Claims Management Framework

OneSpark (Pty) Ltd ("the Company")

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Approved/Reviewed by:	Life Operations Executive – Guardrisk Life
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Chief Operations Officer

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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 Section 62 of the Long Term Insurance act and 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 Insurer's business and risks;
2.2 Is appropriate for the business model, policies, services and policyholders and beneficiaries of the Insurer;
2.3 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 Does not impose unreasonable barriers to claimants.

3. Definitions

- **"Beneficiary"** in respect of a –
  registered insurer means –
  a) a person nominated by the Policyholder as the person in respect of whom the Insurer should meet policy benefits; or
  b) 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;
  c) 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;
  a) **“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 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.
- **“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 –
  a) Goodwill payment;
  b) payment contractually due to the Claimant in terms of a policy; or
  c) refund of an amount paid by or on behalf of the Claimant to the Insurer where such payment was not contractually due;
  d) and includes any interest on late payment of any amount referred to in (b) or (c);

- **“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.
- **“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 –
  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;
- **“Plain Language”** means communication that –
  a) is clear and easy to understand;
  b) avoids uncertainty or confusion; and
  c) 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 life policy where the Policyholder is a-
  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, insurers its liability to provide benefits to such person in terms of its rules;
- **“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 –

  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;
- **“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;
- **“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.

4. Allocation of duties

The Operations Manager of the Company is responsible to ensure that all claims lodged are treated in line with this framework. The Operations Manager 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 be subject to a conflict of interest; and
4.4 Be adequately empowered to make impartial decisions or recommendations.

5. The claims process

The process that a claim will follow at the Company:

5.1 Claim received from claimant. The claimant must notify the Company within 3 months of the relevant Claim Event unless there are extenuating circumstances for the late notice thereof.
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 full working day)
5.5 Any outstanding or additional information and documentation requested by claims manager from claimant or relevant party.
5.6 Assessment of claim, decision making and oversight made in specified time period
- Assessment and Finalisation period differs per product. For example, Funeral claims have a 48-hour Assessment and Finalisation period.

5.7 Referral of recommendation to the Insurer
- This is part of Assessment and Finalisation period.
- Assessment and Finalisation period differs per product. For example, Funeral claims have a 48-hour Assessment and Finalisation period.

5.8 Insurer response in writing with claim outcome
5.9 Claim outcome communicated to the claimant (within 1 full working day of decision)
5.10 Escalation to follow where applicable time lines are exceeded to management and the Insurer or claimant is dissatisfied with the outcome.

6. Claim escalation and review process

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

6.1 the Operations Executive
6.2 the Insurer
6.3 the Reinsurer (where applicable)

7. Interest on late payment

The Company will endeavour to finalise claims within 48 hours (2 business days) of receipt of all required documentation. In instances where a delay occurs on the part of the Company, and such delay causes financial loss or any form of prejudice to a claimant, and where the delay is proven to have been unnecessary, the Company will pay interest @ 6% of the claim value.

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 filled 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. Repudiations or disputes

The Insurer must communicate the following to the claimant:

9.1 The reason for the decision;
9.2 Include the facts that informed the decision;
9.3 That the claimant may within a period of not less than 180 days after the date of receipt of the notice make representations to the Insurer;
9.4 Have the right to lodge a complaint to the relevant Ombud and provide the contact details and time limitations of the applicable Ombud scheme.

10. Claim escalation and appeals process

Should a claimant or customer 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 Long Term Insurance.

The Insurer's details are:
Guardrisk Life Limited
Postal Address: PO Box 786015
Sandton, 20196
Tel: (011) 669-1000
Email: LifeClaims@guardrisk.co.za

In addition, the claimant may send a formal complaint to the Company at the details below:

complaints@onespark.co.za

The Company will acknowledge the complaint within a minimum of 1 working day.

11. Prohibited claims practices

The Company and the Insurer may not:
11.1 Dissuade a claimant from obtaining the services of an attorney;
11.2 Deny a claim without performing a reasonable investigation; or
11.3 Deny a claim based on the outcome of a polygraph, lie detector or truth verification or similar test.

12. 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.

13. Claim Submission Contact Details

All claims can be submitted to:

E-mail: claims@onespark.co.za

Telephone: 0861 777 271

Postal address: PO Box 2960, Randburg, 2125