LONG LIFE INSURANCE

Long Life Insurance
Claims Management Framework

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1. Introduction

Long Life Insurance, as a licensed microinsurer, has a responsibility to conduct itself with integrity and fairness and in doing so, must ensure that its claims management process is transparent and accessible to policyholders, and that it does not impose any unreasonable post-sale barriers to claimants.

This framework provides structure, guidance and direction on claims processing and management. Detailed procedures and processes to proactively ensure compliance with this framework are documented separately.

This framework seeks to ensure fair treatment of policyholders, claimants and beneficiaries and will be reviewed regularly.

2. Aim

The aims of this framework are:

2.1. To empower and train employees and distributors handling claims in regular claims handling, as well as escalation of complex or unusual claims. Those responsible for claims handling must have the necessary experience, knowledge and skills.

2.2. To ensure claims resolution is fair to policyholders, claimants, product distributors, the business and its staff.

2.3. To ensure objectivity and impartiality in claims processing and management.

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

2.5. To ensure fair treatment of policyholders and claimants that

- 2.5.1. Is proportionate to the nature, scale and complexity of Long Life's business and risks;
- 2.5.2. Is appropriate for the business model, policies, services, policyholders, and beneficiaries of Long Life;
- 2.5.3. Enables claims to be considered after taking reasonable steps to gather and investigate all relevant information and circumstances with due regard to the fair treatment of claimants;
- 2.5.4. Does not impose unreasonable barriers on the claimants.

2.6. Address and provide for, at least, the matters provided for in the Policyholder Protection Rules.

3. Objectives

3.1. Document procedures for the appropriate management of the claims process from the time the claim is received until it has been finalised.

3.2. Document procedures setting out the circumstances in which interest will be payable in the event of late payment of claims, the process to be followed in such an instance and the rate of the interest payable.
3.3. Document procedures which clearly define the escalation and decision making, monitoring and oversight and review processes within the claims management framework.
3.4. Ensure 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-
  3.4.1. identified risks, trends and actions taken in response thereto; and
  3.4.2. the effectiveness and outcomes of the claims management framework.
3.5. Ensure appropriate communication with claimants and their authorised representatives regarding the claims processes and procedures.
3.6. Meet the requirements for reporting to the Financial Sector Conduct Authority and public reporting.
3.7. Establish a compliance programme for combating fraud and money laundering.

4. Scope

This framework applies to employees of Long Life and their intermediaries partners including

- Executive directors;
- Senior / Executive Management;
- Full time, part time or temporary employees (including any learners);
- Any independent consultants employed or requested to assist who may be in possession of or have access to confidential information regarding Long Life;
- Any third party who, by virtue of their profession and engagement with any entity associated with Long Life, has access to confidential information regarding Long Life; and
- Any legal entity controlled by, benefitting or acting on the instructions of any of the persons listed above.

All policies and process or procedure guides relating to claims management of any intermediary must comply with this framework.

5. Definitions

5.1. **“Beneficiary”** in respect of a licensed Insurer, has the meaning assigned to it in Schedule 2 of the Insurance Act.
5.2. **“Business Day”** means any day excluding a Saturday, Sunday or public holiday.

5.3. **"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.

5.4. **"Claimant"** means a person who makes a claim.

5.5. **"Claim Outcome"** shall relate to the following:

5.5.1. **"Approved"** shall mean that the claim has been finalised to the reasonable satisfaction of Long Life and the Claimant has not taken any action against Long Life to obtain any greater benefits.

5.5.2. **"Disputed"** shall mean the Claim is neither approved nor rejected, but Long Life disputes the Claim or the quantum of the Claim.

5.5.3. **"Rejected"** shall mean that the Claim has been wholly or partly Rejected, the Rejected issues are either not disputed by the Claimant within the applicable timeframes or have been resolved in Long Life's favour, and Long Life regards the Claim as finalised.

5.6. **"Compensation Payment"** means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of Long Life to a Claimant to compensate the Claimant for a proven or estimated financial loss incurred as a result of Long Life's contravention, non-compliance, action, failure to act, or unfair treatment forming the basis of a complaint, where Long Life accepts liability for having caused some or all of the loss concerned, but excludes any –

5.6.1. goodwill payment;

5.6.2. payment contractually due to the Claimant in terms of a policy; or

5.6.3. refund of an amount paid by or on behalf of the Claimant to Long Life where such payment was not contractually due; and

includes any interest on late payment of any amount referred to in 5.6.2 or 5.6.3. Interest accrued at 5% per annum.

5.7. **"Customer Query"** means a request to Long Life, either directly or via a distributor, by or on behalf of a policyholder/nominated beneficiary, for information regarding a Claim or a policy, including policy benefits, 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.

5.8. **"Escalated Claim"** shall refer to the following:

5.8.1. a claim that is not resolved within the prescribed timelines;

5.8.2. a complex or unusual claim that requires intervention by a senior functionary of Long Life appointed to deal with escalated claims;

5.8.3. the referral of the Claim to a Claims Committee mandated and authorised to review the Claim and provide an outcome;

5.8.4. situations where 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 Long Life's Complaints Management Framework; and

5.8.5. any other claim which the Long Life personnel dealing with it believe should be escalated.

5.9. **"Exclusion"** means the losses or risk events not covered under a policy.

5.10. **"Goodwill Payment"** means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of Long Life to a Claimant as an expression of goodwill aimed at resolving a claim, where Long Life does not accept liability.

5.11. **"Intermediary"** means an independent intermediary or representative, respectively.

5.12. **"Intermediary Agreement"** means an agreement entered into between Long Life and an intermediary setting out the terms under which the intermediary will render services as intermediary in respect of the policies of the Long Life.

5.13. **"Long Life"** means microinsurer Long Life Insurance (Pty) Ltd licensed to provide cover in the funeral class of business.

5.14. "**Nominated Beneficiary"** means the person nominated by the policyholder and named in the policy to be the person to whom the cover amount is paid upon the death of the Policyholder. The nominated beneficiary does not need to be an insured person in terms of the insurance policy.

5.15. **"Ombud"** has the meaning assigned to it in the Financial Sector Regulation Act.

5.16. **"Outsource Agreement"** means any arrangement of any form between Long Life 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 Long Life business, which would otherwise be performed by Long Life in conducting insurance business, but excludes rendering services as an intermediary (Outsourced business partner will have a corresponding meaning).

5.17. **"Outsourcing"** means an outsourcing arrangement as defined in section 1 of the Financial Sector Regulation Act but excludes rendering services as intermediary, and "outsourced" has a corresponding meaning.

5.18. **"Plain Language"** means communication that –

5.18.1. is clear and easy to understand;

5.18.2. avoids uncertainty or confusion; and

5.18.3. 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.

5.19. **"Policy"** means a long-term policy.

5.20. **"Policyholder"** has the meaning assigned to it in the Act, and includes any person in respect of whom a fund, under a fund member policy, insures its liability to provide benefits to such person in terms of its rules.

5.21. **"Potential Policyholder or potential member of a group scheme"** means a person who - a) has applied to or otherwise approached Long Life, an Intermediary, a fund or a group scheme to become a member of a group scheme; b) has been solicited by Long Life, an Intermediary, a fund or a group scheme to become a member of a group scheme; or c) has received advertising, as defined in rule 10, in relation to any fund group scheme.

5.22. **"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.

5.23. **"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.

5.24. **"Representative"** has the meaning assigned to it in Part 3A of the Regulations.

5.25. **"Service Provider"** means any person (whether or not that person is the agent of Long Life) with whom Long Life has an arrangement relating to the marketing, distribution, administration or provision of policies or related services.

5.26. **"Waiting Period"** means a period during which a Policyholder (or any insured person) is not entitled to Policy benefits.

6. Key Principles and Standards for Effective Claims Management

The following principles and standards shall apply to any claims management processes within Long Life:

6.1. **Accessible:** Long Life will endeavour to make claims processes easily accessible to Policyholders through accessible channels, including on key disclosure documents provided to them as well as on the relevant websites.

6.2. **Client-centric:** Fair treatment of customers is a top priority at every point of the claims management process.

6.3. **Timeous resolution:** Long Life endeavours to ensure that all claims are 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 and the Policyholder must be kept informed of any delays and or revised timelines.

6.4. **Consistent and impartial decision-making:** Long Life will take reasonable steps to ensure that employees and decision-makers avoid bias when handling claims so that principles of fairness, equity and objectivity are upheld.

6.5. **Quality of investigation:** Long Life and its product distributors must take reasonable steps to gather and investigate all relevant information and circumstances when handling claims to ensure only valid claims are paid and all invalid claims are repudiated, unless there are mitigating / extenuating circumstances leading to consideration of a goodwill payment in the interests of fairness and equity to both Long Life and the Claimant.

6.6. **Claims handling responsibility:** Long Life will take reasonable steps to ensure that any person that is responsible for making decisions or recommendations in respect of claims generally or a specific claim is -

6.6.1. adequately trained;
6.6.2. experienced in claims handling and appropriately qualified where necessary;
6.6.3. not subject to a conflict of interest; and
6.6.4. adequately empowered to make impartial decisions or recommendations.

6.7. **Independent review:** Through the Long Life Executive Management and Senior Claims Management Team, Long Life 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 the independence of employees responsible for handling claims.

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

6.9. **Accuracy of record-keeping:** Claims must be accurately, efficiently and securely recorded as required by relevant legislation and as set out below.

6.10. **Communication:** Long Life and / or intermediaries and product distributors must provide customers with clear upfront communication concerning how they can claim, how to dispute a rejection or the quantum of a claim and how to escalate such a claim. This will be evidenced in policy documentation, on a website, in a claim form and in a rejection letter.

6.11. **Quality assurance:** Long Life 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 through the analysis of monthly claims reports of Long Life product distributors.

6.12. **Reporting:** Useful management information reports pertaining to claims will be developed and implemented, subject to regulatory requirements and business needs. Claims information will be analysed and scrutinised on an on-going basis to identify trends of poor customer treatment and findings will be contained in monthly management reports presented to operational and executive forums.

7. Claims Handling Process

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

7.1. The general process that a claim will follow is documented below:

7.1.1. Claim is received from claimant at a branch of an FSP and is captured as it is received using Long Life's preferred software system.
7.1.2. Receipt of the claim is acknowledged to the claimant via SMS/Email.
7.1.3. The claim pre-assessor in the branch performs a pre-assessment and any outstanding or additional information and documentation is requested from the claimant, and the pre-assessor finds out if the claimant would prefer receiving the benefit as monetary payment or, where relevant, as payment to a nominated funeral parlour to pay expenses related to the provision of a funeral service.
7.1.4. Once all information and documentation is correct and complete, the claim pre-assessor submits the full claim to Long Life.
7.1.5. A claim assessor at Long Life will assess the claim and make a decision on the outcome and approve payment of the claim where relevant. The claimant and FSP shall be notified.
7.1.6. Payment will be made as per claimant's preference.

7.2. The time from submission of all documentation to payment shall not be longer than 2 business days except in exceptional circumstances. Where timelines are exceeded or the claimant is dissatisfied with the outcome, the claim will be escalated to management.

7.3. As Long Life appoints its FSPs to perform activities related to claim submission, Long Life acknowledges its responsibility to monitor that these FSPs have adequate resources and record keeping processes to uphold the standards described in this

framework. Intermediary agreements will stipulate minimum requirements for claims handling. In particular:

7.3.1. An FSP must ensure that claims are recorded no later than the first business day after the date the initial claim is received. The FSP may not delay until such time as all requirements relating to the claim have been received. A claim received by an FSP is deemed to have been received by Long Life itself.

7.3.2. Each FSP must ensure they have a documented claims management process that is transparent, visible and accessible to Policyholders through appropriate channels, including on key disclosure documents provided to them as well as on its website. Such claims management processes may not impose any unreasonable barriers or unnecessary administrative burdens on claimants.

7.3.3. FSPs must ensure that they have the resources to fulfill claimant communication requirements documented below.

7.3.4. FSPs must ensure they have the necessary resources for claims record keeping, monitoring and analysis of claims and reporting as per section 9 below.

7.3.5. FSPs must ensure that their own Claim Management Frameworks allow for all the requirements stipulated in the Policyholder Protection Rules and Long Life's own claim requirements.

7.3.6. The appointment of FSPs to perform parts of the claims management process does not in any way diminish Long Life's responsibility in terms of this framework.

8. Policyholder Communication

8.1. All communications with Claimants must be in plain language.

8.2. The following must be disclosed to any Claimant –

8.2.1. the information required from the Claimant (only relevant information may be requested);
8.2.2. where, how and to whom a claim and related information must be submitted;
8.2.3. any time limits on submitting claims;
8.2.4. any other relevant responsibilities of the Claimant.

8.3. A Claim is deemed to have been received when it is received by the FSP and captured onto the system. Receipt of the claim must be acknowledged within 2 business hours.

8.4. The Claimant must be informed of the process to be followed in processing the claim, including –

8.4.1. contact details of the person or department that will be processing the Claim;
8.4.2. indicative timelines for finalising the Claim; and
8.4.3. details of any outstanding requirements.

8.5. Claimants must be kept adequately informed of –

8.5.1. the progress of their claim;
8.5.2. causes of any delay in the finalisation of a claim and revised timelines; and
8.5.3. the decision made in response to the claim.

8.6. When a final payment or offer of settlement is made to a Claimant, it must be clearly explained to the Claimant what the payment or settlement is for and the basis used for calculation of the payment or settlement.

8.7. Where the Claimant is a member or a Beneficiary of a group scheme, the person receiving the claim must –

8.7.1. obtain the contact details of the Claimant to enable all communications required by this rule to take place directly with the Claimant; or

8.7.2. obtain consent from the Claimant that communications required by this rule may take place through the Policyholder concerned.

8.8. Claims should be assessed within 2 business days after all required documents in respect of a claim have been received. The following must then take place -

8.8.1. payment of the claim must be authorised; or
8.8.2. the claim must be rejected; or
8.8.3. in the case of a disputed claim, the claimant must be notified of the dispute.

8.9. If a Claim is disputed, as referred to above, the following must take place within 14 business days after the expiry of the initial 2 business days–

8.9.1. further investigate the claim;
8.9.2. make a decision whether or not the claim submitted is valid; and
8.9.3. then pay or reject the claim.

8.10. Where a claim is rejected or disputed, such communication must inform the Claimant of the following:

8.10.1. the reasons for the outcome, within 10 (ten) business days of the decision being made;
8.10.2. that the Claimant has a period of not less than 90 (ninety) calendar days from receipt of the outcome to make representations to Long Life in relation to the outcome;
8.10.3. the details of both the FSP's and Long Life's escalation and review process;
8.10.4. that the Claimant may refer the matter to the relevant Ombudsman. The Ombudman's contact details and any time limitations applicable must be provided to the Claimant; and
8.10.5. that the Claimant may refer the matter to its legal representative. Anytime limitations and prescription period applicable to the institution of legal action must be set out.

8.11. Should the Claimant make representations in relation to the outcome of the claim, within 45 (forty-five) days of receipt of those representations, communication regarding the outcome must be sent to the Claimant in writing. If the initial decision to reject or dispute is confirmed, such communication must inform the Claimant of the following:

8.11.1. the reasons for the outcome;

8.11.2. the facts forming the basis of the outcome;

8.11.3. the details of the internal escalation and review process, details of the Claimant's right to refer to the matter to the relevant Ombud or to a legal representative, including time limitations and prescription period (where applicable).

8.12. For claims that are approved, any payment must be made without undue delay and within a reasonably agreed timeframe. The Claimant must be informed regarding what the payment is for and the basis used to formulate such payment.

8.13. All evidence, supporting documents, communication with the Claimant and action taken must be recorded.

9. Claims Data Requirements and Record Keeping

9.1. Long Life and its FSPs must ensure that systems and processes are in place that provide for accurate, efficient and secure recording of all claims received, irrespective of whether the claims are valid or not and be able to extract claims data for reporting and analytical purposes.

9.2. The following is recorded electronically by Long Life and its FSPs in respect of each claim received -

9.2.1. all relevant details of the Claimant and the subject matter of the claim;
9.2.2. copies of all relevant evidence, correspondence and decisions;
9.2.3. full and complete audit trail for every claim; and
9.2.4. progress and status of the claim, including whether such progress is within or outside any set timelines.

9.3. The following Claims related data must be maintained on an ongoing basis and for at least 5 years after the date of the last claims transaction by Long Life–

9.3.1. number and quantum of claims received;
9.3.2. number and quantum of claims paid;
9.3.3. number and quantum of Rejected claims and reasons for the Rejection;
9.3.4. number of claims escalated by Claimants to the internal claims escalation and review process and their outcome (categorised as required in Rule 18 of the PPR's as per Long Life's Complaints Management Framework);
9.3.5. number of claims referred to an Ombudsman and their outcome, and
9.3.6. total number of claims outstanding.

9.4. Identified trends, risks and any remedial actions or product design reviews will be disclosed on a half yearly basis in line with Treating Customer Fairly principles.

10. Rejections or Disputes

10.1. In the case of rejections or disputes, Long Life must communicate the following to the claimant:

10.1.1. The reason for the decision;
10.1.2. The facts that informed the decision;
10.1.3. The fact that the claimant may within a period of not less than 90 days after the date of receipt of the notice make representations to Long Life; and
10.1.4. That the claimant has the right to lodge a complaint to the relevant Ombudsman. The Claimant must also be provided with the contact details and time limitations of the applicable Ombudsman scheme.

11. Claims received during Grace Periods

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

12. Claims Escalation and Review Process

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

12.1.1. follow a balanced approach;

12.1.2. provide for the internal escalation of complex or unusual claims at the instance of the initial claim handler;

12.1.3. provide for claimants to escalate claims not resolved to their satisfaction;

12.1.4. provide for the allocation of claims to an impartial, senior functionary for managing the claims escalation or review process of Long Life.

12.2. Complex or unusual claims shall be escalated from the initial assessor to the Claims Manager.

12.3. If a claimant or customer is dissatisfied with the outcome of the claim assessment, he/she may direct their dissatisfaction to the FSP concerned who will refer the matter to Long Life, or the client may escalate the matter directly to Long Life, for review of the decision. Long Life must respond to the claimant within 15 business days. Should this result in a decision that is still unacceptable to the Claimant, the matter may be referred to the Ombudsman for Long Term Insurance.

13. Prohibited Claims Practice

Neither Long Life nor any of its FSPs may:

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

14. Regulator Interaction

Long Life is required to report prescribed claims' information to appropriate regulators.

15. Responsible Persons

15.1. The following persons are responsible for claims management:

Person / Department / Body	Entity	Role
Board of Directors	Long Life	• Approves this framework and holds final responsibility for monitoring its implementation.
Chief Operations Officer	Long Life	• Approves and oversees the effectiveness of this framework. • Is responsible for operational implementation of this framework but delegates administration of this framework to the Claims Manager to address or monitor operational matters.
Compliance Manager	Long Life	• Resolution of escalated claims. • Reviews claims process and monitors adherence to this framework. • Ensures framework remains in line with legislation.
Fraud Detection Team	Long Life	• Fraud detection and prevention within the claims process.

Claims Manager	Long Life	• Monitors ongoing operating effectiveness of the framework.
		• Ensures operational implementation of this framework and processes developed in accordance with this framework.
		• Ensures the execution of agreed standards including quality assurance.
		• Reports to Executive Management and other forums on the business performance and adherence to requirements, procedures and standards set out in this framework.
		• Ensure adequate resources allocated to claims handling and that any person dealing with claims is adequately trained, experienced in claims handling, not subject to conflict of interest and adequately empowered to make impartial decisions or recommendations.
		• Ensures that clearly defined parties are responsible for:
		  ○ Decision-making authority
		  ○ Claims Escalation
		  ○ Claims Monitoring
		  ○ Claims Reporting
		  ○ Regular Analysis of Claims
		• Review, Approval & Escalation of claims

Claims Assessor	Long Life	• Assessment, Approval & Escalation of claims.
Claims Pre-Assessor	Long Life / FSP	• Checks all relevant information and documentation is submitted.

16. Policy Review

16.1. The Policy will undergo a full review on an annual basis.

16.2. Amendments to the policy outside of this annual review may be suggested to the Risk & Compliance and Claims Departments if any inadequacy of any element of the policy is identified as a result of any new risks.

16.3. The Executive Committee is responsible for approving any amendments, with board consultation where necessary or advised.

Particulars of Long Life Insurance (Pty) Ltd:

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Email: claims@longlife.co.za

Particulars of the Long-Term Ombudsman	**Particulars of the FAIS Ombudsman**
Postal Address: Private Bag X45,Claremont, Cape Town, 7700 Telephone Number: 021 657 5000 Facsimile Number: 021 674 0951 Email: info@ombud.co.za	Postal Address: PO Box 74571, Lynnwood Ridge, 0040 Telephone Number: 012 470 9080 Email: info@faisombud.co.za