Claims Management Framework

for

GUARDRISK GROUP (PTY) LTD

Incorporating the following operating entities:

GUARDRISK INSURANCE COMPANY LIMITED

GUARDRISK MICROINSURANCE LIMITED

Policy Owner: Head: Market Conduct and Claims

October 2023

Contents

1. Overview

1.1 Document history

Revision Date	Doc Version	Summary of Changes	Author / Reviewer
March 2023	1	Initial framework drafting	Buyisiwe Hlatshwayo
July 2023	2	Lega & Compliance review	Makhabo Mabena
October 2023	3	Final	Buyisiwe Hlatshwayo

1.2 Operational approvals

This document has obtained the following approvals:

Name	Nature	Doc Version	Approval Signature	Date of Approval
GGI Management Committee	Approval & recommendation	3	Refer to GGI Manco Minutes	September 2022
Non- Life Management Committee	Approval & recommendation	3	Refer to Non-Life Manco Minutes	March 2023
Market Conduct Steerco	Approval & recommendation	3	Refer to Market Conduct Steerco	June 2023

1.3 Governance Approvals

Name	Title	Doc Version	Approval Signature	Date of Approval
GRI Management Committee	Manco	3	Refer to Manco Minutes	March 2023
Executive committee	Exco	3	Refer to Exco Minutes	July 2023
Board of Directors	Board	3	Refer to Board resolutions	October 2023

1.4 Purpose

The objective of this Framework serves as an internal guideline for our cell captive binder holders, (promotor binder holders, non-mandatory intermediaries (NMI), UMAs and/or claims administrators) to:

- Create operational standards, accountability and expectations set by Guardrisk Insurance;
- Set out clear requirements for claims management and oversight from a contractual, legislative, and regulatory perspective; and
- Align and clarify the roles and responsibilities of agents for better management and oversight of the cell captive binder holder area, for assurance to the regulatory bodies that govern the Non-Life industry (for the purposes of clarity, reference to Non-life shall include the Non-Life component of Guardrisk Microinsurance).

Through the development of this Framework, Guardrisk Insurance can ensure that the claims management processes are consistent, properly developed, meet quality requirements, consider market conduct standards and principles; and are regularly updated to remain compliant with applicable laws and regulations.

This Framework endeavours to promote:

- Operational efficiencies and best practices across all Guardrisk Insurance binder holders;
- Compliance with applicable laws and regulations;
- Identification of responsible divisions for the claims management process; and
- Effective governance systems and controls in all areas in respect of claims management.

Other policies and documents related to this Framework includes:

Document Name	**Relationship**
Binder Agreement for UMAs and NMIs	Referenced
Outsource Agreement	Referenced
Policyholder Protection Rules	Referenced
SAIA Code of Conduct	Referenced

1.5 Definitions

1.5.1 This framework contains the following definitions:

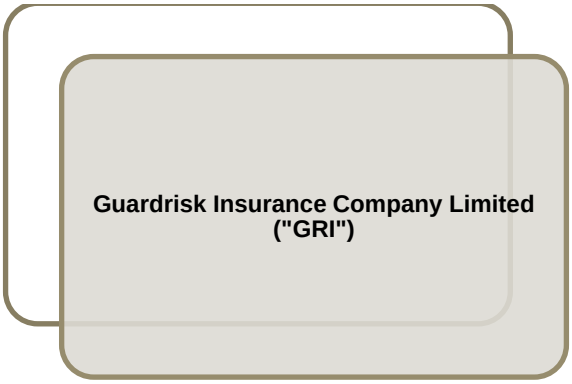
Approvals	means all approvals, consents, authorisations, permissions, licences, resolutions, exemptions, registrations, filings, permits and rights from all governments, regulatory and statutory entities and authorities.
Authorised Agent	means a person authorised by an insurer to provide financial products and services on behalf of the insurer.
Administrator	means an entity that performs binder functions on behalf of the insurer.
Benefits	means the benefits in terms of the policies.
Beneficiary	in respect of a registered insurer means – a) a person nominated or defined 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.
Binder holder	means the binder services and incidental services to be rendered by the binder holder in terms of the Binder Agreement.
Binder services	means the binder service and incidental services to be rendered by the binder holder in terms of the Binder Agreement.
Business Day	means any day excluding a Saturday, Sunday or public holiday.
Claim	means a demand for policy benefits by a Claimant in relation to a policy, irrespective of whether or not the Claimant's demands is valid.
Claimant	means a person who makes a claim.
Compensation payments	means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of the 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 the claim, whether 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 as not contractually due; and includes any interest on late payment of any amount referred to in (b) or (c).

Financial sector Conduct Authority (FSCA)	means the Financial Sector Conduct Authority, established in terms of the Financial Sector Regulations Act and its successor in title.
Fund	refers to insurance premium held in an account which is used to pay insurance claims.
Goodwill payments	means a payment outside of the policy terms and conditions, 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.
Independent intermediary	means a person who acts as a representative of a prospective or current policyholder in the arrangement of an insurance agreement which meets the prospective or current policyholders needs.
Insurer	means Guardrisk Insurance Company Limited, who is also deemed the insurer, and includes representatives of the insurer; and any independent intermediary referred to in section 48 (2) of the Short-term Insurance Act.
Loss	means without limitation, all claims, losses, damages, costs, charges, liabilities, penalties, interest, fines and expenses (including legal and other professional charges and expenses (on an attorney and on client scale, and VAT thereon).
Person	means a natural person or a legal entity.
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 non-life insurance policy underwritten by the insurer in respect of legislated classes of Non-life insurance where the policyholder is a natural person or 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
Policyholder	means a person who holds a non-life insurance policy and may include person to whom the benefit on a non-life insurance policy extends. Potential policyholder means a person who – (a) has applied to or otherwise approached an insurer or an intermediary to become a policyholder; (b) has been solicited by an insurer or an intermediary to become a policyholder; or (c) has received advertising, as defined in rule 10, in relation to any policy or related service of an insurer.
Policyholder Protection Rules (PPR)	means section 55 of the Short-Term Insurance Act 1998.
Products	means the non-life insurance products of the insurer underwritten in terms of the Policy.
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 "Repudiation" shall have a corresponding meaning.
South Africa Insurance Association/SAIA	means South African Insurance Association NPC, the representative industry association for the non-life insurance industry.
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 or provision of goods or services in respect of an authorised claim.

1.6 Scope

1.6.1 This framework applies to Guardrisk Insurance Company.



1.6.2 This framework prescribes the minimum standards for claims management.

2. Communication and Escalation Process

2.1 Roles and responsibilities

The table below outlines the roles and responsibilities of the stakeholders responsible for governance of this Policy.

Responsibility	Structure	Interest, Duties and Responsibilities
Supervision	Management Committees	The Management Committees are responsible for supervision and adherence of the framework.
Operational Implementation	Executive and Non-Life Technical claims team	The Executive and the Technical claims teams are responsible for adherence to this Framework and operational implementation of the claim's management process.

3. General Standards: Claims Handling

3.1 Communication with current and potential policyholders

- The insurer must communicate effectively with current and potential policyholders throughout the insurance contract lifecycle, as effective communication enables the policyholder to make informed decisions relating to the subject matter Insured and the relevant Insurance products.
- All communication to the policyholder must be channelled via the policyholder's nominated contact method.

3.2 Standard for dealing with policyholders at claims stage

- The claims management process/framework must be accessible, transparent, expeditious, and efficient and designed to accommodate all activities necessary for the proper handling of insurance claim.
- Claims received by an independent intermediary, binder holder or any other service provider that has been mandated by the insurer to manage claims on its behalf, is deemed to have been received by the insurer itself.
- The insurer and mandated binder holder of the insurer must honour promises arising from valid insurance claims.
- Insurance claims should be fairly repudiated/rejected and only be repudiated/rejected in circumstances permitted by legislation and in terms of the insurance contract.

- All reasonable steps must be taken to investigate the merits of a potential claim.

- Any person dealing with claims must have the necessary training and competence, with working knowledge of insurance legislation and practices relating to claims management.

- Persons dealing with claims must be empowered to make impartial decisions or recommendations.

- The insurer/binder holder and /or independent intermediary must promptly correct errors or mistakes that may take place when dealing with claims, and advise the policyholder, where appropriate.

- The claims management framework must accommodate the analysis of trends, risks and remedial actions in order to review the product design and disclosures in line with Treating Customers fairly (TCF) principles.

- Appropriate procedures must be in place for the identification and assistance of vulnerable policyholders who may need assistance throughout the insurance claims process.

3.3 Claims reporting standards

- The insurer/binder holder and /or independent intermediary must advise policyholders of the claims reporting process at underwriting stage and/or when a claim is lodged.

- To ensure efficient claims reporting process, the insurer/binder holder and/or independent intermediary must provide the policyholder with the information necessary to help them lodge a claim. Information provided must address the following:

    - How to minimise loss.
    - The importance of co-operating in the investigation by providing the insurer with all the required facts, information, and official documents regarding the loss.
    - Reporting of the claim in a timely manner as provided for in the policy.
    - The need to allow the insurer to handle inspection and assessment of damage prior to settlement.
    - The need to understand that the policyholder may be required to cede their rights to the insurer for recovery from the third party (if applicable) after settlement of the claim under the principles of subrogation.
    - The insurer, the independent intermediary and the binder holder on notification of claim, must within a reasonable time after receipt of a claim (**no more than 48hrs**) acknowledge receipt thereof and inform a c claimant of the process to be followed in processing the claim.
    - All evidence, supporting documentation, communication with policyholder/claimant and action taken must be recorded by the insurer, the Intermediary, and the binder holder.
    - Accurate, efficient, and secure recordings of all claims received, irrespective whether the claims are valid or not must be kept for the required time frame.

3.4 Claim assessment and processing standards

- Claims must be assessed based on information or documentation that is material to the assessment of the claim, in terms of the insurance policy and the law.

- The assessment of the claim must be done in line with the principles of equity and fairness, as well as treating the customer fairly (TCF).

- The claims assessment methods used must be reasonable and coherent.

- The policyholder must be notified where the insurer/binder holder has opted to appoint a loss assessor, loss adjuster, investigator and/or other service provider to investigate the loss or assess the damage.

- The loss adjuster, loss assessor and other service providers used to assess the claim must be competent and qualified to do so.

- The policyholder must regularly be kept informed of the progress of the claim and the insurer must respond timeously to requests made about the claim by the policyholder.

3.5 Making decisions regarding claims

- Once all relevant information has been collected and all enquiries have been completed, the insurer must decide whether to accept or reject/repudiate the claim within a reasonable time.
- The insurer or binder holder must notify the claimant/policyholder within 7 (seven) days of its decision to reject/repudiate the claim in writing.

3.6 Claim rejection/repudiation

- The insurer and/or binder holder will only reject/repudiate claims in the following circumstances:
  - Where conditions stipulated in the policy contract were not met by the policyholder.
  - The loss is specifically excluded in the policy contract.
  - The loss is not covered by the policy contract.
  - Evidence exists that the claim is fraudulent.
  - There is non-payment of premiums.
  - Voiding a policy from inception for non-disclosure and material change in risk.
  - In any legally permitted circumstances.
  - The repudiation process must be documented.
  - If the binder holder is a non-mandated intermediary, all potential claim repudiations/rejections must be referred to the insurer for approval prior to sending the repudiation/rejection letter to the policyholder.
  - Claim repudiations/rejection decisions must be made at senior level or at repudiation forums or committees.

- Should the insurer/binder holders make the decision to reject/repudiate a claim:

  - If the claim is rejected/repudiated, the insurer and or binder holder must advise the policyholder explicitly of the policy provisions, conditions, or exclusions on which the rejection/repudiation is based in writing.

- The claim repudiation/rejection must be in plain language and must inform the claimant or policyholder:
  - Reasons for the repudiation/rejection reason which must be in an explicit manner.
  - That the claimant/policyholder may within a period not less than 90 days from the date of receipt of the claim repudiation/rejection make representation to insurer in respect of the decision.
  - Of details of the internal escalation and review process, as well as details of the Guardrisk Insurance Non-Life Arbitrator.
  - Of the right to lodge a complaint to a relevant Ombud, the relevant contact details, time limitations, and other relevant legislation provisions relating to the lodging of such a complaint.
  - If the relevant policy contains a time limitation provision for the institution of legal action, attention must be drawn to that provision and the implication of the provision to the claimant/policyholder.

- If the amount offered is different from the amount claimed, the insurer must explain the reasons for this to the policyholder.
- Where the insurer is not responsible (by virtue of policy clauses) for meeting all or any part of the claim, it must notify the policyholder of this fact and explain why.
- The insurer will inform the policyholder about its complaint's procedure, as well as other recourse avenues available to the policyholder.
- Copies of all documents and information that is not subject to legal privilege and that influenced the decision will be provided on request.

3.7 Repudiation approval by insurer for NMI binder holders

3.7.1. Repudiation requests

3.7.1.1 Repudiation requests must be submitted to Guardrisk Insurance for review and approval for NMI's/binder holders. The centralised inbox email address **claimsrepudiation@Guardrisk.co.za**, must be used.

3.7.1.2 Repudiation requests shall be reviewed by Guardrisk Insurance, and a response will be provided to the binder holder within **5 working days and/or as per the agreed Service Level Agreement with the binder holder**.

3.7.1.3 Once the repudiation is approved, Guardrisk Insurance shall forward a final repudiation letter on a Guardrisk Insurance letterhead to the NMI **or** authorise/approve the NMI binder holder to proceed with the repudiation letter on their own letterhead as per agreed arrangement.

3.7.1.4 In the event that a repudiation request is declined by Guardrisk Insurance, Guardrisk Insurance will provide adequate reasons to the binder holder and request review and settlement of the claim.

3.7.1.5 The repudiation approval request will be presented to the Guardrisk Insurance Repudiation Forum which meets once a week, every Wednesday. As part of the repudiation pack to be presented, the following documents are to be provided to

Guardrisk Insurance by the binder holder for all repudiation requests, large losses, ex gratia requests, representations and disputed claims:

(a) Summary of claim merits;
(b) Completed claim form;
(c) Assessors/investigators/expert reports;
(d) Repudiation template with reasons for the repudiation;
(e) Claims history;
(f) Record of advise and/or proposal form;
(g) Sales conversation;
(h) Renewal documents;
(i) Schedule of insurance;
(j) Applicable policy wording, and
(k) Any other document which may be necessary for the review of the claim.

3.7.2 Representations made following a repudiation:

3.7.2.1 Claim representations must be forwarded to **claimsrepudiation@Guardrisk.co.za**

3.7.2.2 Representations sent to the **claimsrepudiation@Guardrisk.co.za** inbox shall be acknowledged with **24 hours**.

3.7.2.3 The acknowledgement above shall include the name, email address and contact number of the technical specialist and the expected response time to the claim representation. Guardrisk Insurance will be reviewing the representation and request claims detail and/or documentation from the binder holder who will be required to provide such detail to Guardrisk Insurance within 10 working days. Guardrisk Insurance will then review the claim documentation and provide a response to the insured and/or policyholder within 45 working days with reasons as to whether the decision is being upheld or overturned and reasons for the decision made.

3.8 Claims settlement

- When a final payment or offer of settlement is made, the insurer must explain to the policyholder the payment or settlement calculation and the basis used to arrive at the payment/settlement.
- In the case of a settlement involving several insurers, indemnification to the policyholder should be priority: the claim should be settled in an appropriate time period while potential disputes between the insurers are resolved at a later stage.
- The insurer must not attempt to settle a claim for less than the amount which the policyholder would be entitled to receive.
- Where any excess is payable by the policyholder, such excess must be clearly disclosed to the policyholder.
- A documented procedure setting out the circumstances in which interest will be payable in the event of the late payment of claims needs to be available and disclosed. Further the process to be followed in such an instance and the rate of the interest payable.

- Should the policyholder/claimant demonstrate a need of urgency based on financial hardship as a result of the loss, the insurer will, if possible, fast-track the process of the claim and/ or consider interim payment to the policyholder.

3.9 Dual/multiple insurance

- Subject to the principles that insurance is not intended to place a person in a better position than before the claim, when and insurer becomes aware of the fact that a policyholder is insured by another insurer, The insurer must:
    - Pay the full claim and arrange with the other insurer to be reimbursed for its rateable proportion or arrange with the other insurer to each pay the rateable proportion due by each within a reasonable time;
    - OR refund premiums in accordance with respective rateable proportion of the risk, where appropriate.

3.10 Extraordinary circumstances (catastrophes and disasters)

- In extraordinary circumstances where a large number of claims are lodged at once, it is possible that the insurer might not meet the standards set out in other sections. The following standards will apply:
    - The insurer/binder holder will respond in a fast, professional, practical, and compassionate manner to the circumstances of the loss.
    - The insurer, binder holder or independent intermediary must take internal measures to ensure appropriate response to the situation.

- Where the claim is handled by binder holder and/or independent intermediary, ensure reporting and regular feedback to insurer on these claims.

- If claim handled by binder holder and /or independent intermediary, a catastrophe claim code to be obtained from insurer for proper categorisation of these claims and correct reporting to reinsurers.

3.11 South African Special Risk Insurance (“SASRIA”) claims

- Claims related to civil commotion, riots or terrorism will need to be lodged against SASRIA.

- All SASRIA claims must be forwarded to **Sasriaclaims2@Guardrisk.co.za** for Guardrisk Insurance.

- The SASRIA claims need to firstly be assessed in terms of the underlying policy and with each notification a repudiation letter which confirms that the underlying policy does not respond and that this is a SASRIA claim.

- Guardrisk Insurance will acknowledge claim within 24 hrs.

- SASRIA will be notified, after confirmation of applicable coupons, policy schedules and confirmation of premium payment with Underwriting.

- Guardrisk Insurance will facilitate the claim with SASRIA and update the binder holders on the progress of the claim.

3.12 Notification of above claims/large losses and requests

- Notification of claims over the agreed and/or allocated mandate is deemed a large loss claim by Guardrisk Insurance and must be forwarded to **largelosses@Guardrisk.co.za.**

- Guardrisk Insurance will acknowledge notification within 24 hrs and request that all the information relating to same be provided within 5 working days.

- Progress updates needs to be provided to Guardrisk Insurance until claim is finalised.

3.13 Goodwill payments/gestures, commercial settlements, and compensation payments

- All settlements outside the policy terms and conditions need to refer to the insurer for approval and noting. The insurer needs to keep a record of these settlements and the reasons for them.

- Requests for Goodwill payments are to be forwarded to **technicalclaims@Guardrisk.co.za.** Guardrisk Insurance will review the claim and the motivation request by the binder holders within reasonable time and/or comply with the urgency of the request shall provide a response to the binder holder by electronic mail.

- Should Guardrisk Insurance be of the view that the request for goodwill payment ought to be declined Guardrisk Insurance shall provide reasons for their views on the matter. The process is not to support policy defects and/or process deviations and the requests will be closely monitored for trends.

3.14 Third-party claims and recoveries

- In the event of a third-party claim or recovery, the following standards will apply:

    - The insurer will act in good faith, and the third-party claims and/or recoveries will be dealt with judiciously and expeditiously, and in a transparent fashion.
    - As this is an area in which a lack of knowledge and confusion is the norm for both the policyholder and the uninsured third party, the insurer will follow a communication process which will explain to both the policyholder and the uninsured third party what the procedures, processes and expected timelines involved in third party claims are with the aim of creating an understanding and managing the expectations of the policyholder and the uninsured third party.
    - The method of communication used to relay the abovementioned information is to be decided by the insurer, in line with the insurer's business process.
    - Effective communication will be implemented by the insurer at the fulfilment stage and at claims stage.

- The insurer will ensure that all its contracted third parties (mandated brokers, underwriting managers, recovery agents and any other relevant contracted third parties) will adhere to the procedures regarding third party claims and recoveries.

3.15 Claims received during the grace period

- The binder holders must ensure that a policy contains a proviso of grace for the payment of premiums of not less that 15 days after the relevant due date.
- In the case of a monthly policy, such provision must apply with effect from the second month of the currency of the policy.
- If a claimant submits a valid claim in respect of an event that occurred during the period referred above, the value of the claim may be reduced by the sum of the unpaid premium.

3.16 Non-disclosure and misrepresentation

- Should the insurer become aware that a misrepresentation or non-disclosure has taken place; the insurer must within a reasonable period decide whether it wishes to continue with or void the policy. Should the insurer elect to continue with the policy despite the initial misrepresentation or non-disclosure, the insurer will accept liability of the policy.
- Where the effect of the misrepresentation or non-disclosure is that the insurer calculated the premium incorrectly, the insurer shall be entitled to recalculate the premium for the risk assumed or impose other appropriate underwriting measures and, where applicable, to recover any shortfall from the policyholder.

3.17 Fraud and dishonest conduct

- The insurer is unequivocally opposed to fraud and dishonest conduct, and will do everything in their power to identify, verify, investigate, and prevent such behaviour.
- Insurers/binder holders obligations in terms of fraud and dishonest conduct:
    - The insurer is expected to participate in combating fraud and dishonest conduct as well as establishing systems and controls for detecting and identifying fraud appropriate to the insurers exposure and vulnerability.
    - Discourage fraudulent claims by making policyholders aware of the consequences of submitting false statements when lodging a claim.
    - Train employees and authorised agents who deal with claims to scrutinise claim documents to detect dishonesty and possible fraud.
- Should an insurer cancel a contract because the contracting party is found to have acted fraudulently or in a dishonest manner, the following procedure will apply:

- Apply and exhaust their internal mechanisms for detecting, identifying, and verifying the fraud.
- Inform affected clients about the cancellation and the options available to the policyholder.
- Inform the Insurance Crime Bureau ("ICB ") of the cancellation of the contract and the reason for it.
- Informs the ICB of employees dismissed as a result of fraud or a financial related crime.

- Should an insurer/binder holder be approached by an intermediary with a book of business, the insurer should establish with the ICB whether another insurer was notified about the cancellation of a contract with that particular intermediary due to the fact that the intermediary was found to have acted fraudulently or in an improper manner. Should the insurer find out that the intermediary had in fact been referred to the ICB; the insurer should not accept business through that intermediary.

3.18 Standards relating to insurers employees, authorised agents and contracted service providers

- In dealing with policyholders, insurers and their contracted service providers shall ensure that:
  - Policyholders will always be treated with respect, and they will not be harassed, intimidated, misled or threatened at any time.
  - There is a presumption of innocence until the established facts indicate otherwise.
  - Insurers, binder holders and/or independent intermediaries will only request access to relevant information when investigating potential dishonesty and fraud and will treat any personal information in terms of the relevant privacy laws.
  - Information regarding established insurance fraud will only be shared for the purpose of combating crime.

- The insurer will exercise appropriate governance and oversight of their employees and Authorised Agents.

- At all times tact fairly, professionally, honestly, transparently and with due skill, care, and diligence.

- Service providers are to be competent and provide service which match their expertise.

- The insurer/binder holder or independent intermediaries must:
  - Ensure that contractual arrangements with employees and Authorised Agents address the matters stipulated above.
  - Provide their employees and Authorised Agents with the requisite training in respect of the services they are to perform on behalf of the insurer.
  - Request their Authorised Agents to notify them of any complaints received against them while acting on the insurer's behalf.
  - Have appropriate controls in place to ensure the robust identification, assessment, measurement, and management of any risk associated with the outsourcing of activities to Authorised Agents.

3.19 Standard for dealing with repairs and workmanship

- The insurer/binder holder or independent intermediaries must take accountability for the services provided by the Service Providers they appoint and must exercise adequate oversight over the services provided by duly authorised Service Providers.

- The insurer/binder holder or independent intermediaries must appoint appropriately skilled, certified, or professionally qualified service providers. Where recognised professional bodies exist, the appointment of members of these bodies is preferred.

- An assessor and/or service provider must be dispatched to address the policyholders claim within a reasonable time period, taking into consideration the circumstances of the claim.

- A decision regarding the repairs and/or any other action must be made within a reasonable period after receiving the relevant information from the assessor and/or other service provider, in relation to the type and urgency of the event.

- Where a service provider has been selected and directly authorised by the insurer/binder holder or independent intermediaries, they must:

    - Accept responsibility for the quality of the workmanship and materials used.
    - Handle any complaint about the quality or timelines of the work or conduct of the service provider accordingly.
    - Service level Agreement to be in place with penalties imposed on sub-standard work and/or poor workmanship.
    - A rotation system to be in place in respect of the appointment of service providers to ensure objectivity in the assessment of claims.
    - Quarterly or annual reviews on service providers and review of Service Level Agreements to ensure compliance with required standards and service delivery.

3.20 Prohibited claims practices

- An insurer/binder holder or independent intermediaries may not –

    - 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 PPR rule 7.1(a).**

4. Claims management directives as per Binder Agreement

4.1 Authority/mandate

- Relates to all claim activities and incidental functions associated with the authorised business as covered by the insurer's policies issued by the underwriting manager/non-mandated

intermediary:

4.1.1 Scope and authority

- This authority relates to all claim's activities associated with the products covered by the insurer and entered into by the underwriting manager on behalf of the insurer.
- The authority will be restricted to the listed classes of business and limits per claim as noted and agreed in the signed Binder Agreement.
- Where a claim exceeds such limits prescribed above, and in respect of classes not specifically mentioned, the underwriting manager will continue to obtain all relevant documentation and handle the claim. However, the underwriting manager will not authorise repairs or replacement of property or make any cash payments or admit liability without prior written consent of the insurer.
- Where any Goodwill payment/gesture/commercial consideration payment is sought, the binder holder will be required to keep a record of such payment and report to the insurer monthly. The report must note the following:
    - The binder holder will need to note the details and need to continue to obtain all relevant documentation and handle the claim on a 'without prejudice basis' but shall not make any cash or credit payments or admit liability without prior written consent of the insurer.
    - The details to be forwarded to the insurer will need the claim details and note the reasons for the request of this good will payment. The date it was forwarded to insurer and the date approved.

4.1.2 Functions and responsibilities: registration of claims

- All claims must be registered separately by the binder holder and must contain at least the following information:
    - Insured's name
    - Date of loss or occurrence and date of intimation
    - A brief description of the circumstances of the claim
    - The class of the claim
    - Period of insurance
    - Estimates for own and third party damage
    - Excesses applicable
    - Aggregate and inner excesses and or any stop loss that may apply
    - Confirmation that premium has been paid for the period of the loss
    - Reinsurance applicable
    - Policy number
    - Salvage and recovery estimates
    - Where a loss category can be more specifically defined, the binder holder shall report claims in such categories (i.e. motor own damage, motor third-party, motor theft, motor hijack etc.)

4.1.3 Appointment of loss adjustors, assessors, salvage contractors, or attorneys

- If, during the initial review of any claim submitted or within a reasonable time after intimation, it becomes apparent that the appointment of an assessor or loss adjuster is required in the normal course of such claim, the underwriting manager shall appoint same from an approved list provided by the insurer. (If such a list is not annexed hereto, the underwriting manager does not have the authority to appoint loss adjusters/claims assessors on behalf of the insurer).

- Claims litigation where Guardrisk Insurance is cited as a defendant, the binder holder needs to ensure that Guardrisk Insurance is aware of the merits of the matter and the basis on which the matter needs to be defended. Guardrisk Insurance will needs to be updates on the progress of the matter and before the matter goes to trial the appointed attorney needs to provide a report/opinion on the prospects of success on the matter to the insurer.

4.1.4 Functions and responsibilities: recoveries

- The binder holders shall take all reasonable steps to effect recoveries and risk management to minimise losses in terms of those claims intimated against the insured business.

- Proper record and prospects of success in the recoveries needs to be managed, so as to make informed decision on recoveries pursued by the insurer.

- All amounts recovered/received in terms of any claim recovery against the insured business shall be paid over to insurer by the binder holder and /or independent immediately.

4.1.5 Functions and responsibilities: reporting of claims

- The binder holder will report all claims data to the insurer in the prescribed format and at intervals required by the insurer.

- The binder holder must notify the insurer in Writing within 7 (seven) days after receipt of notification of any loss or damage which is or may be the subject of a claim against any SASRIA coupon in force. All detailed information and documentation regarding the incident must be submitted to the insurer.

- **Salvage management** – there needs to be a clear process on the management of salvages and record keeping.

- Any claim regarding a stolen vehicle must be registered on the Unicode system for ease of tracking and vehicle being linked to the insurer for recovery purposes.

- **Reserving methodology** – The underwriting manager is to apply appropriate reserving methodology to ensure adequate tracking of risk.

4.1.6 Functions and responsibilities: reinsurance

- The underwriting manager/binder holder shall inform the insurer as soon as practicable of the intimation of a claim against a reinsurer.
- The underwriting manager/binder holder shall inform the insurer, in the prescribed format, and at the intervals required by the insurer, of any claims which may require a reinsurance recovery.

4.1.7 Insurer claims reviews

- The underwriting manager agrees to allow the insurer or its agents at reasonable times and on reasonable notice to audit on a quarterly basis or on frequency solely determined by the insurer all files controlled or supervised by the underwriting manager relating to this agreement.
- Findings made in the claims reviews will need to be addressed and closed out by the underwriting manager.

4.2 General performance standard

- In rendering the binder services, the underwriting manager/binder holder shall:
  - Adhere to and comply with all reasonable and lawful directives and instructions of the insurer as provided from time to time.
  - Comply with any laws or directives relating to treating policyholder fairly, including but not limited to the directives that may be provided in this document.
  - Not make any representations or give any warranties or undertakings on behalf of the insurer other than expressly permitted.
  - Not publish in anyway any material or any circular of whatever nature in respect of the products or in respect of any of the insurer's other products or policies, unless authorised by the insurer in writing.

4.3 Performance criteria

- The following will be considered performance criteria for the measuring of the underwriting managers performance:
  - Loss ratios
  - Claims ratio (claims paid/repudiated and outstanding ratio)
  - Claims reviews (compliance to best practices and Claims Management Framework)
  - Complaints (regulatory/internal escalations/representation/arbitrations in relation to claims)
  - Monitoring plan risk ratings (Guardrisk Insurance claims team risk rating)

5. Claims Record Keeping

- The insurer will ensure accurate, efficient, and secure recording of all claims received, irrespective of whether the claims are valid or not. Such records will conform to the requirements of the Protection of Personal Information Act and any other applicable data privacy laws.
- The following will be recorded in respect of each claim:

    - Details of the claimant and details of the claim and circumstances surrounding the incident resulting in the loss.
    - Copies of the claims form, all relevant evidence and supporting documentation.
    - Copies of correspondence and decisions.
    - Progress and status of the claim, including whether such progress is within or outside the communicated or set timelines.

- The following data will be maintained by the underwriting manager/binder holder on an on-going basis:

    - Number and quantum of all claims received.
    - Number and quantum of all claims paid.
    - Number and quantum of repudiated claims and reasons for repudiation.
    - Number of claims escalated by claimants to the internal claim's escalation and review process and their outcome, which data must also be included in the records and reports required.
    - Number of claims referred to an Ombud and their outcome, which data must also be included in the records and reports, and
    - Total number of claims outstanding.

- The information in relation to claims that have been repudiated and settled needs to be kept for a period of 5 years. To which after this period, the personal information of the Insured or claimant must be de-identified as per the POPIA requirements.
- Claims where there is a minor involved, the time for keeping the information only starts from the time the minor reaches age of majority (18 years of age).

6. Claims Complaints

6.1 Internal escalation and review process standards

- Where a policyholder is not satisfied with the outcome of the claims and/or there is a dispute of settlement proposal, the underwriting managers/binder holders must follow the Guardrisk Insurance internal escalation and review process.

- Guardrisk Insurance has an established internal escalation process which should be utilised to ensure fairness and impartiality to the policyholder.

- The complaint must be reviewed by a person with the appropriate experience, knowledge, and authority. The insurer must inform the complainant of the contact details of the person to whom the complaint has been escalated for review.

- Once the complaint has been reviewed and a decision has been made, the insurer must convey it to the complainant in writing, advising on:

    - The reasons for the decision.
    - Information about how the complainant can access external dispute resolution or other recourse mechanisms.
    - Complex/contentious and specialised claims/referrals where there are disputes and/or need to check insurers views may be referred to the Non-Life Claims Arbitrator for consideration. The details are as follows:

      Miss Buyisiwe Hlatshwayo
      Head: Market Conduct and Claims
      Email: **Buyisiwe.Hlatshwayo@Guardrisk.co.za**
      CC: **technicalclaims@Guardrisk.co.za**

- The arbitrator will acknowledge within 24 hrs. of receipt.

- The arbitrator will request information to assess the matter and allow for 5 days for review or agreed turnaround time.

- A decision will be communicated 7 days once all information has been received.

6.2 External dispute resolution

- The insurer is responsible for responding to all regulatory complaints. The underwriting manager/binder holder must forward all complaints to the insurer.

- The insurer/binder holder and /or independent intermediary must provide complainants with information on how to access the Insurance Ombud scheme and the FAIS Ombud. Such information must be included in Disclosure documentation and documentation related to the rejection / repudiation of the claim.

- The insurer will engage the underwriting manager/binder holder for further documentation or information to address the complaint.

- The insurers decision on the way forward will be discussed with the underwriting manager/binder holder, but the insurer has the final decision.

7. Inclusive Growth and Transformation

- Guardrisk Insurance is committed to the transformation of the South African economy and believes that accelerated growth is best achieved, in an economy conducive of inclusive growth.

- To deliver on transformation objectives for the non-life industry the insurer shall:

    - Take accountability by driving transformation.

- Support the improvement of Black representation at all Management and control sub-elements.
- Support industry commitment to drive transformation of preferential procurement (increasing spend with Broad Bases Black Economic Empowerment (“BBBEE”).
- Support and participate in the sector/industry financial inclusion projects.