Claims Management Framework

for

GUARDRISK GROUP (PTY) LTD

Incorporating the following operating entities:

GUARDRISK INSURANCE COMPANY LIMITED

GUARDRISK LIFE LIMITED

GUARDRISK MICROINSURANCE LIMITED

Policy Owner: Life Operations Executive

October 2019

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1. Overview

1.1 Document History

Revision Date	Doc Version	Summary of Changes	Author / Reviewer
10 June 2018	1	Initial drafting	Russell Krawitz
1 October 2019	2	Annual Update	Russell Krawitz
25 June 2022	3	Annual Update	Russell Krawitz

1.2 Operational Approvals

This document has obtained the following approvals:

Name	Title	Doc Version	Approval Signature	Date of Approval
Russell Krawitz	Life Operations Executive	2		31/10/2019

1.3 *Governance Approvals*

This document has obtained the following approvals:

Name	Title	Doc Version	Approval Signature	Date of Approval
Executive Committee	Exco	1	Refer to Exco Minutes	
Risk Committee	Risk Committee	1	Refer to Risk Committee Minutes	
Board of Directors	Board	1	Refer to minutes of Board meeting	

2. Definitions:

2.1 "Beneficiary" in respect of a –

(a) licensed insurer means –

i. a person nominated by the Policyholder as the person in respect of whom the insurer should meet policy benefits; or

ii. 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;

(b) 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.

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

2.3 **"Claim"** means, unless the context indicates otherwise, a demand for any policy benefits by a person in relation to a policy, irrespective of whether or not the person's demand is valid;

2.4 **"Claimant"** means a person who makes a claim;

2.5 **"Claims Audit"** means the claims review performed by Guardrisk on all its binder holders to assess the claims process (flow) documentation, the application of sound and consistent decisions, the application of fairness, equitable and objective claims handling principles, the assessment of claims staff capabilities and the safe keeping and reporting of all claims documentation. For purposes of this definition, a claims audit will be performed as often as is required should a binder holder not be able to demonstrate fair, objective, equitable or consistent claims handling management processes.

2.6 **"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 complainant to compensate the complainant 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 the complaint, where the insurer accepts liability for having caused the loss concerned, but excludes any –

(a) goodwill payment;
(b) payment contractually due to the complainant in terms of a policy; or
(c) refund of an amount paid by or on behalf of the complainant 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);

2.7 **"Credit Life Insurance"** has the meaning assigned to it in the National Credit Act;

2.8 **"Exclusion"** means a loss or risk event not covered under a policy;

2.9 **"FAIS Act"** means the Financial Advisory and Intermediary Services Act, 2002 (Act No. 37 of 2002);

2.10 **"FAIS General Code of Conduct"** means the General Code of Conduct for Authorised Financial Services Providers and Representatives published in board Notice No. 80 of 2003, and amended from time to time, under section 15 of the FAIS Act;

2.11 **"Fund"** has the meaning assigned to it in Part 1 of the Regulations;

2.12 **"Fund member policy"** has the meaning assigned to it in Part 3A of the Regulations;

2.13 **"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 claim having been repudiated;

2.14 **"Insurer"** means a licensed life insurer, namely Guardrisk Life Limited (Registration No 1999/013922/06 and FSP No 76); a licensed non-life insurer, namely Guardrisk Insurance Company Limited (Registration No 1992/001639/06 and FSP No 75); and a licensed insurer, namely Guardrisk Microinsurance Limited (Registration No 1991/005238/06 and FSP No 51674).

2.15 **"Intermediary"** means an independent intermediary or representative, respectively;

2.16 **"Intermediary Service"** means, subject to subsection 3(b) of the FAIS Act, any act other than the furnishing of advice, performed by a person for or on behalf of a client or product supplier –

(a) the result of which is that a client may enter into, offers to enter into or enters into any transaction in respect of a financial product with a product supplier; or
(b) with a view to-
(c) buying, selling or otherwise dealing in (whether on a discretionary or non-discretionary basis), managing, administering, keeping in safe custody, maintaining or servicing a financial product purchased by a client from a product supplier or in which the client has invested;
(d) collecting or accounting for premiums or other moneys payable by the client to a product supplier in respect of a financial product; or
(e) receiving, submitting or processing the claims of a client against a product supplier;

2.17 **"Loyalty Benefit"** means any benefit (including a so-called cash or premium-back bonus) that is directly or indirectly provided or made available to a policyholder by an insurer or an associate of the insurer, which benefit is wholly or partially contingent upon –

(a) the policy or policies of that policyholder with that insurer remaining in place;
(b) the policyholder increasing any policy benefit to be provided under a policy; or
(c) the policyholder entering into any other policy or policy benefit or utilising any related services offered by that insurer or its associate;

2.18 **"Mandatory Credit Life Insurance"** means any credit life insurance contemplated in section 106(1)(a) of the National Credit Act;

2.19 **"Member"** means a member of a fund or a member of a group scheme;

2.20 **"Member of a fund"** means any person in respect of whom a fund, under a fund policy, insures its liability to provide benefits to such person in terms of its rules;

2.21 **"Member of a group scheme"** means – in a group scheme to insure the lives of one or more other persons in which the first-mentioned person has an insurable interest;

2.22 **"National Credit Act"** ,means the National Credit Act, 2005 (Act No. 34 of 2005);

2.23 **"New Policy"** means a policy entered into on or after the date on which the relevant rule takes effect;

2.24 **"No-claim Bonus"** means any benefit that is directly or indirectly provided or made available to a policyholder by an insurer in the event that the policyholder does not claim or does not make a certain claim under the policy within a specified period of time;

2.25 **"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;

2.26 **"Optional Credit life Insurance"** means credit life insurance contemplated in section 106(3) of the National Credit Act;

2.27 **"Outsourcing"** means an outsourcing arrangement as defined in section 1 of the Financial Sector Regulation Act and includes rendering services under a binder agreement, but excludes rendering services as intermediary, and "outsourced" has a corresponding meaning;

2.28 **"Outsourcing Agreement"** means any arrangement of any form between Guardrisk and another person, whether that person is regulated or supervised under any law or not, in terms of which that party performs a function that is integral to the nature of the Guardrisk business, which would otherwise be performed by Guardrisk in conducting insurance business, and includes rendering services under a binder agreement, but excludes rendering services as an intermediary (**Outsourced business partner** will have a corresponding meaning).

2.29 **"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;

2.30 **"Policy"** means a life, non-life or microinsurance policy;

2.31 **"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;

2.32 **"Regulations"** means the Regulations made under the Long-term Insurance Act, 1998, promulgated by GN R.1492 of 27 November 1998 and amended from time to time

2.33 **"Related Service"** means any service or benefit provided or made available by an insurer or any associate of that insurer, together with or in connection with any policy or policy benefit, and includes a loyalty benefit and a no-claim bonus;

2.34 **"Representative"** has the meaning assigned to it in Part 3A of the Regulations;

2.35 **"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;

2.36 **"Risk Policy"** means a policy that provides risk benefits only or that provides primarily risk benefits;

2.37 **"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;

2.38 **"Waiting Period"** means a period during which a policyholder is not entitled to policy benefits. Where a claim event occurs within a waiting no claim will be payable.

3. Objectives:

3.1 The Claims Management Framework formalises the practices required for effective claims handling for all claimants within the Guardrisk Group of Companies ("Guardrisk"). The objective is to ensure fair treatment of policyholders and claimants that:

(a) is proportionate to the nature, scale and complexity of the insurer's business and risks;
(b) is appropriate for the business model, policies, services, and policyholders and beneficiaries of the insurer;
(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; and
(e) address and provide for, at least, the matters provided for in this rule;

3.2 This framework provides general principles to guide the way claims are managed within Guardrisk. Where an outsourced partner or a company or business within Guardrisk has a policy, process or procedures, guide or training manual relating to claims management, all such documents must comply with, and not contradict, this framework.

3.3 This framework sets out Guardrisk's philosophy concerning the way claims are handled, resolved and maximised (maximised refers to conducting analysis of claims outcomes specifically relating to repudiations for root cause analysis to ensure processes are improved to reduce complaints where necessary).

3.4 This framework will be reviewed by the Life Operations Executive at least annually and presented to the Board of Directors for approval.

4. Scope

4.1 This framework applies to the following entities and any of their subsidiaries that are domiciled in South Africa

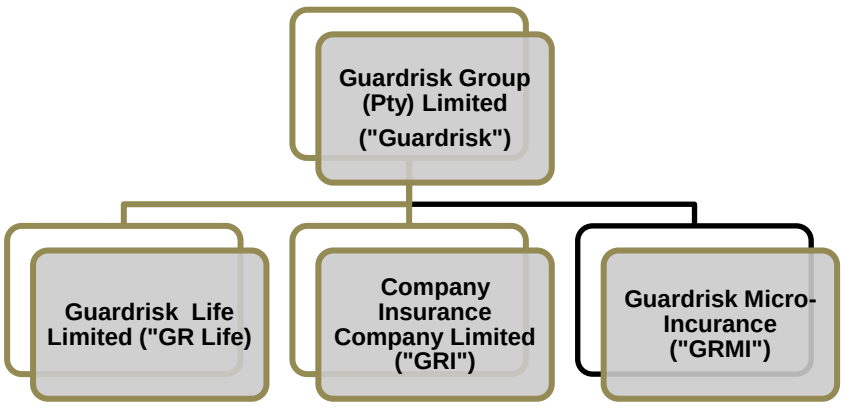

Figure 1 - Organisational Structure

4.2 Where any business units within Guardrisk have agreements with outsourced business partners that have any part to play in the claims handling or resolution or record keeping

process, it is recommended that those agreements state minimum standards necessary for claims management.

4.3 Each entity that has entered into a shareholders agreement with Guardrisk must ensure that they and/or their outsourced business partners have a claims management process that provides for:

(a) relevant objectives, key principles and the proper allocation of responsibilities for dealing with claims across the business of the insurer;

(b) appropriate performance standards and remuneration and reward strategies (internally and where any functions are outsourced) for claims management in general and specifically for claims assessment to –

i. prevent conflicts of interest and the incentivisation of behaviour which could threaten the fair treatment of policyholders or claimants; and

ii. ensure objectivity and impartiality;

(c) documented procedures for the appropriate management of the claims process from the time the claim is received until it is finalised, including the expected timeframes for each of the stages and the circumstances under which any of the timeframes may be extended;

(d) documented 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;

(e) documented procedures which clearly define the escalation and decision-making, monitoring and oversight and review processes within the claims management framework;

(f) 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 –

i. identified risks, trends and actions taken in response thereto; and

ii. the effectiveness and outcomes of the claims management framework;

(g) appropriate communication with claimants and their authorised representatives on the claims processes and procedures;

(h) meeting requirements for reporting to the Authority and public reporting in accordance with this rule; and

(i) the establishment of a compliance programme for combating fraud and money laundering appropriate to the insurer's exposures and vulnerabilities, which programme must be consistent with the relevant risk management policies of Guardrisk.

5. Legislative framework

This framework upholds the provisions of the FAIS Act as well as the PPR's as amended.

6. Key Principles and standards for effective Claims Management

The following principles and standards shall apply to the claims management processes within Guardrisk:

6.1 Accessibility: Guardrisk makes claims reporting visible to customers on all key documents provided to them as well as on its website.

6.2 Client-centricity: Claims handling staff are expected to demonstrate the right attitude toward every client.

6.3 Quality of investigation: Guardrisk will take reasonable steps to gather and investigate all relevant information and circumstances when handling claims; this is to ensure only valid claims are paid and all invalid claims are declined, unless there are mitigating/extenuating circumstances resulting in the application of fairness and equity for consideration of a Goodwill payment.

6.4 Timely resolution: Guardrisk's quality standards recognise that all claims must be resolved in a timely manner and in line with timelines set out in this framework. Where a claim cannot be resolved in a timely manner, there must be valid reasons for when a claim will take longer than the norm to be finalised and these reasons are also set out in this framework.

6.5 Consistent and objective decision-making: Guardrisk will ensure that employees and decision-makers avoid bias when handling claims so that principles of fairness, equity and objectivity are upheld.

6.6 Responsibility in making decisions: Guardrisk will ensure that any person that is responsible for making decisions or recommendations in respect of claims generally or a specific claim must –

a) be adequately trained;
b) be experienced in claims handling and be appropriately qualified;
c) not be subject to a conflict of interest; and
d) be adequately empowered to make impartial decisions or recommendations.
    i. A claim received by an independent intermediary, binder holder or any other service provider that has been mandated by Guardrisk to manage claims on its behalf, or a claim received by a representative of Guardrisk, is deemed to have been received by Guardrisk itself; and
    ii. The outsourcing of the claims management process or any part thereof to an intermediary, a binder holder or any other person, or any other involvement of an intermediary, binder holder or other person, in the claims management process does not in any way diminish the Guardrisk's responsibility in terms of this framework.

6.7 Independent review: Through the Guardrisk Life Operations Executive, and Senior Claims Management, Guardrisk will provide additional opportunities for independent review of claims in line with the escalation and review process contained in this framework. Where required, segregation of duties and escalation procedures will be utilised to maintain and safeguard independence of employees responsible for handling claims.

6.8 Confidentiality of client Information and data: As far as possible, Guardrisk will maintain the confidentiality of customers' personal information and comply with the relevant legislation to ensure that internal controls are in place for safeguarding of data.

6.9 Accuracy of record-keeping: Claims must be accurately, efficiently and securely recorded.

6.10 Communication before, during and after a claim: Guardrisk will provide customers with clear upfront communication concerning how they can claim, how to dispute a repudiation or a claim quantum and how to escalate such a complaint.

6.11 Quality Assurance: Guardrisk will ensure that there is an appropriate level of quality assurance in place to monitor that the standards referred to in this framework are adhered to. This will take place via ad hoc claims audits performed when required on all binder holders.

6.12 Meaningful Management Information and Analysis: Useful management information reports pertaining to claims will be developed and implemented, subject to regulatory requirements and business needs.

7. Allocation of Responsibilities

The table below outlines the roles and responsibilities of the stakeholders responsible for governance of the framework:

Responsibility	**Structure**	**Interest, Duties and Responsibilities**
Supervision	Board of Directors	The Board is ultimately responsible for the requirements of this framework but delegates some functions to board committees, management committees, other forums, managers and any other persons.
	Risk Committee	The Risk Committee must approve changes to this framework and monitor adherence to this framework. The Risk Committee is responsible for ensuring that all committees, forums and individuals who have responsibility under the Policy fulfil their responsibilities in a timely and diligent manner.

	Audit Committee	The Audit Committee is responsible for the governance of the applicable assurance provider's assessment of compliance with a framework. It is responsible for assigning and monitoring remediation of any non-compliance or other findings by the assurance provider.
Operational Implementation	Guardrisk Board	Approves and oversees the effectiveness of this framework. Is responsible for operational implementation of this framework but delegates administration of this framework to the Life Operations Executive and the Life Operational Steering Committee to address or monitor operational matters.
	Life Operational Steering Committee	Assists the Board by: • Implementing the requirements of this framework • Providing ongoing guidance to the business on matters relating to this framework • Monitoring ongoing operating effectiveness of the framework and • Reporting to Exco, the business and other forums on the business performance and adherence in relation to requirements, procedures and standards set out in this framework

	Life / Non-Life Operational Executive	The Operational Executive is responsible for : • Operational implementation of this framework and processes developed in accordance with this framework; • Ensuring the execution of agreed standards including quality assurance.
	Claims Handlers	Implement, communicate & ensure that all claims are managed in accordance with this framework
Consulted	Risk Management	Risk Management is responsible for reviewing adherence to the requirements outlined by this framework.
	Compliance	Compliance is responsible for: • Reviewing adherence to the requirements outlined by this framework. • Ensuring that this framework remains in line with legislation.
Informed	Executive Committee Risk Committee Combined Assurance Forum	Are kept informed of claims received and whether or not there was compliance with this framework in the resolution thereof.

8. Claims Communication

(a) All communications with each binder holder (who in turn issue communication to each claimant) must be in plain language.

(b) Guardrisk will ensure that regular monitoring is done on compliance with as well as the effectiveness of this framework generally.

8.1 Process for Claims relating to a Guardrisk error, employee or service:

8.1.1 The claims channels will be monitored by the claims handling staff daily;

8.1.2 Each declined/repudiated claim will be recorded on the Guardrisk repudiation reporting system by the claims handling staff member within **24 hours** after receipt;

8.1.3 The following details will be captured in respect of each reportable claim:

(a) all relevant details of the claim:

i. Name of deceased
ii. ID No of deceased
iii. Date claim reported
iv. Date claim finalised
v. Claim type
vi. Cause of claim
vii. Date Of Commencement of policy/insurance
viii. Claim event date
ix. Category for repudiation
x. Repudiation reason
xi. Benefit amount / outstanding balance
xii. Name of Dr
xiii. Name of hospital
xiv. DHA1663 number
xv. Name of claim sender
xvi. Name of binder holder
xvii. No of binder holder
xviii. Date claim received to inbox
xix. Date response issued from inbox

(b) copies of all relevant, evidence, correspondence & decisions;

8.1.4 Where Guardrisk does not agree with the recommendation to decline, the claim is to be escalated to the applicable Claims Forums for review and discussion;

8.1.5 A decision will be made on each claim within **1 working day** after receipt of the claim;

8.1.6 Where a claim is escalated to the an applicable Claims Forum, a decision will be made within **3 working days**;

8.1.7 Where a decision is made to escalate the claim to a Reinsurer, this must be done within **2 working days** of such decision being made and full feedback to be provided to the binder holder;

8.1.8 Guardrisk will ensure that any claimants who are financially prejudiced as a result of our contravention, non-compliance, action, failure to act, or unfair treatment are fairly compensated with 6% interest on the benefit amount.

8.1.9 Guardrisk will analyse claims reports on a monthly basis. Findings on identified risks, trends and actions taken will be contained in Claims Due Diligence (Gap identification) reports that are presented to Operational Steerco Committees.

8.2 Process for claims relating to a Guardrisk product or related service offered in terms of an outsourced agreement:

8.2.1 Guardrisk will ensure that each outsource agreement clearly state what our minimum requirements are for claims handling and reporting;

8.2.2 Guardrisk will ensure that each service provider or outsourced business partner has adequate claims management processes in place to ensure the accurate recording of all reportable claims and the fair treatment of claimants;

8.2.3 Guardrisk will ensure that each binder holder has adequate systems in place for the reporting and management of claims handling;

8.2.4 Guardrisk will ensure that each outsource agreement includes an obligation on the outsourced business partner to submit **full** claims data to Guardrisk as prescribed and in the format required by Guardrisk that would allow Guardrisk to analyse and aggregate claims data;

8.2.5 Guardrisk will aggregate and analyse claims reports received from outsourced business partners on a monthly basis. Findings on identified risks, trends and actions taken will be contained in operational reports that are presented to operational and executive forums and the Board.

8.3 Claims Escalation and Review Process

8.4.1 Guardrisk has established and maintains an appropriate internal process in terms of which claims decisions are escalated and/or reviewed and claims related disputes can be resolved. Claims handling staff, outsourced partners and claimants can refer complex or unresolved claims to the relevant Guardrisk Executive for consideration.

The details are as follows:

Life Escalation	**Non-Life Escalation**
Life Operations Executive	Non-Life Claims Executive
Email: LifeClaims@guardrisk.co.za	ClaimsRepudiation@guardrisk.co.za

8.4.2 The escalation or review process:

(a) follows a balanced approach, bearing in mind the legitimate interests of all parties involved including the fair treatment of claimants;

(b) provides for internal escalation of complex or unusual claims at the instance of the initial claim handler;

(c) provides for claimants to escalate claims not resolved to their satisfaction (see Complaints Management Framework document);

(d) allows for a claim to be allocated to an impartial, senior functionary within Guardrisk for managing the claims escalation or review process.

9. Decisions relating to claims and time limitation provisions for the institution of legal action

9.1 Guardrisk accepts, repudiates or disputes a claim or the quantum of a claim for a benefit under a policy within **1 working day** of receiving a claim.

9.2 Guardrisk approves all letters within **1 working day** so that each binder holder can issue the letter ahead of the 10 day period specified under section 17 of the PPR's to notify the claimant of the decision taken on the claim.

9.3 If Guardrisk repudiates or disputes a claim or the quantum of a claim, the notice referred to in 9.2 must, in plain language, inform the claimant –

a) of the reasons for the decision, in sufficient detail to enable the claimant to dispute such reasons if the claimant so chooses;
b) that the claimant may within a period of not less than 90 days after the date of receipt of the notice make representations to Guardrisk in respect of the decision;
c) of the details of the internal claim escalation and review process required by 8.3 above;
d) of the right to lodge a complaint to a relevant ombud and the relevant contact details and time limitation and other relevant legislative provisions relating to the lodging of such a complaint;
e) in the event that the relevant policy contains a time limitation provision for the institution of legal action, of that provision and the implications of that provision for the claimant; and
f) in the event that the relevant policy does not contain a time limitation provision for the institution of legal action, of the prescription period that will apply in terms of the Prescription Act, 1969 (Act No. 68 of 1969) and the implications of that Act for the claimant.

9.4 If a claim or quantum of a claim is repudiated or disputed as contemplated in rule 9.1 on behalf of Guardrisk by a person other than Guardrisk, such other person must provide the notice contemplated in rule 9.2 and include in that notice, in addition to the information referred to in rule 9.3, the name and contact details of Guardrisk and a statement that any recourse or enquiries must be directed directly to Guardrisk.

9.5 If the claimant makes representations to Guardrisk in accordance with the internal claim escalation and review process referred to in rule 8.3, Guardrisk will within 45 days of receipt of the representation, in writing, notify the claimant of its decision to accept, repudiate or dispute the claim or the quantum of the claim.

9.6 If Guardrisk, despite the representations of the claimant, confirms the decision to repudiate or dispute the claim or the quantum of the claim, the notice referred to in rule 9.5 must –

a) Inform the claimant of the reasons for the decision in sufficient detail to enable the claimant to dispute such reasons if the claimant so choose;
b) Include the facts that informed the decision; and
c) Include the information referred to in rules 9.3 (c) to (f)

9.7 Any time limitation provision for the institution of legal action that may be provided for in a policy entered into before 1 January 2011 may not include the period referred to in rule 9.3(b) in the calculation of the time imitation period.

9.8 Any time limitation provision for the institution of legal action that may be provided for in a policy entered into on or after 1 January 2011 –

a) may not include the period referred to in rule 9.3(b) in the calculation of the time limitation period; and
b) must provide for a period of not less than 6 months after the expiry of the period referred to in rule 9.3(b) for the institution of legal action.

9.9 Despite the expiry of the period allowed for the institution of legal action in a time limitation clause provided for in a policy entered into before or after 1 January 2011, a claimant may request the court to condone non-compliance with the clause if the court

is satisfied, among other things, that good cause exists for the failure to institute legal proceedings and that the clause is unfair to the claimant.

9.10 For purposes of section 12(1) of the Prescription Act, 1969 (Act No. 68 of 1969) a debt is due after the expiry of the period referred to in rule 9.3(b).

10.1 Guardrisk ensures accurate, efficient and secure recording of all claims received, irrespective of whether the claims are valid or not.

10.2 The following is recorded 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; and
c) progress and status of the claim, including whether such progress is within or outside any set timelines.

10.3 Guardrisk maintains the following claims related data on an ongoing basis –

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, which data must also be included in the records and reports required by rule 18 or the PPR's in relation to the category of complaints referred to in rule 18.5.1(h);
e) number of claims referred to an ombud and their outcome, which data must also be included in the records and reports required by rule 18.8.3(e); and
f) total number of claims outstanding.

10.4 Claims information recorded in accordance with this rule will be scrutinised and analysed by the Life Operations Specialist on an ongoing basis and utilised to manage conduct risks and effect improved outcomes and processes for its policyholders, and to prevent recurrences of poor outcome and errors.

10.5 Guardrisk has established and maintains appropriate processes for reporting, accepting valid claims, approving repudiations or disputing a claim or the quantum of a claim for a benefit under a policy within a reasonable period after receipt of a claim. This period will not exceed **3 working days** at any given time.

11. Communication with Claimants

11.1 Guardrisk approves all policy wording to ensure that the claims process is detailed, and the claims requirements are documented so that it is clear and transparent for any policyholder and/or claimant to determine what is required for a claim to be submitted. Each binder holder is required to confirm the claims lodgement channel and both the contact number and email

address for submission of a claim. The following information is detailed on all claim forms, and in all policy documentation:

a) the type of information required from the claimant;
b) where, how and to whom a claim and related information must be submitted;
c) any time limits on submitting claims;
d) details of any administrative fee payable in relation to management of the claim; and
e) any other relevant responsibilities of the claimant.

11.2 A claim is deemed to have been received on the day that Guardrisk's binder holder or its representatives, or an independent intermediary or any other service provider that has been mandated by Guardrisk to manage claims on its behalf, receives notification thereof and Guardrisk or such independent intermediary, binder holder, service provider or representative must within a reasonable time after receipt of a claim acknowledge receipt thereof and inform a claimant of the process to be followed in processing the claim, including:

a) contact details of the person or department that will be processing the claim;
b) indicative timelines for finalising the claim; and
c) details of any outstanding requirements.

Guardrisk will only request information or documentation from a claimant which is essential to the assessment of a claim and will waive other requested information such information or documentation is no longer required.

11.3 A claimant, must at all times, be kept adequately informed of –

a) the progress of their claim;
b) causes of any delay in the finalisation of a claim and revised timelines; and
c) the insurer's decision in response to the claim.

11.4 Guardrisk will record a claim no later than 1 business day after the date the initial claim was received and may not delay recording the claim until such time as all requirements relating to the claim have been received.

11.5 When a final payment or offer of settlement is made to a claimant, the claimant must be explained what the payment or settlement is for and the basis used for the payment or settlement.

12. Prohibited claims practices

12.1 An 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 solely on the outcome of a polygraph, lie detector, truth verification or similar test or procedure referred to in PPR rule 7.1(a).

13. Claims received during periods of grace

If a claimant submits a valid claim in respect of an event that occurred during the period referred to in rule 15A.1, the value of the claim may be reduced by the sum of the unpaid premium.

14. Unclaimed Benefits

If a benefit under a Policy is an Unclaimed Benefit, the Binder Holder must take action to determine if the Nominated Beneficiary is alive and/or aware of the benefit payable to him/her under the Policy. Specifically, in the 3 (three) year period after the Unclaimed Benefit arises, the Binder Holder must:

- attempt to contact the Nominated Beneficiary telephonically and electronically to advise them of the Unclaimed Benefit; or

- determine the last known contact information of the Nominated Beneficiary by comparing internal and external databases, including the use of internet search engines and/or social media; or

- appoint an external tracing company to locate the Nominated Beneficiary.

Before the end of the 3 (three) year period referred to above, the Binder Holder must confirm the Unclaimed Benefit and transfer the amount of the Unclaimed Benefit to an account in the name of the Insurer, and the Insurer will accept liability for the Unclaimed Benefit.