1. INTRODUCTION

The Company, as an authorised financial services provider, has a responsibility to conduct itself honestly, with integrity, fairness, dignity and ethically wherever it operates, with due regard to the societies in which it operates and its other stakeholders. The Claims Management Framework serves to meet the requirements of both the Long Term Insurance act and Short Term Insurance Act as well as Rule 17 of the Policyholder Protection Rules. It needs to ensure fair treatment of policyholders and beneficiaries. This policy is reviewed annually.

2. OBJECTIVE

The Claims Management Framework must be efficiently maintained and operated to ensure that:

2.1 It is proportionate to the nature, scale and complexity of The Insurer's business and risks;

2.2 Is appropriate for the business model, policies, services and policyholders and beneficiaries of the Insurer;

2.3 Enables claims to be assessed after taking reasonable steps to gather and investigate all relevant and appropriate information and circumstances, with due regard to the fair treatment of claimants; and

2.4 Does not impose unreasonable barriers to claimants.

3. DEFINITIONS

3.1 **"Beneficiary"** in respect of a –

registered insurer means –

a) a person nominated by the Policyholder as the person in respect of whom the Insurer should meet policy benefits; or

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

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

3.2 **"Business Day"** means any day excluding a Saturday, Sunday or public holiday.

3.3 **"The Company"** means Total Risk Administrators (Pty) Ltd, an authorised financial services provider, FSP No 40815

3.4 **"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;

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

3.6 **"Claim Outcome"** shall relate to the following:

a) "Accepted" shall mean that the claim has been finalised in such a manner that the Claimant has either explicitly accepted that the policy benefits have been fully paid or in such a manner that is reasonable for The Insurer to assume that the Claimant has so accepted. A Claim should only be regarded as accepted once any and all undertakings made by The Insurer to provide policy benefits wholly or in part have been met.

b) **"Repudiated"** shall mean that the Claim has been wholly or partly rejected (or repudiated) and The Insurer regards the Claim as finalised after advising the Claimant (both verbally and in writing) that it does not intend to take any further action to pay the Claim. This can arise either where a Claim is rejected without offering to take steps to pay it because The Insurer regards the Claim as invalid, or where the Claimant does not accept or respond to proposals to pay the Claim and The Insurer then advises the Claimant that it does not intend to take any further action to attempt to pay the Claim.

c) **"Disputed"** shall mean the Claim is neither accepted nor rejected, but The Insurer disputes the Claim or the quantum of the Claim.

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

a) goodwill payment;

b) payment contractually due to the Claimant in terms of a policy; or

c) refund of an amount paid by or on behalf of the Claimant to the Insurer where such payment was not contractually due;

d) and includes any interest on late payment of any amount referred to in (b) or (c);

3.8 **"Customer Query"** means a request to The Insurer by or on behalf of a policyholder/beneficiary for information regarding a Claim or a policy, including policy benefits, no-claim bonus (if any), loyalty benefit (if any), 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.

3.9 **"Escalated Claim"** shall refer to the following:

a) an extension of a Claim relating to the outcome of the initial Claim;

b) the Claim is complex or unusual that it requires intervention by an impartial senior functionary appointed to deal with escalated claims;

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

d) the resolution of the initial Claim is not to the Claimant's satisfaction and is then treated as a complaint and dealt with in terms of the Insurers Complaints Management Framework.

3.10 **"Exclusion**" means the losses or risk events not covered under a policy;

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

3.12 **"The Insurer"** means Guardrisk Life Limited for assistance and funeral benefits and Auto & General Insurance company Limited for short term business;

3.13 **"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;

3.14 **"Policy"** means a long-term / short term policy where the Policyholder is a –

a) natural person; or

b) 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;

3.15 **"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;

3.16 **"Repudiate"** in relation to a Claim means any action by which an Insurer rejects or refuses to pay a Claim or any part of a Claim, for any reason, and includes instances where a Claimant lodges a Claim –

a) in respect of a loss event or risk not covered by a Policy; and

b) in respect of a loss event or risk covered by a Policy, but the premium or premiums payable in respect of that policy was not paid and "Repudiation" shall have a corresponding meaning;

4. ALLOCATION OF DUTIES

The Claims Manager of the Company is responsible to ensure that all claims lodged are treated in line with this framework. The Claims Manager will ensure that adequate resources are allocated to claims handling and that any person dealing with claims are:

4.1 Adequately trained;

4.2 Experienced in claims handling and appropriately qualified;

4.3 Not be subject to a conflict of interest; and

4.4 Be adequately empowered to make impartial decisions or recommendations.

5. THE CLAIMS PROCESS SUMMARISED

The process that a claim will follow at the Company:

5.1 Claim received from claimant

5.2 Lodging of claim by Company's claims department on internal system

5.3 Communication to acknowledge receipt of claim sent to claimant contemporaneously when claim lodged

5.4 Claim notification and documents reviewed (within 2 full business days for assistance benefit claims and 5 full business days for short term claims)

5.5 Any outstanding or additional information and documentation requested by the claims department from claimant or relevant party is sent within the time frame mentioned in 5.4 above

5.6 Assessment of claim, decision making and oversight (2-day Assessment and Finalisation period for assistance business claims and 5-day assessment and finalisation period for short term claims)

5.7 Claim outcome communicated to the claimant (within 1 full business day of decision)

5.8 Escalation to follow where applicable time lines are exceeded to management and The Insurer or claimant is dissatisfied with the outcome.

6. CLAIM ESCALATION AND REVIEW PROCESS

Complex or unusual claims shall be escalated to the internal complaints committee which includes the operations executive and if unresolved will be escalated to The Insurer.

7. COMPENSATION PAYMENT (INTEREST ON LATE PAYMENT)

The Company will endeavour to finalise claims within 2 business days (assistance claims) or 5 business days (short term claims) of receipt of all required documentation. In instances where a delay occurs on the part of the Company, and such delay causes financial loss or any form of prejudice to a claimant, and where the delay is proven to have been unnecessary, the Company will pay a "compensation payment" equal to but not greater than interest @ 6% of the claim value.

8. RECORD KEEPING, MONITORING AND ANALYSIS

8.1 All claims received, assessed, and finalised will be kept for a minimum period of 5 years.

8.2 The documents are electronically scanned and kept on the internal system.

8.3 Trends, risks and remedial actions to review product design and disclosures in line with Treating Customers Fairly principles will be taken on a minimum annual basis.

9. REPUDIATIONS OR DISPUTES

The Insurer must communicate the following to the claimant:

9.1 The reason for the decision;

9.2 Include the facts that informed the decision;

9.3 That the claimant may within a period of not less than 90 days after the date of receipt of the notice make representations to The Insurer;

9.4 Have the right to lodge a complaint to the relevant Ombud and provide the contact details and time limitations of the applicable Ombud scheme.

10. CLAIM ESCALATION AND APPEALS PROCESS

Should a claimant or customer be dissatisfied with the outcome of the claim assessment and results in a "customer query", he/she may direct their dissatisfaction to the Company, who will refer the matter to The Insurer for review of the decision. The Insurer must respond to the claimant within 15 business days. Should this result in a decision that is still unsatisfactory, the matter may be referred to the Internal Dispute Arbitrator at The Insurer, before referring it to an external body, such as the Ombud for Long Term Insurance or Short Term Insurance.

The Insurer's details for assistance / funeral claims are:

Guardrisk Life Limited

Postal Address:
PO Box 786015
Sandton, 20196

T: (011) 669-1000
E: info@guardrisk.co.za

The Insurer's details for short term claims are:

Auto & General Insurance Company Limited

Address:
Auto & General Park
1 Telesure Lane
Riverglen, Dainfern
2191

T: (011) 489-4000
W: www.autogen.co.za

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

complaints@totalrisksa.co.za

The Company will acknowledge and respond to the complaint within 5 business days.

11. PROHIBITED CLAIMS PRACTICES

The Company and The Insurer may not:

11.1 Dissuade a claimant from obtaining the services of an attorney or adjustor;

11.2 Deny a claim without performing a reasonable investigation; or

11.3 Deny a claim based on the outcome of a polygraph, lie detector or truth verification or similar test.

12. VALID CLAIMS RECEIVED DURING PERIODS OF GRACE

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

13. CLAIM SUBMISSION CONTACT DETAILS

All claims can be submitted to:

E: claims@totalrisksa.co.za
E: 011 372 1540

Postal Address:
PO Box 8012
Greenstone
1616