# TRACKER FINANCIAL SERVICES

## CLAIMS MANAGEMENT FRAMEWORK

***VERSION 4***

These products are brought to you by Tracker Financial Services (Pty) Ltd. An Authorised Financial Services Provider, FSP license number 42862 and underwritten by Guardrisk Insurance Company Ltd., an Authorised Financial Services Provider and a licensed non-life insurer, FSP license number 75.
Tracker Connect (Pty) Ltd is a Juristic Representative of Tracker Financial Services (Pty) Ltd.

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## 1. DOCUMENT HISTORY

| Revision Date | Document Version | Summary of Changes | Author/Reviewer | Approvals |
|---|---|---|---|---|
| Sept 2019 | 1 | Name change | Alisha Delport | Ronel Hanekom: KI |
| Aug 2020 | 2 | Annual Review | Alisha Delport | Ronel Hanekom: KI |
| Jan 2022 | 3 | Annual Review | Alisha Delport | Mitesh Lakha: KI |
| Aug 2023 | 4 | Annual Review | Alisha Delport | Key Individual; Compliance officer. |

## 2. INTRODUCTION

The Company, as an authorised financial services provider, has a responsibility to conduct itself honestly, with integrity, fairness, dignity and ethically wherever it operates, with due regard to the environment, the societies in which it operates and its other stakeholders. The Claims Management Framework serves to meet the requirements of Rule 17 of the Policyholder Protection Rules. It needs to ensure fair treatment of policyholders and beneficiaries and must be reviewed regularly.

## 3. DEFINITIONS

**"Business Day"** means any day excluding a Saturday, Sunday or public holiday.

**"Claim"** means, unless the context indicates otherwise, a demand for any policy benefits by a Claimant in relation to a policy, irrespective of whether the Claimant's demand is valid.

"**Company"** means Tracker Financial Services (Pty) Ltd.

**"Claimant"** means a person who institutes a claim.

**"Claim Outcome"** shall relate to the following:

a) **"Accepted"** shall mean that the claim has been finalised in such a manner that the Claimant has either explicitly accepted that the policy benefits have been fully paid or in such a manner that is reasonable for Guardrisk to assume that the Claimant has so accepted. A Claim should only be regarded as accepted once any and all undertakings made by Guardrisk to provide policy benefits wholly or in part have been met.

b) **"Repudiated"** shall mean that the Claim has been wholly or partly rejected (or repudiated) and Guardrisk regards the Claim as finalised after advising the Claimant (both verbally and in writing) that it does not intend to take any further action to pay the Claim. This can arise either where a Claim is rejected without offering to take steps to pay it because Guardrisk regards the Claim as invalid, or where the Claimant does not accept or respond to proposals to pay the Claim and Guardrisk then advises the Claimant that it does not intend to take any further action to attempt to pay the Claim.

c) **"Disputed"** shall mean the Claim is neither accepted nor rejected, but Guardrisk disputes the Claim or the quantum of the Claim.

**"Customer Query"** means a request to Guardrisk by or on behalf of a policyholder/beneficiary for information regarding a Claim or a policy, including policy benefits, no-claim bonus, loyalty benefit, waiting period or related service in relation to such policy. This shall also include a progress update on a request previously made or a progress update on a Claim.

**"Escalated Claim"** shall refer to the following:

a) an extension of a Claim relating to the outcome of the initial Claim;
b) the Claim is complex or unusual that it requires intervention by an impartial senior functionary appointed to deal with escalated claims;
c) the referral of the Claim to a Claims Committee mandated and authorised to review the Claim and provide an outcome;
d) the resolution of the initial Claim is not to the Claimant's satisfaction and is then treated as a complaint and dealt with in terms of the Guardrisk Complaints Management Framework.

**"Ombud"** has the meaning assigned to it in the –

a) Financial Services Ombud Schemes Act, 2004 (Act No. 37 of 2004) up until such time as such Act is repealed through Schedule 4 of the Financial Sector Regulation Act; and
b) Financial Sector Regulation Act, from the date on which such Act repeals the Financial Services Ombud Schemes Act, 2004 (Act 37 of 2004) through Schedule 4 of such Act.

**"Policyholder"** has the meaning assigned to it in the Act and includes any person in respect of whom a fund, under a fund member policy, insurers its liability to provide benefits to such person in terms of its rules.

**"Policy"** means a short-term policy where the Policyholder is a –

a) natural person; or
b) a juristic person, whose asset value or annual turnover is less than the threshold value as determined by the Minister of the Department of Trade and Industry in terms of section 6(1) of the Consumer Protection Act, 2008 (Act No. 68 of 2008), currently R2 000 000.

**"Repudiate"** in relation to a Claim means any action by which an Insurer rejects or refuses to pay a Claim or any part of a Claim, for any reason, and includes instances where a Claimant submits a Claim –

a) in respect of a loss event or risk not covered by a Policy; and
b) in respect of a loss event or risk covered by a Policy, but the premium or premiums payable in respect of that policy was not paid

and "Repudiation" shall have a corresponding meaning.

## 4. OBJECTIVE

**4.1** This framework sets out our philosophy concerning the way claims are handled and settled and provides guidance on quality assurance processes to be conducted thus promoting compliance with standard operating claims processes during the lifecycle of a claim.
**4.2** The Claims Management Framework formalises the practices required for effective claims handling for all claimants.
**4.3** The objective is to ensure fair treatment of policyholders and claimants that:

a) is proportionate to the nature, scale and complexity of the Binder Holder's business and risks;
b) is appropriate for the business model, policies, services and policyholders and beneficiaries of the Binder Holder;
c) enables claims to be assessed after taking reasonable steps to gather and investigate all relevant and appropriate information and circumstances, with due regard to the fair treatment of Claimants;
d) does not impose unreasonable barriers to Claimants.
e) ensures claims are lodged, assessed and finalised in a timely and standardised manner; and
f) address and provide for, at least, the matters provided for in the Policyholder Protection Rules.

## 5. ALLOCATION OF DUTIES

The Manager of the Tracker Financial Services & Key Individuals are responsible to ensure that all claims lodged are treated in line with this framework and will ensure that adequate resources are allocated to claims handling and that any person dealing with claims are:

a) adequately trained;
b) experienced in claims handling and appropriately qualified;
c) not subject to a conflict of interest; and
d) adequately empowered to make impartial decisions or recommendations.

## 6. THE CLAIMS PROCESS

a) The Claimant to provide their policy number upon notification of claim and if required, complete a claim form (dependant on product).
b) Lodging of claim by Company's claims department on the internal system.
c) Communication to acknowledge receipt of claim sent to Claimant within 48 hours.
d) Claim notification and documents reviewed (one working day).
e) In the event that there are outstanding or additional information and documentation required, it will be requested from the Claimant or relevant party, by the Company's claims department.
f) Assessment of claim, overview and decision making (Assessment and Finalisation Period Up to 15 working days).
g) Claim outcome communicated to the Claimant in writing.
h) The Claimant can contact the Company's claims department at any stage of the claims process should the Claimant require an update or information pertaining to the claim.
i) The Escalation process will be followed where stated timelines are exceeded without agreement by the Claimant to management and the Insurer or should the Claimant be dissatisfied with the outcome.

## 7. CLAIM ESCALATION AND REVIEW PROCESS

Should a Claimant be dissatisfied with the outcome of the claim assessment, he/she may direct their dissatisfaction to us who will refer it to the Insurer. Representation can also be made directly to the Insurer. The Claimant have a period of 90 days in which to make representation.

The Insurer has within 45 days of receiving the representation to notify the Claimant of their final decision after reviewing the representation.

Should the Claimant be dissatisfied with the Insurer's decision, the Claimant have 6 months in which to institute legal action, a complaint can be lodged with the Ombudsman for Short-Term Insurance.

Tracker Financial Services Claims Escalations:

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|---|---|
| Tel: | 0860 60 50 40 |
| Email: | TFSPClaims.Escalations@tracker.co.za |

Guardrisk:

| | |
|---|---|
| Tel: | 011 669 1000 |
| Email: | info@guardrisk.co.za |
| Postal address: | PO Box 786015<br>Sandton<br>2146 |

The Ombudsman for Short-term Insurance:

| | |
|---|---|
| Tel: | 011 726 8900 |
| Telefax: | 011 726 5501 |
| Postal address: | PO Box 32334<br>Braamfontein<br>2017 |

If the Insured's dispute is not satisfactorily resolved, the Insured may institute legal action against the Insurer for the enforcement of the claim by way of the service of summons against the Insurer. Summons must be served on the Insurer within 180 days of the Insurer's original letter of rejection or avoidance after the expiry of the 90-day period. If this is not done, the Insured's claim will be unenforceable against the Insurer and it will become time barred and the Insurer will no longer be liable for the claim.

## 8. INTEREST ON LATE PAYMENT

Where a binder Holder has delayed a claim payment, and the delay has been through no fault of any Claimant, but a failure in an internal process, causing prejudice to a Claimant, or additional interest being charged on an account (loan, credit card etc.), then the binder holder will be liable to add interest to the benefit amount/sum assured or to write off/waive any interest accrued.

## 9. RECORDKEEPING, MONITORING AND ANALYSIS

**9.1** The Company must ensure that systems and processes are in place that provide for accurate, efficient and secure recording of all claims received, irrespective of whether the

claims are valid or not and be able to extract claims data for reporting and analytical purposes.

**9.2** The following must be recorded (electronically) in respect of each claim received –

a) all relevant details of the Claimant and the subject matter of the claim;
b) copies of all relevant evidence, correspondence and decisions;
c) full and complete audit trail for every claim; and
d) progress and status of the claim, including whether such progress is within or outside any set timelines.

**9.3** The Company must maintain the following Claims related data on an ongoing basis and for a minimum period of 5 years after the last claim transaction –

a) number and quantum of claims received;
b) number and quantum of claims paid;
c) number and quantum of repudiated claims and reasons for the repudiation;
d) number of claims escalated by Claimants to the internal claims' escalation and review process and their outcome;
e) number of claims referred to an Ombud and their outcome, which data must also be included in complaints reports.
f) total number of claims outstanding.

## 10. PROHIBITED CLAIMS PRACTICES

The Company and the Insurer may not:

a) Dissuade a Claimant from obtaining the services of an attorney or adjustor;
b) Deny a claim without performing a reasonable investigation; or
c) Deny a claim based on the outcome of a polygraph, lie detector or truth verification or similar test.

## 11. VALID CLAIMS RECEIVED DURING PERIODS OF GRACE

If a Claimant submits a claim in respect of an event that occurred during a grace period, the value of the claim may be reduced by the sum of the unpaid premium.