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Claims Management Framework

Tracker Financial Services (Pty) Ltd

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Approved/Reviewed by:	Sandra Page
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Sandra Page – Head: Tracker Financial Services

Date	Version & Status	Summary of Changes
Jan 2019	1	First policy draft & Alignment to PPR

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1. 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.

2. Objective

The Claims Management Framework must be maintained, operated adequately and effectively and ensure that:

2.1 It is proportionate to the nature, scale and complexity of the Binder Holder's business and risks;
2.2 It is appropriate for the business model, policies, services and policyholders and beneficiaries of the Binder Holder;
2.3 It 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; and
2.4 It does not impose unreasonable barriers to Claimants.

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 the appointed Reinsurer for further review and feedback;
d) the referral of the Claim to a Claims Committee mandated and authorised to review the Claim and provide an outcome;
e) 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. Allocation of duties

The Administration Manager of the Company is 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:

4.1 Adequately trained;
4.2 Experienced in claims handling and appropriately qualified;
4.3 Not subject to a conflict of interest; and
4.4 Adequately empowered to make impartial decisions or recommendations.

5. The claims process

5.1 Claim notification received from Claimant. Claimant to provide policy number and if required, complete claim form (dependant on product).
5.2 Lodging of claim by Company's claims department on internal system.
5.3 Communication to acknowledge receipt of claim sent to Claimant contemporaneously when claim lodged.
5.4 Claim notification and documents reviewed (one working day).
5.5 In the event that there are outstanding or additional information and documentation required, it will be requested from Claimant or relevant party by the Company's claims department.
5.6 Assessment of claim, overview and decision making (Assessment and Finalisation Period Up to 15 working days).
5.7 Claim outcome communicated to the Claimant in writing of its decision.
5.8 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.
5.9 Escalation process will be followed where stated time lines are exceeded without agreement by the Claimant to management and the Insurer or should the Claimant be dissatisfied with the outcome.

6. Claim escalation and review process

Should a Claimant be dissatisfied with the outcome of the claim assessment, he/she may direct their dissatisfaction to the Company, who will refer the matter to the Insurer for review of the decision. The Insurer must respond to the Claimant within 15 working days. Should this result in a decision that is still unsatisfactory, the matter may be referred to the Internal Dispute Arbitrator at the Insurer, before referring it to an external body, such as the Ombud for Short Term Insurance.

6.1 Where a repudiation is not accepted by the Claimant, the matter may be referred to the Non-Life Claims Arbitrator for consideration.
The details are as follows: Miss Buyisiwe Hlatshwayo (Claims Executive)
Email: Buyisiwe.Hlatshwayo@guardrisk.co.za

6.2 The arbitrator will acknowledge within 24 hours of receipt.

6.3 The arbitrator will request information to assess the matter and allow for 5 days.

6.4 Decision will be communicated 7 days once all information has been received.

7. 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.

8. Record keeping, monitoring and analysis

8.1 All claims received, assessed, and finalised will be kept for a minimum period of 5 years.

8.2 The documents are filed physically or electronic scanned copy on the internal network drives.

8.3 Trends, risks and remedial actions to review product design and disclosures in line with Treating Customers Fairly principles will be taken on a minimum half yearly basis.

9. Prohibited claims practices

The Company and the Insurer may not:

9.1 Dissuade a Claimant from obtaining the services of an attorney or adjustor;

9.2 Deny a claim without performing a reasonable investigation; or

9.3 Deny a claim based on the outcome of a polygraph, lie detector or truth verification or similar test.

10. 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.