

Phakama Administration Services (Pty) Ltd (FSP 1473)

Claims Management Framework

Document Review and Signoff Sheet

Document Review

Review Date	February 2024
Comments / Amendments	Reviewed
Next Review Date	February 2025
Responsible Person	Legal, Risk & Compliance Manager

Aim

- Empower and adequately train responsible people in our business to deal with claims, as well as to handle the escalation of complex or unusual claims. The responsible person will have the experience, knowledge and skills in claims handling.
- To resolve policyholder claims in such a way that is fair to the policyholders, our business and our staff.
- To ensure the fair treatment of policyholders that –
 - is proportionate to the nature, scale and complexity of the insurer's business and risks;
 - is appropriate for the business model, policies, services, policyholders, and beneficiaries of the insurer;
 - enables claims to be considered after taking reasonable steps to gather and investigate all relevant information and circumstances with due regard to the fair treatment of claimant; and
 - does not impose unreasonable barriers on the claimants.

Objectives

- Prevent conflicts of interest and the incentivisation of behaviour which could threaten the fair treatment of policyholders or claimants.

- Ensure objectivity and impartiality.
- Document procedures for the appropriate management of the claims process from the time the claim is received until it has been finalised.
- Document procedures setting out the circumstances in which interest will be payable in the event of late payment of claims, the process to be followed in such an instance and the rate of the interest payable.
- Document procedures which clearly define the escalation and decision making, monitoring and oversight and review processes within the claims management framework
- Appropriate claims record keeping, monitoring and analysis of claims, and reporting (regular and ad hoc) to the executive management, the board of directors and any relevant committee of the board on-
 - identified risks, trends and actions taken in response thereto; and
 - the effectiveness and outcomes of the claims management framework;
- Appropriate communication with claimants and their authorised representatives regarding the claims processes and procedures.
- Meet the requirements for reporting to the Authority and public reporting.
- The establishment of a compliance programme for combating fraud and money laundering..

Definitions

“Administrator” means Phakama Administration Services (Pty) Ltd with FSP no.1473.

“Beneficiary” in respect of a –

registered insurer means –

- a person nominated by the Policyholder as the person in respect of whom the Insurer should meet policy benefits; or
- in the case of a fund member policy, a fund policy or a group scheme, a person nominated by the fund, member of the fund or member of the group scheme, or person otherwise determined in accordance with the rules of that fund or group scheme as the person in respect of whom the Insurer should meet policy benefits;

- licensed Insurer, has the meaning assigned to it in Schedule 2 of the Insurance Act; and for purposes of the Policyholder Protection Rules, includes in the case of a fund policy, a person nominated by the fund, or person otherwise determined in accordance with the rules of that fund as the person in respect of whom the Insurer should meet policy benefits.

“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 or not the Claimant’s demand is valid.

“Claimant” means a person who makes a claim by submitting a duly completed claim form and supporting documentation to the Administrator.

“Claim Outcome” shall relate to the following:

- **“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 the Insurer to assume that the Claimant has so accepted. A Claim should only be regarded as accepted once any and all undertakings made by the Insurer to provide policy benefits wholly or in part have been met.
- **“Repudiated”** shall mean that the Claim has been wholly or partly rejected (or repudiated) and the Insurer 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 the Insurer regards the Claim as invalid, or where the Claimant does not accept or respond to proposals to pay the Claim and the Insurer then advises the Claimant that it does not intend to take any further action to attempt to pay the Claim.
- **“Disputed”** shall mean the Claim is neither accepted nor rejected, but the Insurer disputes the Claim or the quantum of the Claim.

“Compensation Payment” means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of an Insurer to a Claimant to compensate the Claimant for a proven or estimated financial loss incurred as a result of the insurer’s contravention, non-compliance, action, failure to act, or unfair treatment forming the basis of a complaint, where the Insurer accepts liability for having caused the loss concerned, but excludes any –

- goodwill payment;
- payment contractually due to the Claimant in terms of a policy; or

- refund of an amount paid by or on behalf of the Claimant to the Insurer where such payment was not contractually due;
- and includes any interest on late payment of any amount referred to in (b) or (c);

“Customer Query” means a request to the Administrator 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:

- an extension of a Claim relating to the outcome of the initial Claim;
- the Claim is complex or unusual that it requires intervention by an impartial senior functionary appointed to deal with escalated claims;
- the referral of the Claim to the appointed Insurer or Reinsurer for further review and feedback;
- the referral of the Claim to a Claims Committee mandated and authorised to review the Claim and provide an outcome;
- 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 Insurers Complaints Management Framework.

“Exclusion” means the losses or risk events not covered under a policy.

“Existing policy” means a policy entered into before the date on which the relevant rule takes effect.

“Goodwill Payment” means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of an Insurer to a Claimant as an expression of goodwill aimed at resolving a claim, where the Insurer does not accept liability for any financial loss to the Claimant as a result of the matter complained about.

“New Policy” means a policy entered into on or after the date on which the relevant rule takes effect.

“Ombud” has the meaning assigned to it in the –

- 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
- 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.

“Plain Language” means communication that –

- is clear and easy to understand;
- avoids uncertainty or confusion; and
- is adequate and appropriate in the circumstances,

taking into account the factually established or reasonably assumed level of knowledge of the person or average persons at whom the communication is targeted.

“Policy” means a long-term policy or a short-term policy where the Policyholder is a natural person.

“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, insures its liability to provide benefits to such person in terms of its rules.

“Reports (or reporting)” means any periodic or ad-hoc reports (and related documents) obtained from the Claims management system and other sources in the business which shall be used for analysis, monitoring, submissions to regulatory authorities, and the making of recommendations to the business in respect of Claims management.

“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 lodges a Claim –

- in respect of a loss event or risk not covered by a Policy; and
 - 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
 - in respect of a loss event or risk that is excluded by a policy
- and “Repudiation” shall have a corresponding meaning;

“Service Provider” means any person (whether or not that person is the agent of the Insurer) with whom an Insurer has an arrangement relating to the marketing, distribution, administration or provision of policies or related services.

“Waiting Period” means a period during which a Policyholder (or any affected Insured) is not entitled to Policy benefits and includes any deferred period to determine permanency of disability.

Claims Handling Process

The comprehensive internal Claims Handling Procedure is documented separately to this Claims Management Framework.

The process that a claim will follow is documented below:

- The claim is received from the claimant.
- The claim is lodged by Phakama's claims department on its internal system.
- Communication is sent to the claimant to acknowledge receipt of the claim.
- The claim documentation, once received, is reviewed.
- Any outstanding or additional information and documentation is requested from claimant by the claim administrator.
- Once all documentation has been received, the claim is assessed and verified using various methods to ensure the validity of the claim. A determination will then be made.
- If the claim is valid, the claim will be paid. If the claim is not valid, it will be repudiated.
- There is a two (2) day assessment and finalisation period, from the date all valid claims documents are received, in respect of all claims.
- The claimant is kept up-to-date with the progress of the claim through sms or email communication.

Where the Insurer pays the claim -

- Referral of recommendation is made to the Insurer (Part of two (2) day assessment and finalisation period).
- Once the Insurers response, as it relates to the claim outcome is received, the claim outcome is communicated to the claimant (within 1 business day of the decision being made).
- Escalation to management and the Insurer is made where applicable timelines are exceeded or claimant is dissatisfied with the outcome.

Policyholder Communication

- All communications with Claimants must be in plain language.
- The following must be disclosed to any Claimant –
 - the type of information required from the Claimant (only relevant information may be requested);

- where, how and to whom a claim and related information must be submitted;
 - any time limits on submitting claims;
 - details of any administrative fee payable in relation to management of the claim; and
 - any other relevant responsibilities of the Claimant.
- A Claim is deemed to have been received on the day that the notification is received. Receipt of the claim must be acknowledged within a reasonable time after receipt of a Claim (within no more than two (2) days), and the Claimant informed of the process to be followed in processing the claim, including –
 - contact details of the person or department that will be processing the Claim;
 - indicative timelines for finalising the Claim; and
 - details of any outstanding requirements.
- Claimants must be kept adequately informed of –
 - the progress of their claim;
 - causes of any delay in the finalisation of a claim and revised timelines; and
 - the decision made in response to the claim.
- When a final payment or offer of settlement is made to a Claimant, it must be clearly explained to the Claimant what the payment or settlement is for and the basis used for calculation of the payment or settlement.
- Where the Claimant is a member or a Beneficiary of a group scheme –
 - obtain the contact details of the Claimant to enable all communications required by this rule to take place directly with the Claimant; or
 - obtain consent from the Claimant that communications required by this rule may take place through the Policyholder concerned.
- Funeral claims must be assessed within two (2) business days after all required documents in respect of a claim have been received. The following must then take place -
 - payment of the claim must be authorised;
 - the claim must be repudiated; or
 - in the case of a disputed claim, the claimant must be notified of the dispute.
- If a funeral claim is disputed, as referred to above, the following must take place within 14 business days after expiry of the initial two (2) business days–

- further investigate the claim;
- make a decision whether or not the claim submitted is valid; and
- then pay or repudiate the claim.
- Where a claim is repudiated or disputed, such communication must inform the Claimant of the following:
 - the reasons for the outcome, within 10 (ten) days of the decision being made;
 - that the Claimant has a period of not less than 90 (ninety) days from receipt of the outcome to make representations to the Insurer in relation to the outcome;
 - the details of both Phakama and the Insurers escalation and review process;
 - that the Claimant may refer the matter to the relevant Ombudsman and must include such Ombudman’s contact details and any time limitations applicable; and
 - that the Claimant may refer the matter to its legal representative, and must include any time limitations and prescription period applicable to the institution of legal action.
- Should the Claimant make representations in relation to the outcome of the claim, within 45 (forty-five) days of receipt of those representations, communication regarding the outcome must be sent to the Claimant in writing. If the initial decision to repudiate or dispute is confirmed, such communication must inform the Claimant of the following:
 - the reasons for the outcome;
 - the facts forming the basis of the outcome;
 - the details of the internal escalation and review process, details of the Claimant’s right to refer to the matter to the relevant Ombud or to a legal representative, including time limitations and prescription period (where applicable).
- For claims that are accepted, any payment must be made without undue delay and within a reasonably agreed timeframe. The Claimant must be informed regarding what the payment is for and the basis used to formulate such payment.
- All evidence, supporting documents, communication with the Claimant and action taken must be recorded.

Claims Data Requirement and Record Keeping

- 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..
- The following is recorded in respect of each claim received -
 - all relevant details of the Claimant and the subject matter of the claim;
 - copies of all relevant evidence, correspondence and decisions;
 - full and complete audit trail for every claim; and
 - progress and status of the claim, including whether such progress is within or outside any set timelines.
- the following Claims related data must be maintained on an ongoing basis and for at least 5 years after the date of the last claims transaction –
 - number and quantum of claims received;
 - number and quantum of claims paid;
 - number and quantum of Repudiated claims and reasons for the Repudiation;
 - number of claims escalated by Claimants to the internal claims escalation and review process and their outcome;
 - number of claims referred to an Ombudsman and their outcome, and
 - total number of claims outstanding.

Repudiations or Disputes

The Insurer must communicate the following to the claimant:

- The reason for the decision;
- Include the facts that informed the decision;
- That the claimant may within a period of not less than 90 days after the date of receipt of the notice make representations to the Insurer;
- Have the right to lodge a complaint to the relevant Ombudsman and provide the contact details and time limitations of the applicable Ombudsman scheme.

Claims received during Grace Periods

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

Claims Escalation and Review Process

Procedures within the claims escalation or review process should not be overly complicated, or impose unduly burdensome paperwork or other administrative requirements on claimants. It must:

- follow a balanced approach;
- provide for the internal escalation of complex or unusual claims at the instance of the initial claim handler;
- provide for claimants to escalate claims not resolved to their satisfaction;
- provides for the allocation of claims to an impartial, senior functionary for managing the claims escalation or review process of the insurer.

Complex or unusual claims shall be escalated from the initial assessor to:

1. Claim is escalated to the Claims Manager

2. Claim is escalated the Compliance Task Team (internal)
3. Claim is escalated to the Insurer (external)

Should a claimant be dissatisfied with the outcome of the claim assessment, he/she may direct their dissatisfaction to Phakama 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 Ombudsman for Long Term Insurance.

Prohibited Claims Practice

No entity may:

- dissuade a Claimant from obtaining the services of an attorney or adjustor;
- deny a claim without performing a reasonable investigation; or
- deny a claim based solely on the outcome of a polygraph, lie detector, truth verification or similar test or procedure referred to in (a) above.

Responsible Persons

- Claims Department : processing
- Claims Manager : review, approval and escalation
- Compliance Task Team (Internal) : escalation and resolution
- Insurer (External) : escalation and review

Contact Details

PARTICULARS OF THE ADMINISTRATOR / BINDER HOLDER	
Telephone Number:	012 348 8310
Facsimile Number:	086 514 1115
Email:	claims@phakama.co.za

PARTICULARS OF THE INSURER	
Various Insurers:	Details to be provided to policyholder

PARTICULARS OF THE NATIONAL FINANCIAL OMBUD SCHEME SOUTH AFRICA (the NFO)	
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