the outset and then try to control spend, by putting in place rigid processes via IT, audit and supervision.

If the cost of claims at any point in time (including the estimated future cost) exceeds the available resources to pay such liabilities, then the insurance company technically insolvent and must enter into insolvency. Hence, the estimation of future liabilities is just as important as the control of current claim payments.

## 2.9.Software Requirements

In order to develop and maintain reliable claims management no expensive procurements are needed. The necessary work processes can be carried out using a standard office software package without any special adaptation (European Union 2013). The office software package should-irrespective of the operating system-include a word processing application and a spreadsheet application in order to maintain master data and list of outstanding receivables. For e-mail correspondence a Personal Information Manager (PIM) should be used.

The necessary banking application can be procured from the companys regular bank. The latter will assume responsibility for care of maintenance and guarantee that the SEPA facility is available. Insurance claims are also susceptible to fraudulent activity. As a result, the information required to combat insurance fraud is an important part of insurance business intelligence (www.Insfocus.com).

Insurance focus business intelligence (www.Insfocus.com) claims handling solutions are detailed below.

### 2.9.1. Claim Activity Monitoring

This involves measuring activities such as the opening, closing, and re-opening of claims, claim payments, and outstanding claim reserves. Measurements of such activity should be conducted separately by claim type on a daily basis.

### 2.9.2. Claim Elements Analysis

This involves individual analysis for claim indemnity payments, claim expense payments, deductibles set off from claim payments, separately collected deductibles, and subrogation collections. These functions are required for monitoring and measuring the effectiveness of claim department activities. The system provides the infrastructure needed to separate claim elements and perform the required analysis.

## 2.9.3. Service Providers and Claim Parties

Claims activity involves a large number of external entities. Service providers include those entities that provide claim services to the company such as medical centers and clinics, auto repair shops, lawyers, and claim adjusters. Claim parties include those entities with which the company maintains regular claims activity such as other insurance companies, port authorities and social benefits institutions. Ins Focus BI provides reporting tools enabling the follow-up of payments and claims activity between the insurance company and its external entities, as well as their effective control.

### 2.9.4. Run-Off Analysis

Claim reserving is an important part of financial management. Measuring the run-off of ultimate claim costs compared to reserves is an essential reporting tool for insurance companies. Using flexible claim status filters, Ins Focus BI enables precise measurements of claims run-off, which helps the company improve future reserving.

## 2.9.5. Fraud Detection Support

Fraud detection is an important part of an insurance company’s activity. One way to detect suspicious claims is by analyzing claims activity and highlighting exceptions. The system contains built-in tools and measurements to facilitate fraud detection.

## 2.10. Issues in Claims Management

### Overpayment of claim or leakage

To identify overpayment, a detailed review of the handling of a claim through its various stages is required. Maqsood (2008) suggests the following stages:

a) The cause of the loss falls within the policy scope.

b) The date of loss falls within the policy dates.

c) The claim was notified within the time limit.

d) There is sufficient proof of the extent of loss.

e) The correct policy excess has been properly applied.

f) The effect of underinsurance has been properly calculated and applied to the settlement figures.

g) All recoveries have been made.

h) All subrogation has taken place.

i) All contribution has been taken into account.

j) Depreciation factor has been taken into account.

k) Is it a repair claim?

l) The insured damage or site has been (re) inspected.

m) The settlement was appropriate and that no unjustified amount was allowed.

Maqsood (2008) also describes those two types of leakages as follows:

a. **Soft Leakage** which is relatively difficult to identify. For example, failure to apply proper rate of depreciation, failure to negotiate an adjustment for wear and tear.
b. **Hard Leakage** whichis relatively easy to identify. For example, failure to deduct policy excess or deductible.

## 2.11.Fraudulent Claims

Insurance fraud cuts across every type of insurance. ABI (2012) states that insurance fraud ranges from opportunists failing to disclose their claims history when applying for cover or exaggerating claims by adding extra items to a genuine claim to highly organized crash for cash' crime rings who contrive often dangerous road crashes and claim for phantom passengers and fictitious injuries. Insurance fraud may be committed by the policyholder or a third party claiming against an insurance policy and may be aided and abetted by so-called professionals, including claims management companies.

Every hour of everyday 15 fraudulent insurance claims are exposed in the UK. In

2011, £983m of fraud was detected money that would otherwise have been lost to fraudsters. This was 7% higher than the value of fraud detected in 2010 and comprises 138,814 fraudulent insurance claims 2,670 every week. The value of savings for honest customers from detected frauds represented 5.7% of all claims in 2011, compared to 5% in 2010. Home insurance was the area where insurers detected the largest proportion of frauds, with 71,000 bogus or exaggerated claims. Dishonest personal motor insurance frauds were the second largest area of insurance fraud with 37,000 frauds uncovered. They were also the most costly, totaling £441m. 7% of all motor claims in 2011 were fraudulent compared to 5% in 2010. This reflects the rise in fraudulent whiplash claims, often encouraged by a small minority of corrupt professionals. Insurance fraud whether inventing or exaggerating a claim or lying to get cheaper covers is a serious criminal offence that affects every honest insurance customer, adding an extra 50 a year to their premiums (ABI, 2012).

Insurance fraud can take a variety of forms, such as:

- The inflation of a genuine claim, e.g. in the case of a burglary including items that were not in fact stolen;
- Creating an entirely fictitious event, e.g. a theft that never took place; and
- Causing deliberate, as opposed to accident, damage to insured property, i5e pouring water in to a video recorder.

## 2.12. Empirical Review

Business researchers Benjamin Schneider and David Bowen assert that service organizations must meet three key customer needs to deliver service excellence: security, esteem, and justice. Research identifies an array of service quality factors that are important for customers, including: timeliness and convenience, personal attention, reliability and dependability, employee competence and professionalism, empathy, responsiveness, assurance, availability, and tangibles such as physical facilities and equipment and the appearance of the personnel (Benjamin Schneider and David Bowen, 1995).

Claims are the defining moment in the customer relationship for non-life insurance firms, with a firms success often defined by one factor: the customers experience around claims. For non-life insurers several inefficiencies-including aging technology, increasing process complexity, and a rising number of fraudulent claims-are driving up claims costs and adversely affecting customers' claims experience (Wedge and Handley, 2013).

### 2.12.1. International Research on Satisfaction and Insurance Selection

Rajkumar and Kannan (2014) conducted a study with the objective of identifying factors influencing the selection of insurance company for purchasing the policy. The variables on selection of company made consisted of the 7 Ps of Services Marketing, which services providing companies like insurance companies are assumed to have given due importance The 7 'P's of services marketing are product, price, place, promotion, people, physical evidence and process. The respondents were queried about which factors strongly influences their choice of a particular company. The findings were analyzed using ANOVA tests for each of the 7 Ps. Findings discovered that Product features, accessibility, low premium amount, advertising, proper re-addressability of complaints and better claim settlement are some of the factors that drastically influences the choice of a company.

Çiğdem (2014) conducted a study to identify selection factors or criteria of insurance companies for Turkish Cypriots, by using experimental surveys in North Cyprus which additionally, the results were examined by using the SERVQUAL instrument. The survey outcomes represent that the most important criteria for an insurance company selection are recommendations from

relatives / friends, location of the insurance company, the service quality, and the costs of the services. Moreover, the SERVQUAL instrument outcomes showed that empathy is the most crucial dimension, whereas tangible is the least important one for an insurance company selection (Çiğdem, 2014).

The research conducted by Ofori-Attah (2012) on 'the effects of slow claims settlement on the sales and marketing of insurance products'; investigated the trends in the company's (Enterprise Insurance Company Ltd) claims settlement system and its effect on the sales and marketing of its insurance products. Data collection was conducted by administering questionnaires to both customers and staff of the company. The results obtained from the data collection were cross tabulated and subjected to descriptive analysis. The results obtained established the fact that prompt and satisfactory claims payment had positive effects on the sales and marketing of insurance products and vice versa (Ofori-Attah, 2012).

Mathur and Tripathi (2014) also conducted a study to identify the Factors Influencing Customer's Choice for Insurance Companies- a Study of Ajmer City. The findings revealed that according to the ranks given the most important factors that influence customers for selecting a insurance companies are computerization and online transactions, connectivity with bank , speed and efficiency in transactions, clear communication and the least important factors are influential marketing campaign, free gifts for customers, peer group impression etc. .

Ernest & Young (2010) conducted a study under the title European motor claims: Is customer satisfaction enough? Almost all over the world especially in Europe motor insurance has the added complexity of being a compulsory, regulated product sold to millions of customers. This survey conducted by Ernest & Young (2010) looks at just one component of buyer behavior - the claim process - and focuses in particular on the impact of customer satisfaction levels. The study acknowledges that the decision to invest in customer service improvements will impact many aspects of an insurance business, and so needs careful analysis. The findings suggest among other things that: claims create strong opinions and making a claim is an experience that polarizes customers opinions of their insurer. It also emphasis the need for good customer communication and support, as it is clearly linked with high levels of customer satisfaction and brand advocacy. This means quality is more important than quantity - customers need to feel that they are dealing with competent staff able to address their concerns in a sensitive way. The study

further suggests that to have control of supply chains - especially over the choice of repairers- has the potential to reduce indemnity and administration costs without harming customer satisfaction.

Most of all study conducted by Ernest & Young (2010) on motor claims indicate that customers do value good service and customers experience of making a claim can boost brand loyalty. The study also strongly suggests that insurers shall be aware that one size does not fit all. Therefore, investment in claims service should form a key part of any customer retention strategy, but each insurer must strike its own balance between the need to control costs, meet hygiene levels of service and realize the potential upside of higher customer satisfaction.

A Study of Customer Satisfaction with Service Delivery in the Motor Insurance Industry: A Case of Metropolitan Insurance Company within Kumasi, Ghana; by Nkrumah-Arkoh and Kweku Amoah (2012) Company to work on customer retention as potential proportion of customers to be lost. Secondly, most of the customers are satisfied with the empathy dimension which has to do with convenient periods & terms for expired policy renewals, convenient operating hours, sound loyalty programme, giving individualized customer attention, understanding specific customer needs and apologizing for inconvenience caused to customers/clients. Although the other dimensions do not seem to be satisfactory; it serves as a sign of caution to the management to think about ways to increase the satisfaction of the customers in those dimensions to a significant level. Distributive justice, responsiveness, technical quality assurance, reliability, and empathy were the main issues. On the other hand, having explored the degree of importance of each service dimension for customers, we found out that distributive justice is the most important dimension to customers (Nkrumah-Arkoh and Kweku Amoah, 2012).

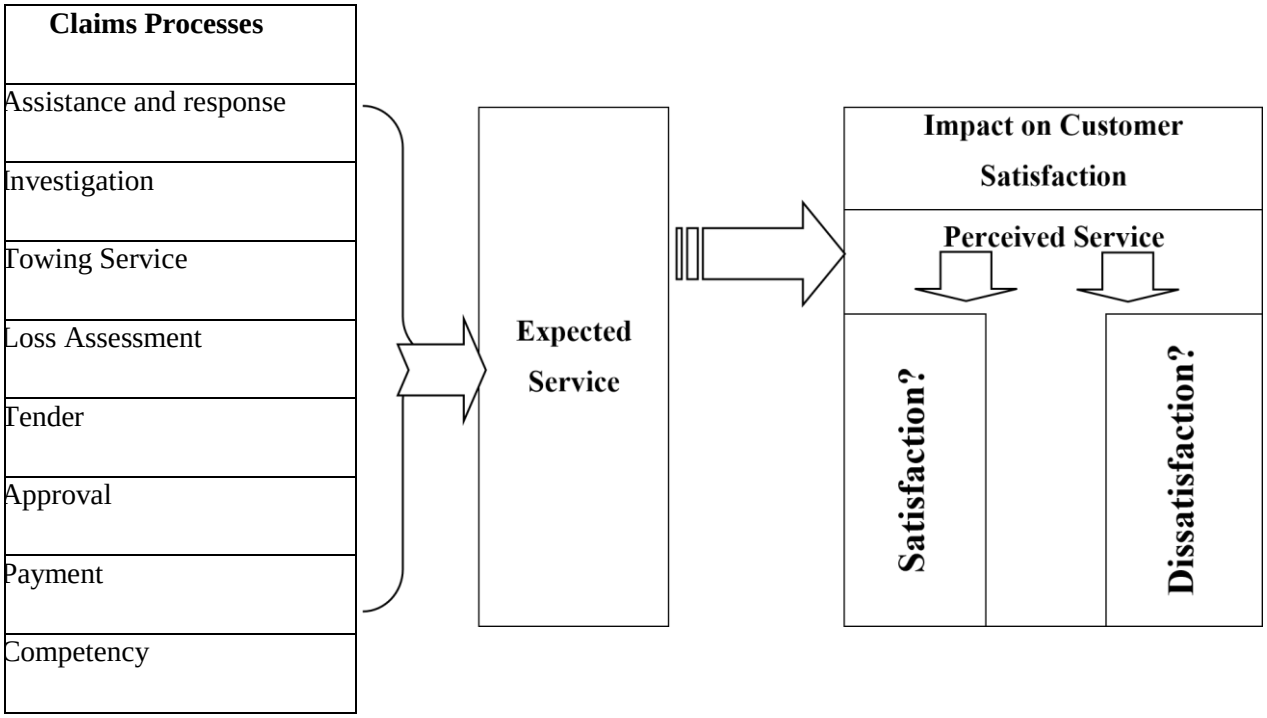
However, the data shows that understanding your policyholders and acting in their best interests are critical to delivering the best experience possible throughout the claims process. In addition customer service representatives have enormous potential to influence customer satisfaction and loyalty, as well as company growth, by how they work with policyholders during this important time. Therefore, recommended among other things to focus analysis on a specific point in the customer journey to ensure a clear and actionable set of results, such as the claims process; and identify the coalition of variables that affect customer experience in the business and identification of key areas have most impact on customer satisfaction (TeleTech, 2015).

Akalu (2015) conducted the effect of service quality on customer satisfaction in selected three insurance companies (in EIC, Nib and Lion Insurance Company) applying SERVEQUAL model. He concluded that in terms of the stated research hypotheses the following specific empirical findings emerged from the investigation: The five service quality dimensions including tangibility, reliability, assurance, responsiveness and empathy have positive and significant effect on customer satisfaction. The findings of this study also indicated that assurance is the most important factor to have a positive and significant effect on customer satisfaction followed by reliability, responsiveness, empathy, and tangibles (Akalu, 2015). In an attempt to reengineer the work process at EIC in 2010, the performance baseline for claims handling in general shows 19.3% customer satisfaction level (EIC, 2010), whereas is 74% in AIC in 2013/14(AIC, 2015).

As indicated above the figures on claims service in the market and AIC vary quite considerably. Motor insurance in particular being the major contributor of its income, constituting 64% of its gross premium income any fortune or misfortune to the Companys endeavors highly depends on delivery of service to this class. As indicated above the claims service of any insurer is the point of contact and acid test of any insurance company of its claims service. Moreover, accurate assessment of the whole motor claims service and claims handling and real challenges encountered in at each individual process has not been properly researched. In order to institute appropriate changes and bring about customer satisfaction and increase in the level of business to the company, as envisaged in AICs Strategic Plan can only be achieved by making refined assessment based on the circumstances on the ground. Therefore, it is important to know the type of claims service in place and the current claims service perception of Africa’s insurance customers, in order to find the problem and recommend appropriate solutions.

## Conceptual frameworks

**Figure 2: Conceptual frameworks on Main Claims Handling Sub Processes**




**Source: Developed by the researcher based on the reviewed literature, 2022**

# CHAPTER THREE

# RESEARCH METHODOLOGY

This chapter deals with the methodology of the study which the research approach, the research type, sample and sampling techniques, source of data collection, data collection instruments.

## 3.1 Research Design

In this research descriptive research design was used to get relevant data from a representative sample of the population; in order to assess claims management in Africa Insurance Company (S.C.). This is becouse based on the research questions and the purpose of the research, it is decided that a descriptive design with mixed methods is the most suitable for this topic because as one can see this study questions are what and how type. Such type of study design enables the researcher to answer research questions such as what and how of a situation. **The Justification is that** Descriptive research design as a systematic, empirical inquiring into which the researcher does not have a direct control of independent variable as their manifestation has already occurred or because the inherently cannot manipulated; Descriptive survey design was used to examine the relationship between or the effect of numerical measures and constructs as it is appropriate for the researcher to establish the extent of relationship between factors or variables which affect the outcome and provides an opportunity to predict scores and explain the relationship among variables.

## 3.2. Research approach

The research can be classified in to three research approaches. These are qualitative research and quantitative research and mixed approaches. Qualitative research involves studies that do not attempt to quantify their results through statistical summary or analysis. It seeks to describe various aspects about behaviour and other factors in the social sciences and humanities. In this kinds of research data are often in the form of descriptions, not numbers. It typically involves in-depth interviews, group discussions, and observations without formal measurement.

Quantitative research is the systematic and scientific investigation of quantitative properties and phenomena and relationships. The objective of quantitative research is to develop and employ

mathematical models, theories and hypotheses pertaining to natural phenomena. It usually starts with a theory or a general statement proposing a general relationship between variables. Quantitative researchers favour methods such as surveys and experiments, and would attempt to test hypotheses or statements with a view to infer from the particular to the general.

## 3.3.Target populations

The population of this study was in Africa insurance share company claims management process centralized in the head office and leaded by claims department. The claims department has 26 workers. All workers were homogenous groups and for homogeneous population census is suitable. Customers also were assessed through questionnaire

## 3.4 Sampling and Sampling Techniques

The sample is Study to the entire population. However, usually it is impossible or unfeasible to do this and therefore one must settle for a sample. Simple random sampling technique was used to select customer. The reason using this sampling technique is, it is preferable to ask the available customer simply.

## 3.5. Sample Size

### 3.5.1. External Clients Sample Size

To reach customers of insurance within the period running from July 1, 2020 to June 30, 2021, the claims register book was used as a reference to enable taking of manageable and representative sample of from the population through structured questionnaires prepared to collect primary data. The total number of claims within the specified period is represented by N. In order to determine the sample size ($n_1$), formula recommended by Kothari (2004) was used: -

$$n1=Z^2.P.q.N/e^2(N-1)+Z^2.P.q,: \quad n1=(1.96)^2(0.5)(0.5)(3,975)/(0.05)^2(3975-1)+(1.96)^2.(0.05)(0.05)$$

Where: z = 1.96 (in the absence of any previous estimate of p = 0.5, and q = 1 – p), e = 5%; and N = number of claims during July 1, 2020 to June 30, 2021 is 3,975. Thus, (Sample Size) = 350 Clients.

Though it was intended to administer 350 questionnaires for external customers, only 315 (90%) of them had properly filled and returned it. The rest, 10 % (N=35) of the respondents had lost, refused to fill, thrash or misfiled the questionnaire.

### 3.5.2. Internal Staff Sample Size

Internal staffs are those individuals that negotiate, enhance and advertise the insurance business on company's behalf. Internal customers include company claims staff, branch managers, and major insurance agents operating in Addis Ababa and Brokers working with the same sample size ($n_2$) was determined based on the list obtained from AIC Human Resource Department. Accordingly there were twenty nine (29) claims staff, fourteen (14) branch managers, thirty (30) active sales agents working for the company; and fifteen (15) brokers working with the company; making a total of eighty eight (88) participants. It is not required to use any formula to determine the sample size, because all of them (i.e., 88) had participated in responding to the questionnaires prepared for that purpose.

## 3.6. Data type and Source

There are two types of sources to collecting data; primary and secondary data sources. Primary sources are directly related to the study purpose. Primary data consists of all the data collect throughout the study that directly can be related to the study purpose, both personally gathered as well as data from a third party that has been collected with equivalent purpose. Secondary data on the other hand, contains relevant data that has been collected for a different purpose, but from which the conclusion is valuable for the purpose.

## 3.7. Data collection Instrument

The collection of data is an important aspect of a research design. The method of collection of data directly affects the credibility of a research. While collecting primary data, the researcher was employed two of the collection techniques, namely a questionnaire and interview in this

study the primary data was collected through self-administer questionnaires and interviews. Questionnaire is the most commonly used method of gathering information because it is less costly way to reach more people, including people at some distance. Depending upon the method of distribution, it can be swiftly done and data analysis can begin right away (Saunders *et al.*, 2007). Accordingly, well designed questionnaires, containing both open and close ended questions, was employed for external customers who have lodged a claim within the specified period of one year (Appendix I). Similarly relevant questionnaires were distributed to Company's claims staff, branch managers, and major insurance agents operating in Addis Ababa (Appendix II).

The secondary sources also was collected from Secondary data obtained through various kinds of documents, research reports, annual reports, books, articles training material prepared to train insurance company workers and web pages written about insurance and claims management.

## 3.8. Reliability and Validity test

The reliability of the study was tested by using statistical packaging for social science and by analyzing the data using scale reliability analysis. **Validity** refers to the quality that a procedure or an instrument used in the research is accurate, correct, true and meaningful (Enon, 1998). According to Kothari (1990) validity is the most critical criterion which indicates the degree to which an instrument measures what is supposed to measure. After the construction of questionnaire, the researcher was conducted a pilot survey on seven respondents which conducted to check whether the questions constructed was supply the appropriate information, and to check if there is any confusion in the way the researcher can make necessary amendment to the questionnaires and remove ambiguities.

## 3.9 Data analysis Techniques

The quantitative data would collected using questionnaire punch and processed using SPSS Version 20.0, in which the validity and consistency of data checked. Thereafter, the gathered data analyzed and interpreted using descriptive statistical tools such as tables and percentages, among others. The collected qualitative data was punched, integrated and analyzed with quantitative information.

## 3.10 Data analysis Techniques

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## 3.11. Ethical Considerations

To make the respondents feel confidence, the purpose of the study was disclosed in the introductory part of the questionnaire and they were not be required to write their name and other information that easily identify them. The researcher assured that their responses was used only for this research paper and inform them strict confidentiality of their responses.

Also, the researchers has used proper citation, follow systematic collection and analysis of data techniques, maintain data confidentiality, obtained the consent of the case organizations and staffs and based on their consent to meet the ethical obligation of research. Furthermore, the researcher avoided misleading or deceptive statements in the questionnaire that may distributed only to voluntary participants.

# CHAPTER FOUR

# DATA ANALYSIS AND INTERPRETATATION

This part of the paper deals with the analysis and interpretation of primary data collected using questionnaire from Africa insurance policy holders and claims department workers and interview conducted with the claims department head of the company.

## 4.1.Response Rate

As describe in chapter three data from Africa insurance policy holders and claims department workers are collected by using questionnaire. In addition to that data from head of claims department is collected by using interview.

From the total 95 questionnaires distributed to policy holders 64 questionnaires are filled in suitable way for this study and collected by the researcher. This means the response rate from policy holders are 67 % of the total questionnaire distributed.

From the total 20 questionnaires distributed to Africa insurance company claims department workers 15 questionnaires are collected. This means the response rate from claims department workers are 75 % of the total questionnaire distributed.

**Table 4.1 Types of claims notified by respondents (employees)**

| Types of claims notified | Respondents | |
|---|---|---|
| | Frequency | % |
| **Motor claim** | 58 | 90.6 |
| **Liability claim** | 3 | 4.7 |
| **Marine claim** | 1 | 1.6 |
| **Other claims** | 2 | 3.1 |
| **Total** | 64 | 100 |

**Source**: Primary Data (2022)

As shown in the table above from the total 64 responses of policy holders 58(90%) are motor insurance policy holders, 3(5%) are liability insurance policy holders, 1(2%) is marine insurance policy holders and the last 2(3%) are others insurance policy holders. This indicates the sample questionnaires collected from the respondents are good representative of the total population.

From the total 79 respondents, about 44 % of the respondents were familiar with 2-5 years with the company, 41 % of the respondents were familiar with more than 5 years with the company and the remaining 15 % of the respondents were familiar with less than 2 years with the company. Since majorities of the respondents spent more time in the company they would have a good knowledge to respond the questionnaires appropriately.

## 4.2. Analysis of Questionnaire Data and Interview Responses

**Table 4. 2: Awareness policy holders and suitability of claims notification methods**

| No | Questionnaires | Responses | Respondents | |
|---|---|---|---|---|
| | | | Frequency | % |
| 1 | Awareness policy holders about claims processing at underwriting | Very enough | 13 | 16.5 |
| | | Enough | 23 | 29.1 |
| | | Moderate | 22 | 27.8 |
| | | Not enough | 18 | 22.8 |
| | | Never got any information | 3 | 3.8 |
| | Total policy holder and worker respondents | | 79 | 100 |
| 2 | Ways in which policy holders notified their notified | Written in letter or fax | 6 | 9.4 |
| | | Telephone | 4 | 6.2 |
| | | Written in person | 54 | 84.4 |
| | Total policy holder respondents | | 64 | 100 |
| 3 | Suitability of claims notification methods | Very suitable | 5 | 33.4 |
| | | Suitable | 8 | 53.3 |
| | | Moderate | 2 | 13.3 |
| | Total worker respondents | | 15 | 100 |
| 4 | Which method is not comfortable? | By telephone | 6 | 40 |
| | | Written in letter or fax | 9 | 60 |
| Total worker respondents | | | 15 | 100 |

**Source**: Primary Data (2022)

Giving clear information about the type of coverage and the claim handling process during under writing minimizes customer dissatisfaction and expectation crises. Form the total 79 respondent

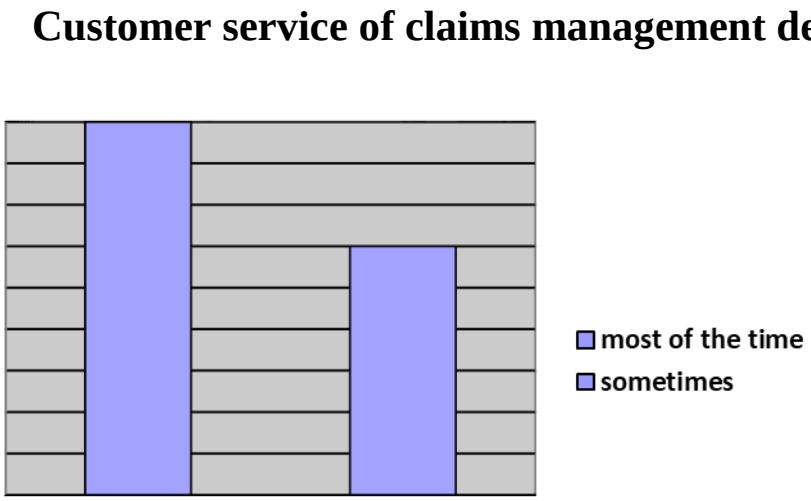
majorities of the respondents 35 % responds that customers got enough information about claims handing process when they bought insurance policy and 32 % responds that customers didn't have enough information about claims handing process when they bought insurance policy. The remaining 28 % responds that customers got moderate information about claims handing process when they bought insurance policy (see table 4.2).

After a loss, the insured must notify the insurance company this notice represents a claim for payment. Usually the claims condition will instruct the policy holder to notify the insurer, in writing, of any incident likely to give rise to a claim immediately, and to supply full details, at their own expense, within the period of time the insurers agree to. The company prepares three ways of claims notification. These are written in person, telephone and written in letter or fax. From the total 64 respondents who notified claims most of the respondents which are 54(85 %) are notified in written in person, 6(9 %) are written in letter or fax and the remaining 4(6 %) are notified in telephone.

From the total 64 respondents who notified claims to Africa insurance company most of those 60(94%) respond that their claims are recorded based on their notifications. The remaining 4(6%) responds that the claims are not recorded based on their notifications. This indicates the claims notification methods are efficient to receive customer's claims.

The claims department workers were asked the question that was the company's claims notification methods/ options are suitable to receive claims notifications? And almost all of them 13(87%) are responds that the company's claims notification methods are very suitable and suitable; and the remaining 2(13%) responds that the company's claims notification methods are moderate suitable.

In addition to that as shown in the table 4.2, from the total 15 respondents of claims department workers most of those 9 (60 %) respondents respond that written in letter or fax of claims notification in the company are not comfortable. The remaining 6(40 %) responds that telephone way of claims notification in the company are not comfortable.




**Source**: Primary Data (2022)

Figure 4.1: Frequency of complaints by policy holders

Claims handling is flexible, as well as, rigid keeping in mind the interest of the insurer. It involves receiving the claims and other procedures for efficient payment of claims. The insurer's commitment to the customer is part of the claims management. As shown in the figure above most of the workers 9(60%) most of the times occurs customer complaints and the remaining 6 (40%) of the workers sometimes occurs customer complaints in the claims management service of the company.

From the total 15 workers who see customer complaints by the policy holders who notified claims 40 % responds that are lack of knowledge about the claim management process and insurance concepts by the policy holders are sources of compliant of claims management services of the company. The others 27% responds that the sources of compliant in claims management services of the company is the difference between the market value and the insured amount, 20 % responds that instability and unavailability of spare parts for motor claims are the major source of compliant in claims management services of the company and the remaining 13 % responds that the sources of compliant in claims management services of the company is the speed of the claims management process.

In addition to the questionnaire, the researcher interviews the claims department head about the major source of customer complaints in claims management process of the company. The interviewee responds that the major source of compliant in the claims process of the company are the difference between the market value and the insured amount, fluctuation of market price of goods and unavailability of spare part.

The interviewee also responds that the company uses different methods to sole customer complaints. The company is open for negotiation and solves problems of customers. The customer can discuss their issues with officers, with claims division supervisor, with claims management head and even with deputy CEO and CEO. The losses which are more than birr 100,000 surveys are outsourced to independent external surveyors. Also for claims less than birr 100,000 based on the interest of the customers the survey could be done by external surveyors.

## 4.3. Efficiency of claim management in Africa insurance company

Efficient claims management is vital to the success of both large and small companies working within the insurance industry. Major components of the claims handling process include developing strategies to cut costs and reduce fraud while keeping customers satisfied.

**Table 4.3: The efficiency of claims management process of the company**

| | Efficiency of claims management process of the company | | Its efficiency compared to the previous years | |
|---|---|---|---|---|
| | Frequency | % | Frequency | % |
| Very efficient | 20 | 25.3 | 8 | 10.1 |
| Efficient | 28 | 35.4 | 18 | 22.8 |
| Moderate/the same | 27 | 34.2 | 49 | 62.0 |
| Not efficient | 4 | 5.1 | 4 | 5.1 |
| Total | 79 | 100 | 79 | 100 |

**Source**: Primary Data (2022)

The sample policy holders and claims management workers were asked about the overall efficiency of the Africa insurance company claims management process. About 61 % the total 79 respondents said that the Africa insurance company claims management process is efficient

while 5 % respondents said that the claims management process is not efficient. The remaining 34 % said it is moderate efficient (see table 4.3).

From the total 79 respondents of policy holders and claims management department workers that responds to how they see the African insurance company claims management process compared to the previous years; about 49(62 %) of the total respondents said that the Africa insurance company claims management process efficiency compared to the previous years is remaining the same and 26(33%) are said the Africa insurance company claims management process efficiency compared to the previous years is going good. The remaining 4(5%) said the company's claims management process efficiency is going bad (see table 4.3).

In addition to the questionnaire, the researcher interviews the claims department head whether they use claims management software to settle claims effectively. The interviewee responds that they use like "prima software" to settle claims effectively and to share the information in all branches what they do in every claims. The interviewee also said about the problems of the software. It is not suitable to prepare reports that is needed by external bodies like National Bank of Ethiopia and the design of the software is not that much good. In addition, the network problem is one of the major issues to use "prima" software effectively. The implication is insured's claim continues complain.

## 4.4.Structure of claims Management process of the company

**Table 4.4: The problems of the company's claims management process**

| Questionnaires | Respondents | |
|---|---|---|
| | Frequency | % |
| I didn't see any problem | 14 | 17.7 |
| Pass through long management chain | 11 | 13.9 |
| Full of unnecessary procedures | 10 | 12.7 |
| Inflexible procedure | 3 | 3.7 |
| Time consuming procedure | 22 | 27.9 |
| Long standing centralization claims management department | 14 | 17.7 |
| Lack of employee in the department | 5 | 6.4 |
| Total | 79 | 100 |

**Source**: Primary Data (2022)

As shown in the table Above (Table 4.4) as the problems of the company's claims management process; 22(28%) of the respondents responds that time consuming procedure is the problem of the company's claims management process, 14(18%) responds that long standing centralization claims management department is the problem of the company's claims management process, 11(14%) responds that pass through long management chain is the problem of the company's claims management process, 10(13%) responds that full of unnecessary procedures is the problem of the company's claims management process, 4(6%) responds that lack of employee in the department is the problem of the company's claims management process, 3(4%) responds that inflexible procedure is the problem of the company's claims management process and the remaining 14(17%) responds that they didn't see any problem in the claims management process of the company. As shown in the data time consuming procedures and long management chain are the problems of the company's claims management process.

**Table 4.5: The process that should amended and time consuming procedures**

| **Claims management process** | Process should be amended | | Time consuming procedures | |
|---|---|---|---|---|
| | **Frequency** | **%** | **Frequency** | **%** |
| Claim Notification | 5 | 6.3 | 8 | 10.1 |
| Claim Review | 9 | 11.4 | 7 | 8.9 |
| Claim investigation | 14 | 17.7 | 25 | 31.6 |
| Response to claimant | 24 | 30.4 | 28 | 35.4 |
| Claim Negotiation | 3 | 3.8 | 4 | 5.1 |
| Claim Settlement | 3 | 3.8 | 7 | 8.9 |
| No need of adjustment | 21 | 26.6 | - | - |
| Total | 79 | 100 | 79 | 100 |

**Source**: Primary Data (2022)

From the total 79 respondents which asked which procedure(s) should be amended or fully changed; most of the respondents 24(30%) responds that response to claimant process of the company should be amended, 14(18%) responds that claim investigation process of the company should be amended, 9(11%) responds that claim review process of the company should be

amended, 5(6%) responds that claim notification process of the company should be amended, 3(4%) responds that claim settlement process of the company should be amended and 3(4%) responds that claim negotiation process of the company should be amended. The remaining 21(27%) respondents respond that no need of adjustment in the claims processes of the company.

Regarding the problem of time consuming procedure of the company; most of the respondents 53(67%) responds that claim investigation and response to claimant process of the company is time consuming. The remaining 10%, 9% 9% and 5% responds that claim notification process, claim review process claims settlement process and claim negotiation process respectively are time consuming process of the company.

## 4.5.Claims Settlement

Form the total 64 policy holder respondents; most of policy holders 27 (42%) respondents responds that the amount of loss claimed for settlement is more than birr 100,000 claims, 14(22%) are between birr 50,000-100,000 claims, 11(17%) are between birr 20,000- 50,000 claims, 8(12%) are less than birr 10,000 claims and the remaining 4(6%) are between birr 10,000-20,000 claims.

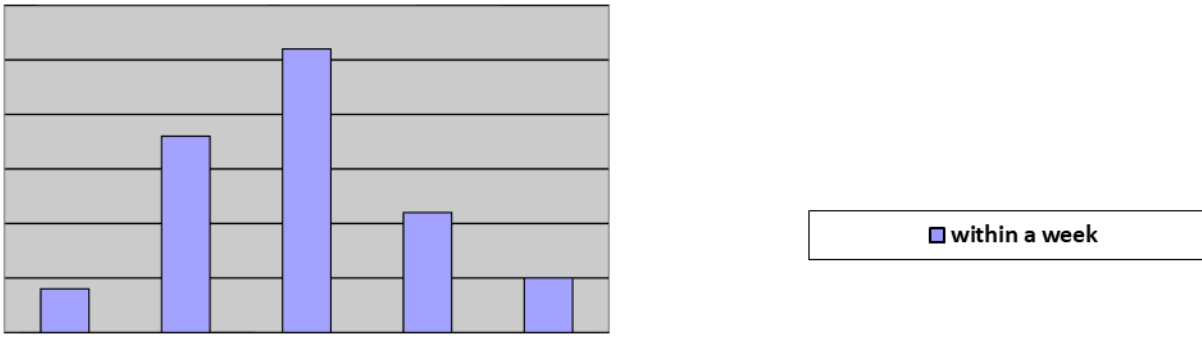



**Figure 4.2: The time which takes to settle claims in African insurance company**

**Source**: Primary Data (2022)

From the total 64 policy holder respondents most of the them 26(41%) responds that the company takes from one to three months to settle their claims, 18(28%) responds that the

company takes from two to four weeks to settle their claims, 11(17%) responds that the company takes three to six months to settle their claims, 5(8%) responds that the company takes more than six months to settle their claims and the remaining 4(6%) responds that the company takes a week to settle their claims(See figure 4.2).

According to the interview conducted with the claims department head, there is a problem of dalliance to settle claims timely even the factors are external factors. The interviewee also mentioned the major factors as late and incomplete submission of documents by the insured, unavailability market price standardization and lack of spare parts.

**Table 4. 6: The speed of claim settlements in African insurance company**

| Speed of settlement | Timeliness of claim payments | | Fastness of repair works by the garages | | The speed of surveyors to submit loss estimations | |
|---|---|---|---|---|---|---|
| | Frequency | % | Frequency | % | Frequency | % |
| **Very fast** | 6 | 7.6 | 3 | 4.1 | 4 | 5.1 |
| **Fast** | 19 | 24.1 | 14 | 19.2 | 49 | 62.0 |
| **Medium** | 37 | 46.8 | 35 | 47.9 | 18 | 22.8 |
| **Dallied** | 7 | 8.9 | 16 | 21.9 | 6 | 7.6 |
| **Very dallied** | 10 | 12.6 | 5 | 6.9 | 2 | 2.5 |
| **Total** | 79 | 100 | 79 | 100 | 79 | 100 |

**Source**: Primary Data (2022)

In addition to the interview, as shown in the table above (table 4.6) majorities of the respondents of questionnaire 37(47 %) respond that claim payments are medial fast. The remaining 25(32%) and 17(21%) responds that claim payments are fast and claim payments are dallied respectively. This indicates most of the claim payments are not in time, there is dalliance in claim payments.

From the total 73 respondents of motor insurance policy holders and claims department workers asked that how fast the repair works completed by the garage; majorities of the respondents 35(48%) responds that the fastness of repair work by garage is medium, 21(29%) responds that the fastness of repair work by garage is dallied and the remaining 17(23%) responds that the

fastness of repair work by garage is fast (See table 4.6). This indicates most of the repair works by the garages are not done on time, which leads dalliance on claim settlement of the company.

From the total 79 respondents most of them (66%) responds the company's surveyors conduct post risk surveys and submit claims estimates or reports to claims division in fast speed, 23% responds the company's surveyors conduct post risk surveys and submit claims estimates or reports to claims division in medium speed and the remaining 10 % responds the company's surveyors conduct post risk surveys and submit claims estimates or reports to claims division slowly.

**Table 4.7: The causes for dalliance of claims settlement in African insurance company**

| | **Total** | |
|---|---|---|
| | **Frequency** | **%** |
| Negligence by the company's officers | 5 | 10.6 |
| Centralization of claims settlement | 2 | 4.3 |
| Late submission of claim form and documents | 19 | 40.4 |
| Inadequate number of workers to perform claims process | 5 | 10.6 |
| Un availability of materials or spare for repair /for motor claims/ | 6 | 12.8 |
| Lack of claims management workers follow up to collect documents from external parts | 3 | 6.4 |
| Unable to possess the claims process in personal case | 4 | 8.5 |
| Unable to possess all the losses by the surveyors | 3 | 6.4 |
| **Total** | 47 | 100 |

*Source: Questionnaire survey result of policy holders and claims department workers, 2022*

As shown in the table above respondents that believe there is claims payments dalliance in Africa insurance company (47 respondents) were asked to answer the causes for dalliance of claims settlement. Most of them 19(40 %) responds that the cause for dalliance of claims settlement is late submission of claim form and documents, 6(13%) responds that the cause for dalliance of claims settlement un availability of materials or spare for repair /for motor claims/, 5(11%) responds that the cause for dalliance of claims settlement is negligence of the company's officers, 5(11%) responds that the cause for dalliance of claims settlement is inadequate number

of workers to perform claims process, 4(9%) responds that the cause for dalliance of claims settlement is unable to possess the claims process in personal case, 3(6%) responds that the cause for dalliance of claims settlement unable to possess all the losses by the surveyors, 3(6%) responds that the for dalliance of claims settlement is lack of claims management workers follow up to collect documents from external parts, and the remaining 2(4%) responds that the cause for dalliance of claims settlement is centralization of claims settlement.

## 4.6.Claims Payment

**Table 4. 8: The fairness of claim payments and loss estimations**

| SN | The causes of claims payment and actual loss difference | Frequency | % |
|---|---|---|---|
| 1 | there is no significant difference between the claim payments compared to the actual loss occurred | 36 | 56 |
| 2 | there is difference between the claims payments compared to the actual loss occurred. | 28 | 44 |
| 3 | there is significant difference between the estimated given by the company surveyors compared to your claim estimation/loss estimation | 39 | 61 |
| 4 | there is no difference between the estimated given by the company surveyors compared to your loss estimation/actual loss/. | 25 | 39 |

As shown in the figure (figure 4.3), majority of the respondents (36 or 56%) responds there is no significant difference between the claim payments compared to the actual loss occurred. While the remaining 28(44%) responds there is difference between the claims payments compared to the actual loss occurred.

As shown in figure (figure 4.3), majority of the respondents (39 or 61%) responds there is significant difference between the estimated given by the company surveyors compared to your claim estimation/loss estimation/. While the remaining 25(39%) responds there is no difference

between the estimated given by the company surveyors compared to your loss estimation/actual loss/.

**Table 4.9: The causes of claims payment and actual loss difference**

| SN | The causes of claims payment and actual loss difference | Frequency | % |
|---|---|---|---|
| 1 | the difference between the loss estimations/claim payments compared to the actual loss occurred is significance difference | 19 | 67.85 |
| 2 | insufficient proof of all losses is the cause of the difference | 3 | 10.71 |
| 3 | the difference between market value and insurance value is the cause of the difference | 6 | 21.42 |
| | Total | 28 | 100 |

**Source**: Primary Data (2022)

From the policy holders which responds that the difference between the loss estimations/claim payments compared to the actual loss occurred is significance difference (28 respondents); were asked to mention the main cause of unfair payment. Majority of the respondents (19 or 68%) response that incorrect assessment of the surveyor is the cause of the difference, 3(11%) response that insufficient proof of all losses is the cause of the difference and the remaining 6(21%) responds that the difference between market value and insurance value is the cause of the difference.

In addition to the questionnaire, claims management department head was interviewed whether there are differences between the loss estimations/claim payments done by the company compared to the amount of loss notified by the company/expected indemnity by the insured or not. The interviewee express that there is difference between the loss estimations/claim payments done by the company compared to the amount of loss notified by the company/expected indemnity by the insured and explains the majors taken to solve these problems as; the loss will be assessed by external surveyors, the repair garage will be selected by the bidding and the

payment will be done based on the amount of sum insured if there is a difference between the market value and the insured value.

## 4.7.Claims Negotiation

**Table 4. 10: Access for claims negotiation**

| | Policy holders | | Workers | |
|---|---|---|---|---|
| | **Frequency** | **%** | **Frequency** | **%** |
| I didn't want to discuss with him | 16 | 35.6 | - | - |
| Yes | 24 | 53.3 | 14 | 93.3 |
| No | 5 | 11.1 | 1 | 7.7 |
| **Total** | 45 | 100 | 15 | 100 |

***Source:*** *Primary Data (2022)*

Policy holder respondent were asked the question, do you have a chance to discuss freely /negotiate/ with claims management department for your claims payment dalliance, unfair payment and claim rejection, and majority of the respondents (24 or 53%) have a chance to negotiate about their claim, 16(36%) didn't want to negotiate and the remaining 5(11%) does not have a chance to negotiate (see table 4.8).

From Claims department worker respondents almost of them (93 %) responds that there is a good access to negotiate /discuss freely/ about their claims while the remaining 7 % responds that there is no good access to negotiate /discuss freely/ about their claims.

From the total 64 collected questionnaires filled by the policy holder respondents 55 of them responds the question that asked do you go to court to settle your claims? and all of the respondents that they don't go to court to settle their claim in judicial process.

Even if none respondent goes to Court to settle their claim in judicial process the Africa insurance company legal service department report indicates that 3 customers sue the company on the causes notifies between June 1-september 30, 2021.

## 4.8.Claims Investigation Process

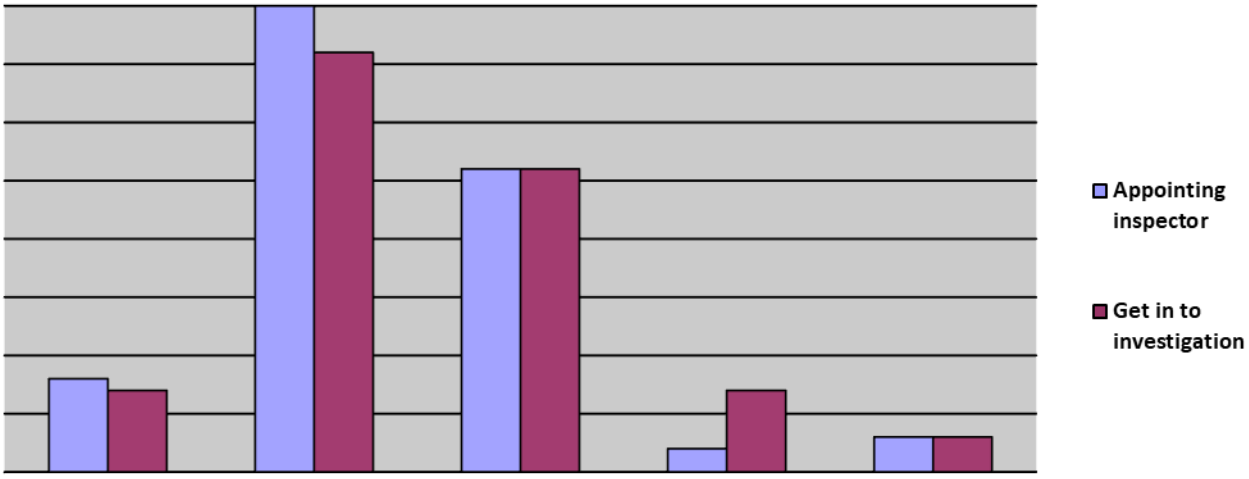



**Figure 4.3: The immediateness of surveyors to handle investigation**

**Source**: Primary Data (2022)

As shown in the graph above the majority of the respondents (48 or 61%) responds that an inspector is assigned immediately to handle the case whenever the claim necessitates his attendance, while 26(33%) responds that an inspector is assigned in medium speed to handle the case whenever the claim necessitates his attendance. The remaining 5(6%) responds that an inspector is not assigned immediately to handle the case whenever the claim necessitates his attendance.

In addition to the immediateness of appointing of surveyors for investigation, the respondent were asked that the immediateness of surveyors to handle investigation, and as shown in the graph above the majority of the respondents (43 or 54%) responds that the assigned inspector is handle the investigation immediately when he/she assigned for it, while 26(33%) responds that the assigned inspector is handle the investigation in medium immediate after he/she assigned for it. The remaining 10(13%) responds that the assigned inspector is handling the investigation lately after he/she assigned for it.

**Table 4. 11: The cause of dalliance to enter in to investigation**

| | Total | |
|---|---|---|
| | **Frequency** | **%** |
| Negligence of inspectors | 4 | 15.4 |
| Inadequate number of inspectors to investigate quickly | 8 | 30.8 |
| Lack of cooperation in claim department | 14 | 53.8 |
| Total | 26 | 100 |

**Source**: Primary Data (2022)

From the total 26 respondents which believe that there is time dalliance to enter to investigation; most of the respondents (14 or 54%) responds that the cause of dalliance to enter into investigation is lack of cooperation in claim department, 8(31%) responds that the cause of dalliance to enter into investigation is inadequate number of inspectors to investigate quickly and the remaining 4(15%) responds that the cause of dalliance to enter into investigation is negligence of inspectors.

## 4.9. Human Resource Structure

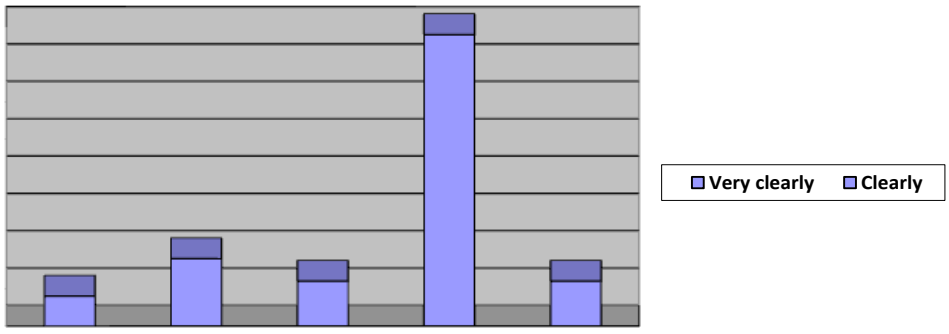



**Figure 4.4: The explanation of claims procedures to policy holders**

**Source**: Primary Data (2022)

Africa insurance policy holders were asked whether the claims management procedures clearly explained to you when you notify claims by the claim management department or by the officer or not; majority of the respondents (39 or 61%) were respond that the claims management procedures are explained slightly to them and 7(9%) responds that the claims management or officer didn't explained about the claims management procedures. While 13(20%) responds that the claims management procedures are explained clearly to them the remaining 4(6%) are neutral.

**Table 4. 12: The adequacy of worker and the arrangement surveyors**

| **No** | **Questionnaires** | **Responses** | **Respondents** | |
|---|---|---|---|---|
| | | | **Frequency** | **%** |
| 1 | The adequacy of workers in claims management department | Very adequate | 12 | 15.2 |
| | | Adequate | 31 | 39.2 |
| | | Medium | 21 | 26.6 |
| | | Low | 13 | 16.5 |
| | | Very low | 2 | 2.5 |
| | | Total | 79 | 100 |
| 2 | The arrangement of surveyors to access all losses | Very arranged | 3 | 3.8 |
| | | Arranged | 38 | 48.1 |
| | | Neutral | 20 | 25.3 |
| | | poorly arranged | 18 | 22.8 |
| | | Total | 79 | 100 |
| 3 | The problems of surveyors to access losses | assessing cause of loss and list of loss/list of damages/ | 4 | 22.2 |
| | | assessing the extent of loss expressed in money/cost of damages/ | 2 | 11.1 |
| | | assessing the possibility for claims recovery/total loss or recovery loss/ | 3 | 16.7 |
| | | assessing the time require for repairing | 9 | 50.0 |
| | | Total | 18 | 100 |

**Source**: Primary Data (2022)

As shown in table 4.10 most of the respondents (43 or 54%) respond that Africa insurance claims department has adequate workers while 15(19%) responds that Africa insurance claims department doesn't have adequate workers. The remaining 21(27%) responds that Africa insurance claims department has medium number of workers. In addition to the questionnaire, claims management department head was interviewed whether there are adequate numbers of workers in claims management department or not. The interviewee responds that there is adequate number of workers in claims department.

Most of the respondents (41 or 52 %) responds that the company's surveyor are arranger or able to assess all losses while 18(23%) of the respondents responds that the company's surveyor are not arranger or unable to assess all losses. The remaining 20(25%) of the respondents responds that they don't know whether the company's surveyor are arranger or able to assess all losses or not (see table 4.10).

As shown the above 18 (23%) respondents of the total 79 respondents were responds that the surveyors are not arranged to access all losses; all of them are policy holders. Half of them responds that the surveyors were have a problem of assessing the time require for repairing, 4(22%) responds that the surveyors were have a problem of assessing cause of loss and list of loss/list of damages/, 3(17%) responds that the surveyors were have a problem of assessing the possibility for claims recovery/total loss or recovery loss/ and the remaining 2(11%) responds that the surveyors were have a problem of assessing the extent of loss expressed in money/cost of damages (see table 4.10).

## 4.10. Causes of Claim Rejection

Form the total 64 respondents of policy holders almost all (64 or 97%) responds that the company didn't reject their claims that notified for settlement. The remaining 2(3%) responds the company reject their claim that notified for settlement.

**Table 4.11: The causes of claims rejection**

| | Respondents | |
|---|---|---|
| | **Frequency** | **%** |
| The cause of loss is not covered by policy | 8 | 47.0 |
| Policy period lapsed | 1 | 5.9 |
| Insufficient proof | 5 | 29.4 |
| The premium is not fully paid | 2 | 11.8 |
| Unable to provide police report about the loss | 1 | 5.9 |
| Total | 17 | 100 |

**Source**: Primary Data (2022)

When the policy holders whose claims are rejected and the claims management department workers were asked the reason for rejection; from the total 17 respondents 8(47%) answered that the main cause of claims rejection is the cause of loss is not covered by policy, 5(29%) answered that the main cause of claims rejection is insufficient proof of the loss, 2(12%) answered that the main cause of claims rejection is the premium is not fully paid, 1(6 %) answered that the main cause of claims rejection is policy period lapsed and the remaining 1(6%) said the cause of claims rejection unable to provide police report about the loss (see table 4.11).

In addition to the questionnaire, claims management department head was interviewed about the main reasons for claim rejection, the process pass to reject claims and the measures take to solve complains on claims rejection. The interviewee responds as; basically annually maximum 10 claims may be rejected in the company. The major reason for claims rejection is the cause of the loss is not covered in the insurance policy. If the loss is not covered by policy, fulfill procedures, conditions, exceptions and lastly it unable handle by ex-gratia payment the claim will be rejected. Additionally the insured comes with fraudulently claims the claim will be immediately rejected. The claim rejection will be approved by the deputy CEO or by CEO when the claims department necessitates its approval.

## 4.11.Fraudulent Claims

Most of Africa insurance company claims department workers respondents, about 53 % seen fraudulent claims notified by the policy holders. The remaining 47 % didn't see any fraudulent claims notified by the policy holders.

From the total 8 workers who see fraudulent claims notified by the policy holders most of them (5 or 63%) automatically reject the fraudulently claims and close the claim file. The remaining 3(37) % respondents reports to the claims division supervisor or claims manager to settle fraudulent claims.

In addition to the questionnaire, the researcher interviewed the claims department head about whether there are misinterpretation or fraudulently act by policy holders on claim requests or not and the measures take to prevent these acts. The interviewee responds that fraudulently claims notified by the policy holders. The customers notify motor insurance claims after they change the insured motors and changes tires after the accident occurs. Sometimes customers bought insurance policy when they face losses and notified the losses as like it has insurance coverage. The company immediately rejects the fraudulently claims. The company seriously investigates the claims when it notifies by the policy holders.

## 4.12. Centralization of claim department

According to the interview conducted with the claims department head, the claims department is mainly concentrated in the head office level. But the company undertakes the claims settlement in its seven branches when the losses notified for settlements are below birr 20,000. In the head office level, the approval of claim payments below birr 50,000 is authorized to the head of claims management department. Above birr 50,000 claim payments are approved by the deputy chief executive officer and chief executive officer.

**Table 4. 13: Impact of claims management centralization**

| Impact of claims management centralization | **Respondents** | |
|---|---|---|
| | **Frequency** | **%** |
| High cost and time to insurers for investigation and to insured for settlement(came from states) | 16 | 21.1 |
| Loss of evidences loss in investigation | 8 | 10.5 |
| Source of complaint of customers | 3 | 3.9 |
| I didn't see any problem on its centralization | 44 | 57.9 |
| Unable process the settlement when we goes in states | 5 | 6.6 |
| Total | 76 | 100 |

**Source**: Primary Data (2022)

As shown the above table 4.12 from the total 79 respondents, 76 respondents respond about the impact of claims management centralization in the company. Most of the respondents (58%) respond that they didn't see any problem on its centralization of claims process of the company. The remaining 21 %, 10 %, 7% and 4 respondents responds that the impact of centralization are high cost and time to insurers for investigation and to insured for settlement (came from states), loss of evidences loss in investigation, unable process the settlement when the insured goes back to states and source of complaint of customers respectively.

**Table 4. 14.: Choice of Garages, Subrogation and Staff Competency**

| *(1) Strongly Disagree; (2) Disagree; (3) Neutral; (4) Agree; (5) Strongly Agree* | | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| **Choice and Appointment of Repairing Garages** | | | | | | |
| The insured is allowed to choose his preferred repairing garage | N | 1 | 10 | 7 | 55 | 15 |
| | % | 1.1 | 11.4 | 8.0 | 62.5 | 17.0 |
| The garages on Company's approved repairer list have similar standard of workmanship and organization | N | 1 | 12 | 33 | 35 | 7 |
| | % | 1.1 | 13.6 | 37.5 | 39.8 | 8.0 |
| Bidding garages repair estimate always provide accurate measurement of the damage sustained | N | 2 | 27 | 12 | 35 | 12 |
| | % | 2.3 | 30.7 | 13.6 | 39.8 | 13.6 |
| The least bidding garage estimate actually represents the exact compensation payable before deduction of contribution | N | 8 | 14 | 24 | 35 | 7 |
| | % | 9.1 | 15.9 | 27.3 | 39.8 | 8.0 |
| Insurers bidding process for repair cost guarantees fairness and equity | N | 2 | 16 | 9 | 47 | 14 |
| | % | 2.3 | 18.2 | 10.2 | 53.4 | 15.9 |
| **Claim Payments, Subrogation and Complaints** | | | | | | |
| The insurer settles the claim promptly in line with the service | N | 0 | 7 | 15 | 58 | 8 |
| | % | 0.0 | 8.0 | 17.0 | 65.9 | 9.1 |
| Subrogation | N | 6 | 10 | 22 | 38 | 12 |
| | % | 6.8 | 11.4 | 25.0 | 43.2 | 13.6 |
| The company has set up a desk to address the customer complaints. | N | 3 | 22 | 18 | 36 | 9 |
| | % | 3.4 | 25.0 | 20.5 | 40.9 | 10.2 |
| Unsatisfied customers are advised to refer their cases to the highest organ of the organization | N | 4 | 9 | 6 | 56 | 13 |
| | % | 4.5 | 10.2 | 6.8 | 63.6 | 14.8 |
| There is a separate Complaints Bureau or an independent Insurance Ombudsman to address insurance customers' complaints. | N | 29 | 17 | 13 | 24 | 5 |
| | % | 33.0 | 19.3 | 14.8 | 27.3 | 5.7 |
| A separate record is made if a number of claims are made from a single accident. | N | 9 | 20 | 10 | 45 | 4 |
| | % | 10.2 | 22.7 | 11.4 | 51.1 | 4.5 |

Source: Own survey, 2022)

The data collected using questionnaire from Africa insurance policy holders and claims department workers and interview with the claims department head of the company presented, analyzed and interpreted as seen above. This presentation, analysis and interpretations able to access the summary of findings deduce the conclusions about the facts of claims management process in the company and recommend solutions for the problems

## 4.13. Staff Competency

Respondent's perception on the competency of AIC staff had been evaluated based on three different indicators. It was assessed if the company maintains competent staff with appropriate skills in claims handling. Besides, the level of customer's perception on whether the company carried out regular internal audit of all claims lodged or not. How internal audit applies to all stages of the claims management process had also been evaluated. In wrapping up, the staff could not be considered as competent by many customers.

Table 4.15.: Staff Competency

| *(1) Strongly Disagree; (2) Disagree; (3) Neutral; (4) Agree; (5) Strongly Agree* | | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| The company maintains competent staff with appropriate skills in claims handling. | **N** | 13 | 14 | 11 | 41 | 9 |
| | **%** | 14.8 | 15.9 | 12.5 | 46.6 | 10.2 |
| The company carry's out regular internal audit of all claims lodged. | **N** | 1 | 9 | 25 | 47 | 6 |
| | **%** | 1.1 | 10.2 | 28.4 | 53.4 | 6.8 |
| The internal audit applies to all stages of the claims management process | **N** | 7 | 5 | 26 | 40 | 10 |
| | **%** | 8.0 | 5.7 | 29.5 | 45.5 | 11.4 |

Source: Own survey, 2022)

As it was indicated in Table 4.14, 56.8 **%** of the respondents said that the company maintains competent staff with appropriate skills in claims handling. 30.7 **%** of the respondents considered that staff as incompetent. The company, according to 60.2 **%** of the respondents, carry's out regular internal audit of all claims lodged. 56.9 **%** of the respondents said that the internal audit applies to all stages of the claims management process. Many agreed on staff competence. But a considerable number saw it from different angle, which may lead to an implication that the company is not satisfying the needs and expectations of the customers.

### 4.13.1. Timeliness of the Claims Process and Service Standards of the Company

The relative speed with which those services had been delivered was accessed (Table 4.15). Claim intimation is usually refined in hours (according to 43.2 **%** of the respondents), in days (according to 26.1**%** of the respondents), in months (according to 30.7 **%** of the respondents). The acknowledgements of claim and acquisition of documents or contacts with the claimant

finished in hours (according to 47.7**%** of the respondents), days (according to 35.2 **%** of the respondents), and months (according to 17 of the respondents). Site visit/or appointment of investigators, internal surveyors, independent assessor / surveyors etc, takes hours (according to 44.3**%** of the respondents), days (according to 33 **%** of the respondents), and months (according to 22.7**%** of the respondents).

**Table 4. 16. Timeliness of the claims process and service standards of the company**

| | Simple (hours) | | Intermediate (days) | | Complicated (Months) | |
|---|---|---|---|---|---|---|
| | **N** | **%** | **N** | **%** | **N** | **%** |
| Claim intimation | 38 | 43.2 | 23 | 26.1 | 27 | 30.7 |
| Acknowledgement of Claim and acquisition of documents / contact with the claimant | 42 | 47.7 | 31 | 35.2 | 15 | 17.0 |
| Site visit / or appointment of investigators, internal surveyors, independent assessor / surveyors etc | 39 | 44.3 | 29 | 33.0 | 20 | 22.7 |
| Making settlement offer or communicating repudiation of claim | 29 | 33.0 | 44 | 50.0 | 15 | 17.0 |
| Settling claim | 29 | 33.0 | 50 | 56.8 | 9 | 10.2 |
| The company provides a written reason explaining why a claim cannot be settled within the indicative timelines for each of the processes. | 21 | 23.9 | 45 | 51.1 | 22 | 25.0 |
| This explanation reaches the regulatory authority (NBE) before expiry of applicable time limit | 16 | 18.2 | 39 | 44.3 | 33 | 37.5 |
| Copies of such correspondences to the insured or intermediary as the case may be. | 30 | 34.1 | 38 | 43.2 | 20 | 22.7 |

N=count, % = percentages, (Source: Own survey, 2022)

The respondents stated that making settlement offer or communicating repudiation of claim takes hours (according to 33**%** of the respondents), days (according to 50 **%** of the respondents), and months (according to 17**%** of the respondents). Settling claim, takes hours (according to 33**%** of the respondents), days (according to 56.8**%** of the respondents), and months (according to

10.2**%** of the respondents). The company provides a written reason explaining why a claim cannot be settled within the indicative timelines for each of the processes takes hours (according to 23.9**%** of the respondents), days (according to 51.1**%** of the respondents), and months (according to 25**%** of the respondents).

Providing copies of correspondences to the insured or intermediary takes hours (according to 34.1**%** of the respondents), days (according to 43.2**%** of the respondents), and months (according to 22.7**%** of the respondents) (Table 4.15). Based on the obtained data, it can be seen that not a few number of the internal customers were satisfied with the timeliness of the services being delivered in handling motor claims in AIC. Internal customers response suggest that AIC doesn't have a procedure that specify the timeliness or the processing time set for each of the claims sub-processes and the related activities which is known and made official to each of the internal and external customers that is rigorously adhered to by all parties including claims staff.

### 4.13.2 Summary of Internal Customers Response on AIC Claims Handling Process

From Table 4.3.11_14 shown below and Appendix VI, presenting cumulative average summary results of internal customers response on AICs main motor claims handling sub-processes, it can be generally concluded they are of the opinion that claims handling process is carried out to the satisfaction of majority of customers; with an approval rate of 61.8%, neutral being about 17.6 % and disapproval rate of 20.7%. Though the approval response rate of 61.8%, is not equal to the prevailing customers satisfaction rate of 76% as indicated on the Five Year Strategic Plan, the overall process as perceived by the internal customer of AIC is to the liking of most customers and meets their expectation as it is based on sound and standard principles and practices.

However, according to the internal respondents there are at least three sub-processes in the whole claims service diluting customers satisfaction requiring due consideration for change and / or improvement by AIC. These are (1) Claim Payments Approval and Processing, Providing due advice to preserve Subrogation Rights of AIC, Having Proper Complaints Handling System, and recording and keeping appropriate motor claims data- particularly Data on Per Event Aggregate Losses and Claims From Single Accident, (2) Customer Education, and (3) Choice and Appointment of Repairing Garages. Besides giving higher approval rating to other sub-processes

and related activities, respondents have strong opinion that the claims staff providing the service is competent enough to provide the claims service and the performance of the system is intact.

Table 4.17: Summary of Internal Customers Response on AIC Claims Service

| **Claims Sub-Processes and Activities** | | **Level of Approval** | | | **Rank** |
|---|---|---|---|---|---|
| | (1) Strongly Disagree: SD; (2) Disagree : D; (3) Neutral: N;<br>(4) Agree: A; (5) Strongly Agree: SA | SD+D | N | A+SA | |
| Ta ble 4.11. : Customer Education, Intimation and Initial Contact wit h Customer | | (%) | (%) | (%) | |
| 1 | Customer Education | 28.8 | 12.1 | 59.1 | 2 |
| 2 | Claim Intimation Process | 16.6 | 16.3 | 67.0 | 7 |
| 3 | Initial Contact with the Client and/or Third Party | 14.2 | 14.2 | 71.6 | 8 |
| Ta ble 4.12. : Reserving, Claims Service Standard and Investigation | | | | | |
| 4 | Reserving | 18.4 | 24.1 | 57.5 | 5 |
| 5 | The Claims Process & Service Standards for Company Surveyor or Independent Loss Assessors / Surveyor | | | | |
| 6 | Claim Investigation, Independent Loss Assessor and Surveyor<br>Appointment Process | 17.5 | 16.1 | 66.4 | 6 |
| Ta ble 4.13. : Choice of Garages, Payments and Subrogation | | | | | |
| 9 | Choice and Appointment of Repairing Garages | 21.2 | 19.3 | 59.6 | 3 |
| 10 | Claim Payments Approval and Processing | | | | |
| 11 | Providing due advice to preserve Subrogation Rights of AIC | | | | |
| 12 | Having Proper Complaints Handling System | | | | |
| 13 | Data on Per Event Aggregate Losses & Claims From Single Accident | | | | |
| | | 30.1 | 15.1 | 54.8 | 1 |
| Ta ble 4.14. : Staff Competency | | | | | |
| 14 | Staff Competency | 18.6 | 23.5 | 58.0 | 4 |
| | **Total Cumulative Average** | **20.7** | **17.6** | **61.8** | |

% = Percentages, Mn= Mean, R= Rank for Improvement (Source: Own survey, 2022)

## 4.14. Key Findings from the Focus Group Discussion

### 4.14.1. The Major Challenges of AIC

The FGD result had shown that there are a lot of critical problems in AIC that hinders its mission. Particularly, the agents, claimants and low-managements of AIC believed that lack of updated and clear claims handling policy and procedure or claims management operations manuals; lack of skilled, knowledgeable, experienced and committed claim staff in motor claims service are the key challenges in AIC. More importantly, centralized claims service mainly at the head quarter level, lack of implementing claims management, external and internal effects of immoral behavior of the clients, surveyors, loss assessors and internal engineers, garages, spare part dealers, and claims staff along with sluggish interdepartmental / work units / communications that are deteriorating customers satisfaction and eroding customers profit and market share are the inherent attributes of the prevailing traditional claims handling process.

Poor or non-existent compliant handling system in the Company, delay of claims process from notification up to settlement, unfair premium price competition rather than service excellence in the insurance industry, shortage of competent manpower and work overload, lack of standard and intensive training for claims staff, and lack of work standard based on outcomes and performance for internal employees, external surveyors and garages, which are also attributes of the traditional claims service deeply embodied in the market, also decelerates the rate at which quality service is delivered in AIC.

Unless the situations mentioned above are not properly addressed in due course, AIC, rather than excelling than competitors, may loss its right full share of the market, from new and existing business, and a further exacerbated loss ratio and miserable profitability.

### 4.14.2. Coping Mechanisms

The interviewees raised the coping mechanisms being implemented them in order of their frequency and effectiveness. They said that updating and replacing the current traditional claims handling procedure and replacing it with proper claims management with defined claims philosophy of the Company; assigning qualified, competent, experienced and committed manpower in all work units; keeping close relationship with clients, police traffic offices,

garages and concerned stakeholder; immediate assigning of inspectors and branch managers at the site of accident to investigate the loss, to deter possible moral hazard and fraudulent acts, to put measures in minimizing exaggerated claims cost at the same time by satisfying clients by meeting their expectations were the major coping mechanisms recommended to reverse the situation at hand.

### 4.14.3. Possible Elucidations of the Way Forward

According to the informants the AIC should do the following to improve satisfaction of the customer: Delivering fast and timely claim service to our claimants, assigning inspector at the site of the accident, notifying claims process in writing up to claims payment and informing helpline or contact point at the time of accident.

### 4.14.4. Learning from Competitors

Considering competitors companies in the same insurance businesses in the country, and international benchmarked insurance institutes, what AIC can learn from other best practices are: (1) decentralization of claims service based on defined and official criteria to branches, in order to minimize work load at head office, (2) introduction of practical claims management, to be efficient in claims service, and (3) upgrading of claims systems and procedures, with current information technology targeting the motor claims handling process, (4) introduction of team works and strong integration of work units and departments towards the objectives of the Company and (5) immediate assignment of investigators and claims officers including branch managers in order to conduct site investigation to minimize exaggerated and fraudulent claims. Assigning company inspector and delegating branch managers at the site of accident is more important to protect manipulation of police report and to minimize moral hazard of third party.

Interviewees further suggested that there is an urgent need for the Company to standardize the quality of services delivered by the company, the external surveyors, and the garages by ranking according to their qualification, competency with defined and official standard; and period of work and performance result.

## 4.15. Key Informants Interview

### 4.15.1. Alignment of Service Delivery with the AIC's Mission and Strategies

Almost all internal customers (informants) know the policy, the mission and strategic plans of the AIC. The Manager from Customer Services stated that: the policy of the company is reflected in the corporate motto of the Company committed to excellence and quality service. The company strives to win its competitors by providing excellent and quality service with reasonable price.

The mission of the company is providing reliable and quality products and services in the best interest of its customers at commensurate price. The newly developed Five (5) Years Strategic Plan has put a vision for the company which makes it shine as most preferred, accessible and market leader insurance company in the country by the year 2025 G.C. In addition to this the strategic plan is to increase the overall wealth of the company.

Most informants having admitted the prevailing motor claims handling process problems, still argue that the prevailing service delivery is in alignment of the Company's strategic objective

### 4.15.2. Excellence of Claims Service and Customers Expectations

According to opinion of internal customers the service standard of AIC exceeds its competitors, and appears to perform well and good. But it still lacks major elements which majority of existing and potential customers expect. Internal customers are of the opinion that the standard of claims service in motor or other class of insurance meets customer's expectation. However, service excellence can be achieved only if total satisfaction is achieved as has been properly identified and stated by the informants. This statement seems to contradict the popular view, such as lack of standard work, standard service, defined processing time / turnaround time, competent staff and etc specified above from the gathering of informants themselves.

### 4.15.3. Identifying the Existence of Claim Management in AIC

The other comment provided at the time of interview is whether the motor claims handling process known by its misnomer as claims management is liberated from problems relating to internal and external actors making fraudulent and/or exaggerated claims corroborated with

tampered evidences/documents and other methods. According to information gathered from internal customers, when compared to competitors in the market, informants are of the opinion that AIC has better claims handling process or claims management that needs improvement.

Among those requiring improvement are the existence of a lot of bureaucratic procedures." The main actors/participants responsible for the exacerbation of the motor claims cost being the clients, claims staff and clerks, internal and external loss assessors and surveyors, police traffic, medical institute workers, third party claimants, garages and etc. All these factors accounts are expected for the skyrocketing of motor claims ratio of 106% during the last quarter as compared to 94% of same period last year.

### 4.15.4. Major Challenges in AIC

The informants had coined various challenges that needed to be addressed and measures should be enacted to tackle these challenges, lack of sufficient knowledge and experience by claims staff. Immoral behavior of the client and internal employees, lack of speedy response from government authority like police, lack of sufficient skill by derivers of motor vehicles, Centralized claims payment system of the company and unfair premium price competition in the insurance industry.

### 4.15.5. Mitigation Measures

It was repeatedly mentioned by these key informants that the company needs to have clear claims handling procedures and processes which can avoid fraud and bad practices. It was also imperative for the company to train its staff consistently to increase their efficiency; and capacitate itself in areas of resources and other vital deliverables. The insurance association has to work strongly together to influence the government and other partners and organs, so that speedy communication and service delivery can be made. Decentralized claims service or claims settlement system of the company should be implemented.

### 4.15.6. Prospects of the AIC

According to the interviewees, Africa Insurance Company will definitely be at top level from the private sector in the next 5 - 15 years through its diverse investment in shares, real estate and

transport sectors. The good image of the company has developed in the past and these lucrative private and government investment in the next five to fifteen years are the opportunities and enablers. While the prevailing unfair market competition, ever increasing price of spare parts and labor cost, high turnover of employees and lack of skilled man power, the possible opening of the financial sector to foreign companies shall be the threats for the coming period. It was underscored in this ever-changing market environment that the company can achieve its five-year strategic plan if only if all stakeholders are participating through sense of ownership.

# CHAPTER FIVE

# FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

## 5.1 Introduction

In the previous chapter, the results of the case study were tabulated and figured, and the findings of the study were discussed in detail. This chapter summarizes major findings and draws several conclusions and recommendations with the overall claims management practices of the Africa insurance company.

## 5.2 Summary of the Major Findings

The company has given information about the claims handing process when the policy holders bought insurance policy. But more customer's respondents don't have enough information and others didn't have any information about the claims handing process of the company.

For most of the customers (94%), their claims are recorded based on their notifications and the company's claims notification methods are suitable. But when customers notify claims the claims management department or the officer that receives the notifications, for most of them, didn't explain the claims management procedures for them.

Policy holders frequently come with complaint about claims handling services of the company. The major sources of complains (87%) are lack of knowledge about the claim management process and insurance concepts by the policy holders, the difference between the market value and the insured amount and instability of price and unavailability of spare parts for motor claims.

Africa insurance overall efficiency of claims management practice is efficient and going to the same efficiency compared to the previous years. The company also use claims management software called PRIMA to handle their work effectively.

The major problems of the company's claims management process are time consuming procedures and long standing centralization claims management department. In addition the response to claimant process of the company and claim investigation process of the company are source of compliant and should be amended. These claim investigation and response to claimant process of the company are also the time consuming procedures from the claim procedures of the company.

The claims department of the company is centralized in the head office level. Most of the claims that notified by the policy holders (66%) are losses that are more than birr 50,000 (fifty thousand). Claims which are more than birr 50,000 are approved by the deputy Chief Executive Officer or Chief Executive Officer based on the rules of the company. The losses less than 50,000 approved by the claims department head. Four branches that are in Addis Ababa settle claims up to birr 20,000 at branch level. The centralization of the claims department doesn't impact most of the policy holders. But for some policy holders especially who come from out of Addis Ababa leads to high claims processing cost.

Most of the claims (66%) take more than one month for settlement and the payments are made in medium speed. The major causes for dalliance of claims settlement are late submission of claim form and documents and unavailability of materials or spare for repair. Because of unavailability of spare parts the repairs made by the garages are dallied.

For most claims (56%) there is no different between the actual loss and the amount of payments. The company also outsourcing the claims surveying for losses more than birr 100,000 and even less than birr 100,000 (based on the customer's interest) to solve customer complains of loss estimation.

The claims management department of the company is open for policy holder to discuss/negotiate freely for their claims payment dalliance, unfair payment and claim rejection. Beyond that 3 policy holders are go to court to settle their claims at court in the 1$^{st}$ quarter year.

The claims department has its own surveyors that assess the losses that occur on the insured property. The department assigned immediately an inspector to handle the case whenever the claim necessitates the surveyor's attendance. The assigned inspectors handle the investigation immediately when they are assigned for it. But sometimes there is time dalliance to enter to investigation. The major causes of dalliance (84%) to enter into investigation are lack of cooperation in claim department and inadequate number of inspectors to investigate quickly. The company's surveyors conduct post risk surveys and submit claims estimates or reports to claims division in fast speed.

The Africa insurance claims department has adequate workers. The company also has organized surveyors that can able to assess all losses. Even they are arranged they have some problems like

a problem of assessing the time required for repairing and a problem of assessing cause of loss and list of loss/list of damages/.

The company's claim rejection percentage is very low (3%). The main reason for claims rejection in Africa insurance company is the cause of loss is not covered by policy and insufficient proof of the loss. The claim rejection is approved by the deputy CEO or CEO of the company if loss is not covered by the policy, fulfill procedures, conditions, exceptions and lastly unable handle by ex-gratia payment. Policy holders in Africa insurance company comes with fraudulently claims. Most workers see those fraudulent claims. Most of them automatically reject those claims.

## 5.3 Conclusions

Based on the major finding of the study the following conclusions were drawn.

The company has given information about the claims handing process when the policy holders bought insurance policy but more customers didn't get enough information. The company's claims notification methods/ options are suitable to receive claims notifications and recorded based on their notification. But when customers notify claims the claims management department or the officer that receives the notifications didn't explain the claims management procedures for them.

The claim management department of the company is full of complains by policy holders based on internal and external factors. The overall efficiency of the Africa insurance company claims management practice is efficient and supported by claims management software, and going on the same efficiency compared to the previous years.

The main problem of the claims department is concentrated in claims investigation process and response to claimant. Lack of knowledge about the claim management process and insurance concepts by the policy holders is the major sources of complains of the company. The centralization of claims department is also source of customer compliant especially for policy holders comes from out of Addis Ababa leads to high claims processing cost.

More claim payments are approved by the deputy chief executive officer or chief executive officer. Dalliance is one of the major problems of the claims department of the company. Most of the claims takes more than one moth for settlement and no different between the actual loss and

the amount of payments. The major causes for dalliance of claims settlement are late submission of claim form and documents and unavailability of materials or spare for repair. The claims management department of the company is open for policy holder to discuss freely /negotiate/ for their claims payment dalliance, unfair payment and claim rejection.

The Africa insurance claims department has adequate workers and organized surveyors. Even the surveyors are arranged they have some problems like a problem of assessing the time require for repairing and a problem of assessing cause of loss and list of loss/list of damages/. The department assigned immediately an inspector to handle surveyors and the assigned inspectors handle the investigation immediately when they are assigned for it. The company's surveyors conduct post risk surveys and submit claims estimates or reports to claims division in fast speed. But sometimes there is time dalliance to enter to investigation. The major causes of dalliance to enter in to investigation are lack of cooperation in claim department and inadequate number of inspectors to investigate quickly.

Even the company's claim rejection percentage is very low; the main reasons for claim rejections are the cause of loss is not covered by policy and insufficient proof of the loss. Policy holders in Africa insurance company comes with fraudulently claims. Most workers see those fraudulently claim. Most of them automatically reject these claims.

## 5.4. Recommendations

Based on the major findings of the study and the conclusions drawn, the following recommendations were made.

The major sources of complains are lack of knowledge about the claim management process and insurance concepts by the policy holders. The company insurance policies are written in English. So, the insurance policy document should have Amharic version with English. This enables the policy holders to understand what the policy say, insurance coverage, rights, obligations etc in their own (National) language and helps to have good concepts in insurance and claims management process.

The major causes for dalliance of claims settlement are late submission of claim form and documents and unavailability of materials or spare for repair. In addition the claims management department or the officer that receives the notifications didn't explain the claims management

procedures for the customers notify claims. There for the company should briefly explain the claims management procedures and the documents which necessary to handle the claims timely for customers when they notify claims. Also, the company should have contractual agreements with some spare part importers to supply necessary spare parts in the demand of the company.

To solve the difference between the market value and the insured amount the company should prepare strategies that solve this problem. The surveyors can estimate the amount of the insured materials and the amount of the insured value will be known in pre-loss period. This helps to settle the claims without complain the difference between the market value and the insured amount.

Even the company's claims notification methods/ options are suitable to receive claims notifications; in addition, it is better to use electronic ways of claims notification like email.

The company's claims management process is centralized in the company's claims management department head. This is source of customers compliant especially customers that come from out of Addis Ababa, which leads them high claims processing cost. It is better to decentralize claim settlements for losses that are less than some amount (determined by the management based on the capacity of branches) branches that are out of Addis Ababa.

The response to claimant process of the company and claim investigation process of the company are time consuming and source of compliant procedures. The company should conduct the investigation process in good cooperation with the department. The department also should respond on timely for the payment, for further investigations or for rejections of claims.

Fraudulent claims increase the cost of the insurance companies in significant way. The company should prepare the list of policy holders which notifies fraudulent claims. This data also should be transferred to underwriting department and the underwriting department should consider this data for determining the premium. In addition the claims department with coordination legal service department should transfer those critical fraudulent claims to police, if those are crimes. In addition, developing and running industry wide data bases, such as the claims and underwriting exchange, which enable the company, and the overall insurance companies, to exchange information to help identify possible fraudulent behavior of the policy holders.

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# Annex-I

**Questionnaire for Africa Insurance policy holders**

Dear respondents,

The purpose of this questionnaire is to present a senior essay that assesses the overall claims management process in Africa Insurance Company as a partial fulfillment of the requirement for the completion of MBA in finance at the St. Mary's University. ***Your response would have been used only for academic purpose and kept confidential.***

**Instructions** Please respond in the following ways

- By putting 'x' mark in the box provided.
- By writing the desired answer for open ended question

**Your cooperation in filling this questionnaire is of paramount importance.**

**PART I: Claims Handling Processes Attributes**

**Illustration to facilitate completion of this Questionnaire**

| Please mark (□) the one that fits the best | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|---|---|---|---|---|---|
| **1.0. Customer Education: - The Company** | | | | | |
| **a)** Always attach standard basic claims guidelines with the policy documents. | | | | | |
| **b)** Provides contact details at the time of accident. | | | | | |
| **c)** There is a 24 hour help-line / claims line to assist clients and third parties. | | | | | |
| **2.0. Claim Intimation Process: - The Company** | | | | | |
| **a)** Always maintain a claims register in which every claim is recorded. | | | | | |
| b) The claim register contain all valuable information according to a standard. | | | | | |
| c) The register is always updated continuously but not later than one month | | | | | |
| **3.0. Initial Contact with the Client and/or Third Party** | | | | | |
| a) Upon intimation of accident or claim the company's claims officer or investigator always visits the scene of loss as soon as | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| practically possible | | | | | |
| b) If the claim needs a surveyor or independent assessor /surveyor / external investigator etc. was appointed immediately in writing. | | | | | |
| c) The company timely provides all documents that can assist the loss assessor in determining the loss. | | | | | |
| d) All correspondences with assessors are copied to the Clients or third party. | | | | | |
| **4.0. Reserving** | | | | | |
| a) The company always maintains a reserve for each claim from the time the claim is intimated. | | | | | |
| b) Such reserve includes additional expenses and charges for assessors, legal and other incidentals and etc., | | | | | |
| c) In case of long tail liability claims provision for inflation or factor is considered. | | | | | |
| d) In the absence of sufficient information, a minimum payable amount is reserved, which later is adjusted as information is obtained | | | | | |
| **5.0. The Claims Process & Service Standards for Company Surveyor or Independent Loss Assessors / Surveyor** | | | | | |
| There is a fixed time limit set for the assessment processes to be completed from the date of assignment. | | | | | |
| **6.0. Claim Investigation Independent Loss Assessor and Surveyor Appointment Process** | | | | | |
| a) There is a written direction or guideline that specifies the reason to appoint an independent loss assessor and surveyor. | | | | | |
| b) There are pre specified requirements to select and appoint one independent loss assessor and surveyor among those licensed by NBE; | | | | | |
| c) Insured is permitted to assign his own loss assessor/surveyor | | | | | |
| d) There is a proper registration system to record each appointment and all information in relation to the undertaking including the opinion of the client | | | | | |
| or third party receiving the service. | | | | | |
| e) Each appointment is made with properly worded contractual agreement. | | | | | |
| f) Each appointment is made in writing. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| g) Any misdeed by the concerned independent loss assessor and surveyor in executing his duty is immediately reported to the NBE. | | | | | |
| h) At the time of each appointment and entering of a contractual agreement with the independent loss assessor and surveyor the insurance company give timelines for submitting final report | | | | | |
| **7.0. Claim Admission** | | | | | |
| For admissible claims, a settlement offer in writing was sent to the insured or third party with a defined time line after receipt of the necessary documents. | | | | | |
| **8.0. Repudiation of Claims** | | | | | |
| a) Any repudiation of claim is decided by the involvement of senior management member of the company. | | | | | |
| b) Repudiation of a claim is communicated in writing to the insured and/or third party using simple language and giving clear grounds for repudiation. | | | | | |
| c) A copy of any letter written to repudiate claim is also communicated to NBE. | | | | | |
| **9.0 Choice and Appointment of Repairing Garages** | | | | | |
| a) The insured is allowed to choose his preferred repairing garage | | | | | |
| b) The garages on Company's approved repairer list have similar standard of workmanship and organization | | | | | |
| c) Bidding garages repair estimate always provide accurate measurement of the damage sustained | | | | | |
| d) The least bidding garage estimate actually represents the exact compensation payable before deduction of contribution | | | | | |
| e) Insurers bidding process for repair cost guarantees fairness and equity | | | | | |
| **10.0 Claim Payments** | | | | | |
| The insurer settles the claim promptly in line with the service standards. | | | | | |
| **11.0. Subrogation** | | | | | |
| From the time a claim is intimated, the insurance company or intermediary guide their insured's on how to conduct in order to preserve the insurers' subrogation rights and the consequences thereof. | | | | | |
| **12.0. Complaints** | | | | | |
| a) The company has set up a desk to address the customer complaints. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| b) Unsatisfied customers are advised to refer their cases to the highest organ of the organization. | | | | | |
| c) Unsatisfied customers are advised to refer their cases to the NBE | | | | | |
| d) There is a separate Complaints Bureau or an independent Insurance Ombudsman to address insurance customers' complaints. | | | | | |
| **13.0. Per Event Aggregate Losses and Claims From Single Accident** | | | | | |
| a) A separate record is made if a number of claims are made from a single | | | | | |
| Accident. | | | | | |
| b) Such types of claims are communicated to NBE with details. | | | | | |
| **14.0. Staff Competency** | | | | | |
| **a)** The company maintains competent staff with appropriate skills in claims handling. | | | | | |
| **b)** The company carry's out regular internal audit of all claims lodged. | | | | | |
| **c)** The internal audit applies to all stages of the claims management process | | | | | |

| **15.0. The Claims Process and Service Standards of the Company: -** | **Activity Indicative Timelines** | | |
|---|---|---|---|
| | **Simple (hours)** | **Intermediate (Days)** | **Complicated (Months)** |
| a) Claim intimation | | | |
| b) Acknowledgement of Claim and acquisition of documents / contact with the claimant | | | |
| c) Site visit or appointment of investigators, internal surveyors, independent assessor / surveyors etc | | | |
| d) Making settlement offer or communicating repudiation of claim | | | |
| e) Settling claim | | | |
| f) The company provides a written reason explaining why a claim cannot be settled within the indicative timelines for each of the processes. | | | |
| g) This explanation reaches the regulatory authority (NBE) before expiry of applicable time limit | | | |
| h) Copies of such correspondences to the insured or intermediary as the case may be. | | | |

16. Any other suggestions? _____

**Thank you very much**

# Annex- II

## Interview questions for Africa Insurance Company claims department manager

Q1. Which claims management process(s) is/are source of complain /customer dissatisfaction/? What measures take to smooth this complain areas?

Q2. Who approves the claims management payment?

Q3. Is claims are settled in branch offices? How many branches did this settlement and how much amount of losses is authorized for settlement?

Q4. Are there any time dalliances for claim settlements? What are the causes & what measures take to settle periodically?

Q5. Are there differences between the loss estimations/claim payments done by the company compared to the amount of loss notified by the company/expected indemnity by the insured?

Q6. What were the main reasons for claim rejection? What process goes for rejection?

Q7. What are the measures apply to solve customer dissatisfaction in claims payment and claims rejection?

Q8. How many cases are goes to court for claim resolution?

Q9. Do you use claims management software? If so, what are problems of this software to apply in your company?

Q10. Is there any misinterpretation or fraud act by policy holders on claim requests? If so, what measures take to prevent these acts?

Q11. Is there available number of workers in the department?