CHALLENGES IN MANAGEMENT OF GENERAL INSURANCE CLAIMS IN KENYA

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DECLARATION

This research project is my original work and has not been presented for examination in any other university.

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This research project has been submitted for examination with my approval as the University Supervisor.

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ABSTRACT

General Insurance companies underwrite homogeneous policies. The product a customer purchases from an insurer is peace of mind, based on the promise the insurer makes to him that he will be compensated in the event of happening of the insured peril. Thus, claims processing is a central service in an insurance company. The objective of this study was to determine main challenges faced by General Insurance companies in claims management.

The study adopted a survey research design where the population of interest entailed all General Insurance Companies in Kenya. Data was collected through the use of a structured questionnaire. Questions were both closed ended and open ended. The open ended questions gave the respondents an opportunity to add more information which could otherwise not be revealed through closed ended questions. The data collected was arranged systematically and coded to facilitate analysis. The data was then analyzed using descriptive statistics.

From the findings, weak underwriting standards form the highest challenge in management of General Insurance claims in Kenya. At the same time, there is a high level of fraud in the Kenyan General Insurance Industry. It is clear that claims departments are more likely to find it necessary to investigate a claim when circumstances of accident are unclear and when vehicle is not valued prior to commencement of cover. Claimant advocates and agents/brokers are the ones highly

used to perpetrate fraud. Moreover, delay in reporting a claim and high work load of staff were the main factors found to contribute to delay in claim payment.

The study recommends that policy makers in the insurance industry, including the Insurance Regulatory Authority (IRA) as well as the Association of Kenya Insurers (AKI) should formulate and put into force policies that would effectively reduce or even completely eliminate weak underwriting standards. At the same time policies should be formulated to ensure that proper procedures are followed at inception of cover. It is especially important to enforce valuation of motor vehicles prior to commencement of cover, to reduce the need to investigate claims which may later arise. Other recommendations the study makes are creation of a police unit to deal with insurance fraud and special courts to handle fraud-related charges. It is also recommended that the insurance industry lobbies for implementation of structured compensation for both motor injury and work injury claims.

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1.1 Background to the study

1.1.1 Concept of Insurance

Insurance is a mechanism by which an organization can exchange its uncertainty for greater certainty. The uncertainty experienced includes whether a loss will occur, when it will take place, how severe it will be and how many there might be in a year (Atkins & Alderman, 2004). It can also be defined as an economic device whereby the individual substitutes a small certain cost (the premium) for a large uncertain financial loss (the contingency insured against) that would exist if it were not for the insurance. The organization agrees to pay a fixed premium and in return, the insurance company agrees to meet any losses which fall within the terms of the policy (Vaughan & Vaughan, 1995).

Mishra (2004) defines insurance from functional and contractual points of view. From a functional perspective, insurance is a co-operative device to spread the loss caused by a particular risk over a number of persons, who are exposed to it and who agree to insure themselves against the risk. The majority bear a nominal expenditure, to cater for losses which may fall on an individual member or his family. From a contractual point of view, insurance is a device through which a sum of money known as a premium is paid in consideration of the insurer incurring the risk of paying a large sum upon a given contingency.

The contract of insurance is governed by principles of insurance, notably; Utmost Good Faith, Insurable Interest, Proximate Cause, Indemnity, Subrogation, and Contribution.

The principles have evolved from practices adopted during the development of insurance over a period of several hundred years, and have been upheld by courts of law or codified by Acts of Parliament. There are two broad classifications of insurance; Life Insurance and General Insurance. Life Insurance is of a long term nature, and includes such policies as Ordinary Life, Group Life, Individual and Group Pension plans, Endowment and Credit policy, among others. General Insurance is of a short term nature, the maximum period being annual, with a provision for renewal. It includes such policies as Aviation, Engineering, Fire, Marine, Personal Accident, Work Injury Benefits Act (WIBA), Employer's Liability, Medical, Burglary, Liability, Loss of Cash, Fidelity Guarantee and Motor, among others (Were & Njiru, 2007).

The primary functions in an insurance company are handled by Marketing, Underwriting and Claims departments. Marketing department is responsible for identifying customers, defining and developing products that the customers want, conducting sales activities and distributing products to customers. It is also responsible for enhancing the company's competitive position through gathering information on its business environment (including competitors), and assessing the company's performance in the marketplace. The function of Underwriting department is to assess and classify the degree of risk represented by the proposed insured or a group of insureds with respect to a specific insurance product, and make a decision to accept or decline the risk. Prudence is required, in that if an underwriter accepts too many questionable risks without the requisite premium adjustments, the insurer may pay more in claims than it can afford. On the other hand, if it is too conservative and fails to accept enough appropriate risks at appropriate premium rates, the insurer will not prosper. The department is also

responsible for preparation and delivery to the customer of the policy document, which is the basis of the contract between the customer and the insurer (Brown, 1997).

Claims department has the strategic role of providing the insurance company with a high quality of service, to enable it differentiate itself from competitors. It must ensure that the amount paid is within the contractual agreement. It must also provide high service that exceeds the customer's expectations in terms of speed, manner and economic efficiency. The department is expected to at least meet or exceed the standards of service set and to operate within budget (Wedge & Handley, 2003). Thus, the claims department is critical in the performance of an insurance company, and can be used as a differentiator between high performing insurance companies and mediocre ones, especially since the products, or policies insurance companies underwrite are homogeneous.

From the definitions of insurance above, it is clear that the fulfillment of the insurance contract hinges on a company's ability to pay claims. The reputation of an insurance company is affected by its ability to, and speed in settlement of claims. Once its reputation is eroded, the company is unable to attract and retain customers. This results to reduced cash-flow, making its inability to pay claims even more serious. A company which is unable to pay claims faces the risk of closure by the regulatory authority. It may also be placed under receivership by its creditors. Thus, an insurance company which intends to maintain a competitive edge must perform better than competition in its management of the claims function.

1.1.2 Claims Management

Wedge and Handley (2003) define Claims Management as the carrying out of the entire claims process with a particular emphasis upon the monitoring and lowering of claims costs. The claims management process has to strike a balance between customer expectations and maintaining cost efficiency. The customer's expectation is to be paid without any delay, while a claims manager will have to ascertain whether the claim is payable, and if so, the amount payable. In order to do so, he relies on service providers including investigators, assessors, garages, hospitals, doctors, advocates and loss adjusters. The service provider may not attach the same priority to a customer as the insurer, resulting to slow turnaround time and complaints from customers.

Section 203 of Insurance Act, Cap 487 requires an insurer to settle claims within 90 days after liability is established. Failure to comply will result to a levy of 5% of all outstanding amounts being imposed by Insurance Regulatory Authority (IRA). Inability of a company to pay this amount will result to its winding up. In addition, various service providers have formed associations, including Kenya Automobile Repairers Association (KARA), Assessors and Engineers Association, and National Association of Kenya Investigators (NAKI), which have given insurers strict benchmarks regarding payment period among other requirements. These factors have placed high expectations on insurance companies regarding claim payment period.

1.1.3 The Kenyan Insurance Industry

There were forty-four (44) insurance companies in 2009. Out of them, twenty (20) wrote General Insurance Business only, nine (9) wrote Long Term Business only, while

fifteen (15) wrote both General and Long Term Business. Other players included one hundred and thirty-seven (137) licensed insurance brokers, twenty-one (21) medical insurance providers, three thousand and seventy-six (3,076) insurance agents, one hundred and six (106) /investigators, fifty-seven (57) motor assessors, eighteen (18) loss adjusters, two (2) claims settling agents five (5) risk managers, and twenty-six (26) insurance surveyors.. The total number of players in the insurance industry was three thousand, four hundred ninety-two (3,492) by end of 2009 (AKI, 2009).

The General Insurance Business in Kenyan has experienced growth over the years, from Kshs 29.20 Billion in 2006, Kshs 32.95 Billion in 2007 (12.8%), Kshs 36.89 Billion in 2008 (12%) and 43.11Billion in 2009 (16.8%) . However, the penetration rate for General Insurance Business was only 1.90% of Gross Domestic Product, compared to 2.9% for South Africa (AKI, 2009). The industry therefore has a huge potential for growth. The challenge is to help the insuring public appreciate the need for insurance, and trust insurance companies enough to take up insurance policies with them.

The Insurance industry is regulated by IRA. The legislation governing operations of the insurance industry is the Insurance Act Cap 487, which came into effect in 1987 and has been revised from time to time. The main co-operative bodies in the industry include Association of Kenya Insurers (AKI), Association of Insurance Brokers of Kenya (AIBK), Association of Kenya Reinsurers (AKR), Association of Kenya Independent Insurance Agents (AKIIA), and Insurance Institute of Kenya (IIK) (Were and Njiru, 2007).

The insurance industry incurred net claims of Kshs 30.66 Billion compared to Kshs 24.83 Billion in 2008, representing an increase of 23.50% (AKI 2009). A number of insurance companies have been put either under statutory management or receivership in the last two decades, including Access Insurance Company Limited (1993) Kenya National Assurance Limited (1995), Stallion Insurance Company Limited (2000), Lakestar Insurance Company Limited (2002), Liberty Insurance Company Limited (2003), United Insurance Company Limited (2005), Invesco Assurance Company Limited (2007), and Standard Assurance Company Limited (2008). The decline of the companies can be traced mainly to their inability to pay claims when they fall due.

1.2 Statement of the Research Problem

General Insurance companies underwrite homogeneous policies. The product a customer purchases from an insurer is peace of mind, based on the promise the insurer makes to him that he will be compensated in the event of happening of the insured peril. Thus, claims processing is a central service in an insurance company. The main differentiator between insurance companies is their turnaround time in claims processing. The insurance companies which will attract and retain customers are those which are able to demonstrate to their current and potential customers their ability to pay claims promptly.

While the above is true and expected by the public, insurance companies may be facing challenges which hamper effective claims management, and this may perhaps explain the collapse of a number of General Insurance companies over the last decade. Besides, the public has a negative perception of the insurance companies due to some previous experience they may have had with an insurance company, ranging from delay or non-

payment of claims, relying on policy exclusions to decline a claim, demand for a lot of documentation which a claimant perceives as delaying tactics, among others. A study to identify challenges faced by General Insurance companies in claims management may perhaps explain the causes of this state of affairs.

Various scholars have researched on insurance related issues. Nderitu (2006) did a research on the causes of high motor vehicle claims in insurance industry in Kenya, and concluded that insuring public service vehicles, inflated and fake claims and fraud contributed greatly to the phenomenon. Ramadhan (2009) did a research on the 2003 reforms on the Public Service Vehicle sector in Kenya, with an emphasis on "Matatu" business, and identified a myriad of challenges facing the "Matatu" insurance sub-sector. Makembo (1992) did a research on problems in compensation system for personal injury and deaths in motor insurance industry, and identified various problems in motor insurance industry. Githiga (2004) did a survey of Fire rating practices in the Kenyan Insurance Market. Kibiwot (2003) studied the challenges in regulation of the insurance industry in Kenya. Ouma (2008) studied the relationship between value chain and competitive advantage in the insurance industry in Kenya. Among his research findings was that the greatest challenge that customers experience is the processing and payment of claims whether to the policy holders or third parties. He concluded that the efficient management of this process not only ensures loyal customers but also the ability to attract new customers.

Although most of the scholars acknowledge claims as an integral function in an insurance company, none of them has addressed the challenges which may be preventing insurance companies from effectively managing the claims function, in order to be competitive in

the marketplace. Whereas some have addressed the claims function from the customer's point of view, others have focused on one class of business. The purpose of this study is to identify challenges affecting the entire Claims Department of a General Insurance company, which if addressed may contribute to customer satisfaction, and also guarantee the survival and profitability of insurance companies.

1.3 Objective of the Study

The objective of this study was to determine main challenges faced by general insurance companies in claims management.

1.4 Importance of the Study

1) The study will be useful to Claims Managers of General Insurance Companies who seek to improve their operational efficiency.

2) It will also be useful to Chief Executives of General Insurance Companies who may be seeking to use claims management as a source of competitive advantage in the industry.

3) Academics and scholars will also find it valuable in enriching their knowledge of management of General Insurance claims.

4) Finally, it will benefit the public in general and policyholders of General Insurance products in particular, who seek to gain knowledge on claims operations and challenges insurers face in management of claims.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This chapter provides literature review on Claims function within the value chain of an insurance company, Claims as a core competence and Claims Procedures. The main challenges in management of General Insurance claims are also discussed.

2.1 Claims function within Value Chain of Insurance Companies

Porter (1998) describes the value chain analysis as a basic tool for examining all the activities a firm performs and how they interact, in analyzing the sources of competitive advantage. He adds that value chain "disaggregates a firm into its strategically relevant activities in order to understand the behavior of costs and the existing and potential sources of differentiation." A firm thus gains competitive advantage by performing the strategically important activities more cheaply, or better than competition. The aim of the value chain framework is to maximize value creation while minimizing costs, in order to gain competitive advantage (Viljoen & Dann, 2003).

The value chain can be classified into two broad categories; primary activities and support activities (Viljoen & Dann, 2003). For an insurance company, the primary activities can be identified as Marketing, Underwriting and Claims. The support activities include Corporate Management, Human Resources (HR), Information Technology (IT), Finance and Asset Management. There are also third party service

providers, including Public Relations (PR) consultants, advocates, motor assessors, claim investigators and loss adjusters.

The marketing department has a responsibility of identifying and opening new markets, recruitment and growing business from new intermediaries, new product development, and competitor analysis among others. Marketing department creates value by carefully vetting intermediaries through background search, to ensure they have not been involved in unethical behavior in the past. Other ways of adding value include product training of intermediaries and marketing staff, selling appropriate products, using professional ways to acquire business among others. On the other hand, the department can erode value by recruiting intermediaries who have a history of unethical behavior, selling inappropriate products due to lack of product knowledge, using unethical ways to acquire business among others. The business which marketing department acquires is transmitted to underwriting, along with the value created or destroyed.

An underwriter decides whether the risk undertaken by insuring a client is acceptable or not. If it is acceptable, he determines the right amount of premium to be charged and any other terms and conditions to be imposed. The value created by marketing will be reflected in underwriting, in terms of proportion of risks which are either accepted or rejected at acceptance stage. If marketing sources business from credible intermediaries, the underwriters will accept most of the business. An underwriter needs to constantly analyze premium per product line, geographical region, intermediary or branch office. He also needs to analyze losses per product line in order to assess whether it is making underwriting profits or losses (Pawan, 2010). Proper underwriting of risks adds value to the next process in the value chain, which is Claims.

The Claims function involves speedy and effective handling of claims, while at the same time guarding against fraud. Hasty claim settlement can result in increased fraud-related costs. On the other hand, slow fraud detection can increase the overall claim cycle time (Pawan, 2010). If claims are processed efficiently and effectively, customers are more satisfied and likely to be retained. Thus, value is created and transferred to the next level of value chain, the customer relationship management. Usually, a customer's experience at claim stage determines whether he will be retained or not.

The value chain is held together by all the support activities (Viljoen & Dann, 2003). As the saying goes "a chain is as strong as its weakest link". The claim is the ultimate "moment of truth" in the insurer/policyholder relationship. Everything from service to customer retention to regulatory compliance to carrier profitability is encompassed by the claims transaction. An insurer's reputation, not to mention its ability to conduct business can be dramatically affected by how it administers claims (The Future of Claims: Finding a Strategic Value, 2007). The collapse of companies in the last decade has been attributed mainly to inability to effectively handle claims. It is therefore important that the link of Claims within the value chain is strengthened; thus the need to identify the challenges which hinder effectiveness in the management of Claims.

2.2 Claims as a Core Competence

Johnson, Scholes & Whittington (2005) refer to core competencies as those activities or processes that critically underpin an organization's competitive advantage. They create and sustain the ability to meet the critical success factors of particular customer groups in ways that competitors are unable to imitate. Core competencies are usually embedded

deep in an organization at the operational level, and in the work routines of the organization. They are represented by the skills, resources, systems and technologies that an organization can use to take advantage of a market opportunity (Viljoen & Dann, 2003). A core competence does not reside in a single individual or small team, but is an integration of skills and technologies. They transcend any particular product or service to the entire organization (Hamel & Prahalad, 1994).

An insurance company is usually rated according to its speed and efficiency in settlement of claims. Thus, most companies do not fail to mention in their advertisements that they pay their customers' claims promptly. A company that would want to attract and retain customers must build its competencies around effective management of claims. On the other hand, a company that is unable to honour promises to its policyholders in terms of prompt and efficient settlement of claims is likely to lose the goodwill of not just the current policyholders, but also of the prospective customers. It is therefore not a wonder that Claims Department receives a lot attention at Corporate and Board levels.

From the foregoing, it is apparent that the claims function is critical for the success of any insurance company. Thus, a company with an intention of being competitive in the market place must address the factors which may hinder the effective performance of the claims function.

2.3 Claims Procedures

The various stages a claim goes through from its occurrence to conclusion are:

2.3.1 Claim notification

Most policies state that the insured should notify their insurer of a claim promptly. The initial report may be verbal, though the insured will be required to give further information by completion of a claim form. For liability claims, the insured is required to forward to his insurer all correspondence from the claimants or their advocates. It is the insured's responsibility to prove that they have suffered a loss, and the loss was caused by a peril which is covered by the policy. He must also prove the amount of loss, such proof being by way of purchase receipts, repair account or a valuation (Roff, 2004).

When a claim is not reported promptly, the insurer misses out the opportunity to investigate facts when they are still fresh. Other factors also come into play, which may aggravate the loss. Besides, an insurer needs to separate genuine claims from fraudulent ones. Late reporting makes this separation difficult.

2.3.2 Claim Review

This involves analysis of the claim, and includes comparison of information in claim form with what was provided in the proposal form, interpretation of the policy in light of the claim, economic considerations such as decision on whether the claim is too small to warrant further investigations or the need to call for additional documentation. Alternatively, a large claim may justify further investigations or legal action. The insurer needs to check that the policy was in force at the time of loss, the insured's details are as per proposal form, the peril insured against is covered by the policy, the insured has complied with the policy terms and conditions and that the loss claimed against does not fall under an exclusion. Claims review is a crucial stage in the claims process, in

view of likely conflicts arising from policy interpretation, economic considerations, market practice and legal requirements. A senior claims handler needs to be involved at this stage, in order to handle major issues accurately and promptly, including properly investigating the claim if need be (James, Lyn & Rowe, 2009). The capacity of claims staff is critical at this stage.

2.3.3 Response to Claimant

The initial response is usually an acknowledgment, or a request for further information. Once the insurer is satisfied with information given, they either convey decision to pay, or decline to pay the claim. A third response may be offer to pay a lower amount than that claimed or enter into negotiations with the insured, without initially making any offer on amount. This is in a situation where liability is accepted, but insurer is not satisfied with amount claimed. Whether the insurer intends to decline a claim, or enter into negotiation, they must convey to the insured their reasons for the decision, to ensure the insured is satisfied with the decision and avoid the insured resorting to litigation (James, Lyn & Rowe, 2009).

2.3.4 Claim Investigation

In some cases, the insurer may not have full facts of the claim, and is unable to make a decision on a claim. They may therefore require to appoint an investigator, to carry out investigations and file a report to the insurer. This is mainly for motor and liability claims. Investigations are also necessary if a claim is suspected to be fraudulent. The nature of other claims requires an insurer to appoint a loss adjuster, to establish liability and quantum of the claim. This is especially for property claims, including Fire, Burglary, Domestic Package, All Risks, and Marine among others. In the case of motor claims, a motor assessor assesses the extent of damage to the vehicle and establishes the cost of repairs. He also advises whether to repair the vehicle, or treat it as a constructive total loss and pay insured pre-accident value of the vehicle. Once investigations are completed, the insurer is expected to convey findings and next course of action to the insured. The investigator must exercise speed but also be efficient. The report should

be comprehensive, covering all the salient features of the claim, while bringing out the issues in an orderly and clear manner (Wedge & Handley, 2003).

2.3.5 Claim settlement

Where liability is not in dispute, and both insurer and insured are in agreement on quantum, settlement follows immediately. However, in situations where either liability or quantum is in dispute, the claim is delayed. In some cases, especially for the liability claims, they are determined in court. Section 203 (1) of Insurance Act Cap 487 provides that once the insured reports a claim and provides all the required documentation, the insurer shall admit liability or deny liability, determine amount payable and identity of claimant, and pay the claim within ninety days of reporting the claim. If liability is determined by court, then insurer must settle the claim within ninety days of the court determination.

2.3.6 Claim recoveries

An insurer may require recovering all or part of their outlay. There are four sources of recovery; from a third party who was to blame for the accident, from a party insurer has subrogation rights against, from a reinsurer if reinsurance protection is in place or from sale of salvage.

2.3.7 Review of performance

It is necessary to review claims from time to time, in order to ensure that internal decisions were correctly made, that the reserve maintained for a file is adequate, and whether any lessons can be learnt from experience from a particular claim. The review is carried out from a sample of files, and any large or problematic claims.

2.3.8 Litigation

The insured and insurer may fail to reach an amicable solution to a claim, and in such a case, the insured may resort to litigation. The courts, listen to both the insured and the insurer, and make a ruling on both liability and quantum. Liability claims are usually determined by courts, after the aggrieved party files a case in court. Liability claims arise out of legal liability for incidents involving injury to third parties or damage to their property. The classes of insurance with liability claims include Employer's Liability, Professional Indemnity, Motor, Public Liability and Product Liability (Cannar, 1983).

2.3.9 Outsourcing of the Claims Function

According to Wedge & Handley (2003), outsourcing is using skilled resource outside the company to handle work traditionally performed by in-house staff. An insurer may outsource all of the above processes, but may also opt to outsource some of them. Though some insurers have in-house assessors, investigators and loss adjusters, most insurers outsource these functions to independent service providers.

2.4 Challenges in Management of General Insurance Claims

A challenge can be described as a new or difficult task that tests a person's ability and skills (Hornby, 2005). In terms of claims management, a challenge may be described as a factor that hinders effective performance of the claims function. Some of the major challenges in management of General Insurance claims are:

2.4.1 Insurance Fraud

Fraud is defined as a deliberate act done with intent to deceive (Cockerell, 1997). A claim is said to be fraudulent if the insured makes false statements of fact in his claim or

made statements, knowing them to be false, or not believing them to be true, or that he made them carelessly not caring whether they were true or false. The insurer has a right to decline a claim if fraud is proved, as it amounts to breach of one of the basic principles of insurance, the principle of Utmost Good Faith (Bennett, 1992). Wedge and Handley (2003) note that fraud can take a variety of forms, including the inflation of a genuine claim, creating an entirely fictitious event, and causing deliberate as opposed to accidental damage to insured property. The main motive of insurance fraud is financial gain.

Insurance companies have had to undergo very tough times and incur huge payouts in claims, some of which have proved to be fraudulent. This has forced insurance companies to rethink the way they handle claims (Karau, 2008). Fraud is perpetrated by a cartel of crooks, through non-existent or exaggerated claims. Fraud has been cited as one of the causes of the collapse insurance companies in the last decade (Wahome, 2010). As much as genuine customers need to be paid promptly, they must be separated from the fraudulent ones through investigations, which is time consuming and a major cause of customer dissatisfaction. If a fraudulent claim is paid, the insurer loses a lot of money to fraudsters. The insurer may resort to increasing premiums, which affects both the good and bad customers. In addition, if a fraudster gets away with it, he may be tempted to continue this practice in the future (Roff, 2004).

2.4.2 Cash flow constraints

Cash flow management is the process of monitoring, reviewing and regulating a company's cash flows. The statement of cash flows reports a company's cash inflows

and outflows for a period, and provides a company's ability to generate cash from operations, maintain and expand its operating capacity, meet its financial obligations and pay dividends (Reeve, Warren & Duchac, 2009). For a general insurance company, cash inflows include premium, investment income, capital injections, policy excess, sale of salvages and reinsurance recoveries. Cash outflows include claim payouts, costs, investments made in shares/bonds, distribution payments to owners and creditors of the insurer, tax to the government and payment of reinsurance premiums (General Insurance, 2010).

A company may experience cash flow constraints due to various reasons, including outstanding premiums, competing priorities, failure or delay of reinsurers to pay their share of claims, huge claims among others. Claims payment usually takes the largest percentage of a company's payments, and the one affected most when a company has cash flow constraints. The claims incurred for General Insurance Business was 62% of gross premium written in 2009, up from 61% in 2008. On the other hand, management expenses constituted 25% of the gross premium written (AKI 2009). Therefore, if a company has cash flow constraints, the item likely to be affected most is claims payments. Failure or delay in meeting financial obligations when they fall due negatively may affect a company's reputation. Further, the Insurance Act Cap 487 stipulates that where the claimant has submitted all required documents, and the insurer has admitted liability, the claimant must be paid within ninety (90) days of the date of reporting the claim, or if liability is determined by court, within ninety (90) days of such determination (Insurance Act, Cap 487). Failure to comply leads to a penalty being

imposed. Inability to pay claims and accrued interest are among grounds that can be used to petition the courts to wind up an insurance company.

2.4.3 Capacity of claims personnel

In a service industry such as insurance, contact employees are the face of the organization, and can directly influence customer satisfaction (Zeithaml & Bitner, 2003). Employees in Claims Department are in close contact with the customer and/or intermediary from the time a claim is reported, throughout its processing, until it is eventually settled or rejected. The difference between one service supplier and another often lies in the attitude and skills of their employees (Lovelock & Wirtz, 2007). Further, the best defenses against claim fraud are well-trained Claims staff. The process of uncovering and battling fraud begins in the Claims Department (Brown, 1997).

It is the responsibility of the Claims Manager to recruit, train and retain intelligent and competent staff. He should also delegate responsibilities within the department in a way that whereas a substantial proportion of claim advices do not have to be referred to his office, decisions with serious ramifications on the business are not left to inexperienced or incompetent staff (Wedge & Handley, 2003).

However, due to various factors, some of which are not within the manager's control, claims staff leave employment and have to be replaced. Whereas direct costs associated with loss and replacement of employees is measurable, there are also indirect costs associated with loss of employees, including loss in customer service and customer satisfaction. The company also suffers loss of specific job skills and disruption of

service (Mwangi, 2008). If the insurance company is not an attractive employer, retention of competent and qualified staff may be a major challenge.

2.4.4 Information Technology Support

Information Technology (IT) is defined as "the use or production of a range of technologies (especially computer systems, digital electronic and telecommunications) to store, process and transmit information)" (Wedge & Handley, 2003). Claims managers need to maximize the use of information technology, in order to reduce claims processing cycle, thus enhancing efficiency and customer satisfaction. Ineffective IT governance and control is likely to be the main cause of the negative experiences many organizations and especially insurance firms have had with the use of IT, including lost business, damaged reputations, weakened competitive position, inability to meet deadlines, failed or aborted projects, budget overruns and poor returns on investments (Nyakomitta, 2009).

Large complex claims, especially liability claims may take long to be concluded. Besides they may involve a lot of correspondence between the insurance company and claimant and/or the claimant's advocate. For such claims, there may be a lot of manual intervention, and the IT system may not be flexible enough to capture all the intricacies of the claims. Further, general insurance claims are paper-based to a large extent; therefore automation may be only partial. In addition, interfaces between insurers and service providers may not be integrated, which may result to poor claims tracking and lack of management information.

2.4.5 Weak Underwriting Standards

Underwriting refers to the process of evaluating a proposal that comes for insurance, and making a decision of whether to accept the proposal or not. If the proposal is to be accepted, at what price and on what terms, conditions and scope of cover (Brown, 1997). The underwriter also has a responsibility to ensure that there is no adverse selection against the insurer, and that the proposer is not a moral hazard. The underwriter must ensure that the premium charged is commensurate with the risk exposure.

To a large extent, the quality of underwriting has a bearing on claims eventually made. Moral hazard proposers and adverse selection are also not detected. Within the insurance period, such proposers lodge claims which would have been avoided if they were detected at underwriting stage. Unissued policy documents pose a major challenge to a claims handler. The insured feels unjustly treated, if the claims manager relies on breach of a policy condition to decline a claim which policy the insurer had not issued and sent it to the insured. Other challenges include wrongly worded policy documents, incomplete or no proposal forms, agents completing proposal forms on behalf of the insured among others. The claims manager ends up paying claims which would otherwise not have been paid if proper underwriting was done.

The underwriting standards in Kenya's insurance companies have been wanting, in that most companies do not adhere to internationally accepted underwriting standards. As a result, underwriters underestimate the level of risk, and charge premium which is less than the risk exposure (Karau, 2008). When the level of claims exceeds premiums

received, the insurance company is unable to meet its obligation to policyholders, and this may result to its closure.

2.4.6 Unpredictable Court Awards

Liability claims emanate from road traffic accidents, work related injuries, Public Liability, Professional Negligence, Owner's and Occupiers liability among others. These claims are usually determined in court, where the judge or magistrate determines the amount of compensation to the aggrieved party. In so doing, he is guided by previous cases of a similar nature which were determined in the past. This leaves the judge with a big margin of subjectivity. Further, court awards vary from court to court and from region to region.

Consumers of insurance and the public at large have become very litigious, which may be attributed to a change in social attitude towards litigation. Until very recently, most people in developing countries were not aware of their legal rights regarding compensation for death or bodily injury caused by another. Societal values are however changing, and people are becoming more claim conscious than before (Makembo, 1992). The court system is usually sympathetic to the weak party. As such, judges are known to give huge court awards if they are aware there is an insurance company to satisfy the judgment. Insurers have in the recent past been reeling under huge court awards. Insurance companies have complained that the awards are unrealistically high, and if courts continue making such awards, insurers may find themselves making losses (Karau, 2008).

Attempts to introduce structured compensation for work related injuries through enactment of Work Injury Benefits Act (WIBA) in 2007 failed when the Act was challenged by the Law Society of Kenya. In the case of Law Society of Kenya vs. Attorney General & Another, Justice Ojwang ruled that employees who were not satisfied with compensation under the Act may seek legal redress under Common Law (KLR, 2009). In the 2010 Budget speech, the Finance Minister Hon. Uhuru Kenyatta proposed to amend the Insurance (Motor Vehicles Third Party Risks) Cap 405, to introduce a structured compensation scheme for motor vehicle accident-related injuries similar to the one envisaged under WIBA. According to the Commissioner of Insurance, Mr. Sammy Makove, the amount of compensation in any motor accident will be capped and defined injuries compensated in a prescribed manner. It is expected that this amendment in legislation will eliminate or reduce the role of advocates in seeking compensation for motor accident victims, and also minimize exaggerated claims (Wahome, 2010).

2.4.7 Incompetent and Corrupt Service Providers

An insurer relies on assessors, investigators and loss adjusters, to ascertain whether to pay a claim, and if so the amount of compensation. Garages are also appointed to carry out repairs for the purpose of indemnifying an insured whose vehicle has sustained accidental damage. For the claims which turn legal, the services of a defense advocate are required. Whereas some insurance companies employ full time employees to perform these functions, others outsource the functions to independent service providers.

Insurers expect their service providers to adhere to the set customer service benchmarks, while at the same time exercising a high level of integrity. In addition, they are expected to assist the insurer reduce claim costs. Usually, this may not happen, either due to lack of the necessary skills to perform the task assigned or due to lack of integrity. The external service provider may also not attach as much importance to customer retention as the insurer. As a result, service to the customer may be compromised (Wedge & Handley).

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Research Design

The researcher adopted a survey research design. Mugenda and Mugenda (1999) note that survey research attempts to collect data from members of a population and describes existing phenomena by asking individuals about their perception, attitude, behaviour or values. They add that it can be used for explaining or exploring the existing status of two or more variables, at a given point in time. According to Orodho (2005), the objective of a survey research is to determine how the psychological and sociological variables are related. Owens (2005) notes that a survey design has the advantage of uniqueness in that information gathered is not available from other sources. In addition, representation of population of interest is unbiased, and information collected from every respondent is the same. Survey data can also be used to complement existing data from secondary sources.

3.2 Target Population

The population of interest entailed all General Insurance Companies in Kenya. According to the Insurance Industry Report (2009), twenty (20) companies wrote General Insurance business only while fifteen (15) wrote both General and Long Term business. Therefore the total population was thirty-five (35) insurance companies who write General Insurance business (Appendix IV). The target respondents were claims managers. Since the population is small, a census was used. This enhanced confidence as data was obtained from the entire population.

3.3 Data Collection

Data was collected through the use of a structured questionnaire (Appendix II). Questions were both close ended and open ended. The open ended questions gave the respondents an opportunity to add more information which could otherwise not be revealed through closed ended questions. The questionnaires were administered to the respondents through mail survey (drop and pick) method. The researcher followed up the respondents through telephone and email, in order to increase the response rate.

3.5 Data analysis and presentation of results

The data collected, which was quantitative in nature, was arranged systematically and coded to facilitate analysis. The data was then analyzed using descriptive statistics. It was then interpreted using frequencies and percentages (see raw data in Appendix III). Mean and standard deviation were used to interpret 5-point Likert scale type. The results were then presented in form of tables, pie charts and bar graphs.

CHAPTER FOUR: DATA ANALYSIS, INTERPRETATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter discusses the data analysis, findings, presentation and discussion of the research findings. Data was analyzed using Statistical Package for the Social Sciences (SPSS) and findings presented in form of tables, pie charts and bar graphs. Interpretation was done using descriptive tools such as the frequencies and percentages as well as measure of central tendencies which included the mean and standard deviation. The target respondents in this study were the Claims Managers, or their assistants. Out of the thirty-five (35) targeted General Insurance companies, twenty-three (23) responded positively to the questionnaires by filling in and returning in time, making the response rate to be 65.7%. This was considered satisfactory, as according to Mugenda and Mugenda (1999), a response rate of 50% or more is sufficient for statistical analysis.

4.2 Demographic Outlook

Demographic findings were based on the position of respondents in their respective organizations, the number of years of experience in the current position as well as their department/sections. Findings from this section were important to determine the respondents experience, capacity and knowledge of challenges faced by General Insurance companies in claims management and thus the ability to handle the research questions.

Table 4.1: Position of the respondent

Position of the respondent		
	Frequency	**Percent**
Claims Manager	17	73.9
Assistant Claims Manager	5	21.7
Claims Clerk	1	4.3
Total	**23**	**100.0**

Table 4.1 is an illustration of the position which the respondent held in the organization, majority (73.9 percent) were claims managers, 21.7 percent were assistant claims managers and 4.3 percent were claims clerk. This shows that a vast majority of respondents interviewed were in a position to handle the research questions by virtue of their designation and tasks associated with such designations.

Figure 4.1: Number of years the respondent have been in the current position

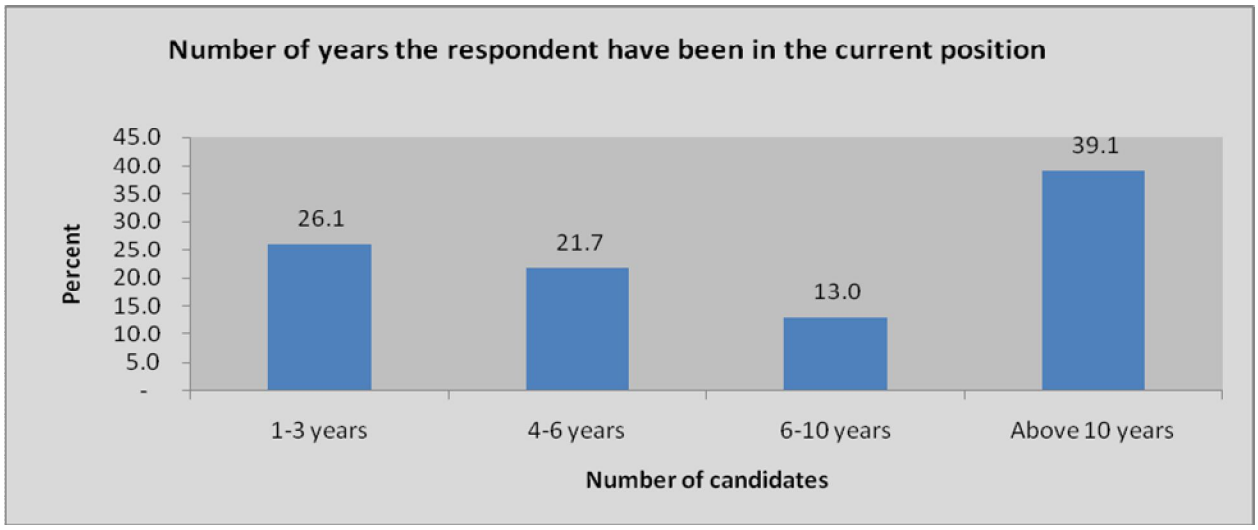


Figure 4.1 illustrates the number of years the respondents have been in the current position. According to the findings, majority (39.1 percent) had held their positions for

over 10 years, 26.1 percent had held their positions for 1-3 years, 21.7 percent had held their positions for 4-6 years and 13.0 percent had held their positions for 6-10 years. This is an indication that majority of respondents had at least 6 years in the claims department. The number of years respondents had served in the claims department was crucial for this study since it directly relate to the level of experience they had in claims management with the ability to handle challenges emanating from their current designations.

Table 4.2: Department

Department		
	Frequency	**Percent**
Claims	23	100.0

Regarding the department where the respondents worked, all respondents were in claims department. Drawing all respondents from the claims department was purposeful and premeditated by the researcher since the study was particularly and predominantly investigating challenges faced by General Insurance companies in claims management and thus only incumbents in the claims department could handle the research objectives.

Table 4.3: Number of employees in the claims department

Number of employees in the claims department		
	Frequency	**Percent**
0-10 employees	1	56.5
11-20 employees	1	30.4
21-30 employees	2	4.3
31-40 employees	6	4.3
More than 40 employees	1	4.3
Total	**23**	**100.0**

Concerning the number of employees in the claims department, majority (56.5 percent) of the organizations had 0-10 employees, 30.4 percent had 11-20 employees, 4.3 percent

had 21-30 employees, 4.3 percent had 31-40 employees and 4.3 percent had more than 40 employees in the claims department. This shows that on average, claims departments were large. This implies that generally there is a lot of work to be done in the claims department, such work being more labour as opposed to IT driven. However, the size of the claims department of different companies would be expected to vary depending on various factors including product mix, market mix, labour productivity among others. It is the responsibility of each company to identify the optimal number of employees in the department, and ensure it is maintained.

Table 4.4: Average working experience of employees in claims department

Average working experience of the employees in claims department				
	Less than 5 years	**5-10 years**	**11-15 years**	**Over 15 years**
0 to 9 employees	91	70	87	96
10 to 19 employees	4	22	9	-
20 to 29 employees	4	4	4	-
30 to 39 employees	-	4	-	-
40 employees and above	-	-	-	4
Total	**100**	**100**	**100**	**100**

The research sought to know the average working experience of the employees in claims department. According to the findings, 91 percent of the organizations had 0-9 employees who had worked for less than 5 years, 4 percent of the organizations had 10-19 employees who had worked for less than 5 years and 4 percent of the organizations had 20-29 employees who had worked for less than 5 years. 70% of organizations had 0-9 employees who had worked for 5-10 years, 22% of organizations had 10-19 employees who had worked for 5-10 years, 4% of organizations had 20-29 employees who had worked for 5-10 years and 4% of organizations had 30-39 employees who had worked for 5-10 years. 87% of organizations had 0-9 employees who had worked for 11-15 years,

9% of organizations had 10-19 employees who had worked for 11-15 years while 4% of organizations had 20-29 employees who had worked for 11-15 years. 96% of organizations had 0-9 employees who had worked for over 15 years and 4% of organizations had 40 and above employees who have worked for over 15 years. When employees in the department are experienced in the tasks they perform, they are in a better position to handle a claim more effectively and efficiently, thus surmounting any challenges which they may experience.

Table 4.5: Highest qualifications of employees in claims department

Highest qualifications of employees in claims department			
	Secondary school	**Diploma holder**	**University graduate**
0 to 9 employees	91	91	87
10 to 19 employees	9	4	4
20 to 29 employees	-	-	4
30 to 39 employees	-	-	4
40 employees and above	-	4	-

Table 4.5 is an illustration of the number of employees in the claims department as categorized according to their highest level of education. The study revealed that, majority of claims departments in the insurance industry had 0 – 9 employees in each level of academic qualification (i.e. secondary level, diploma level and graduate level) with 91%, 91% and 87% respectively. This implies that claims departments have more or less equal number of employees in the three main levels of academic qualifications. Employees in claims department are in close contact with the client or intermediary from the time a claim is reported to its conclusion. Their skills and attitude greatly determine the quality of service they offer a customer (Lovelock & Wirtz, 2007).

From the research findings, it is apparent that employees in claims department have adequate qualifications and experience to effectively handle claims. This is supported by findings in Table 4.6, where capacity of claims was ranked low with a mean of 4.3, though views among respondents were varied with a standard deviation of 1.76. Thus, capacity of claims personnel is not a significant challenge in claims management.

4.3 Objective Findings

This section addresses the research questions by identifying challenges faced in claims management. Specifically, the researcher attempted to establish the extent to which challenges like cash flow constraint, capacity of claims personnel, lack of effective information technology support, weak underwriting standards, insurance fraud, incompetent and corrupt service providers and unpredictable court awards adversely impact on management of General Insurance claims. The researcher also attempted to establish the extent to which claims are used in perpetrating fraud and parties involved in perpetrating fraud, whether there is a computer system for claims processing and generation of required claims reports at the respondents' organization, whether introduction of structured compensation for liability claims can accelerate the speed of processing claims and factors which contribute to delay in payment of claims.

The researcher addressed the research questions by using 5-point Likert scales where responses with 'very frequently' were coded 1, 'frequently' coded 2 and 'sometimes' coded 3. The scale also had 'rarely' coded 4 while 'never' was coded 5. The researcher then used measurers of central tendency, particularly the mean and standard deviation for the various factors, to interpret the findings. The lower the mean for the coded factor, the

higher the specific factor ranked in the prevalence scale and vice versa. On the other hand lower standard deviations put a certain factor at a higher rank, subject to the mean, since it was an indication of lower dispersion of responses. The scale was applicable to Tables 4.8, 4.9, 4.10, 4.13 and 4.14. Table 4.6 illustrates a 7-points rank while Table 4.7 indicated the extent of influence of some factors in decision to investigate a claim. Whereas those factors influencing decision to investigate a claim most were awarded 5 points, those factors with no influence were given only one point.

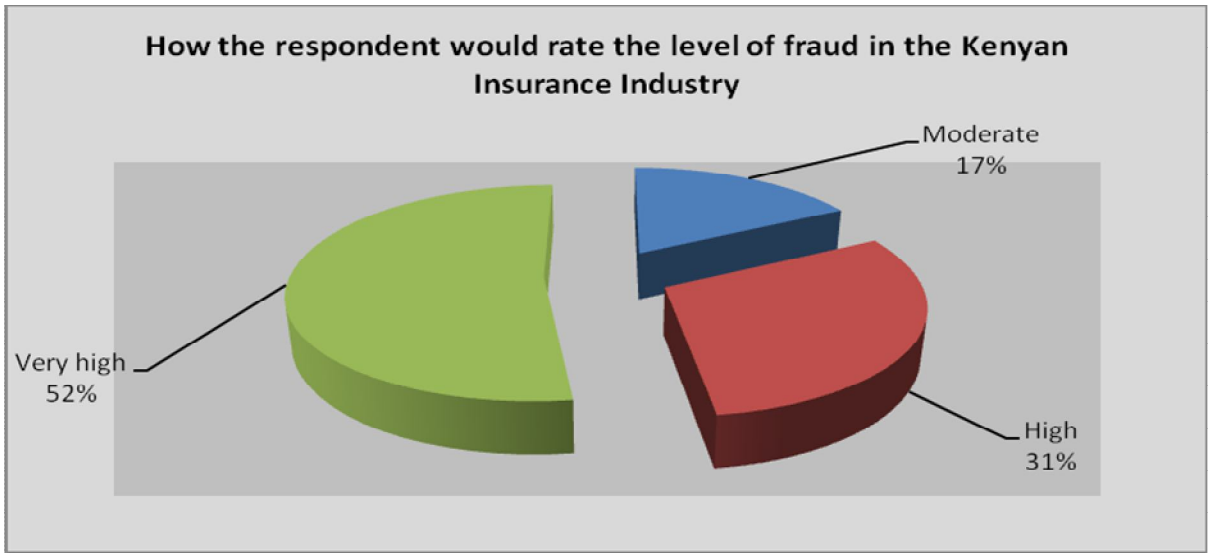
Table 4.6: Challenges in claims management

Challenges in claims management			
	N	**Mean**	**Standard Deviation**
Weak underwriting standards	23	3.0	1.55
Incompetent and corrupt service providers	23	3.1	1.98
Insurance fraud	23	3.4	2.10
Lack of effective information technology support	23	4.2	1.50
Capacity of claims personnel	23	4.3	1.76
Unpredictable court awards	23	4.4	1.95
Cash flow constraint	23	5.5	1.86

The challenges in claims management were ranked from the highest to the lowest as illustrated by Table 4.6. According to the findings, weak underwriting standards, incompetent and corrupt service providers and insurance fraud were ranked as the biggest challenges with mean rank of 3.0, 3.1 and 3.4 respectively. The least perceived challenges, on the other hand, included cash flow constraints, unpredictable court awards as well as low capacity of claims personnel with mean ranks of 5.5, 4.4., 4.3 and 4.3 respectively. This indicates that the most rampant challenges in claims management include weak underwriting standards, incompetent and corrupt service providers and

insurance fraud. As emphasized by Karau, (2008) the underwriting standards in Kenya's insurance companies have been wanting, in that most companies do not adhere to internationally accepted underwriting standards. This in turn makes underwriters underestimate the level of risk, and charge premium which is less than the risk exposure.

Figure 4.2: Rating of the level of fraud in the Kenyan Insurance Industry



The research sought to know how the respondents would rate the level of fraud in the Kenyan Insurance Industry. According to the findings, majority (52 percent) of the respondents rated it very high, 31 percent rated it high, while the remaining 17 percent rated it moderate. The results therefore clearly indicate that the level of fraud in the Kenyan insurance industry is very high. However, lack of consensus on the extent of fraud was evidenced by a standard deviation of 2.10. It is to be noted that none of the respondents indicated level of fraud as either non-existent or low. This is a serious concern as it appears to run across the entire industry. The high level of fraud possibly contributes to the negative perception members of the public have towards insurance.

The collapse of a number of insurance companies in the last decade has also been attributed to a large extent on insurance fraud. This research has shown that majority of the employees in claims departments possess adequate qualifications and experience. They would therefore be expected to have the capacity to identify and curb fraud, since the best defenses against fraud are well-trained claims staff, and the process of uncovering and battling fraud begins in the claims department (Brown, 1997).

Table 4.7: Factors which influence the respondents' decision to investigate a claim

Factors which influence the respondents' decision to investigate a claim			
	N	**Mean**	**Standard Deviation**
Circumstances of accident are unclear	23	4.4	0.71
Vehicle not valued prior to commencement of cover	23	3.6	0.92
Accident was self-involving	23	3.6	0.92
Accident occurred close to inception date	23	3.3	0.99
Insured has been involved in another accident in the recent past	23	3.3	0.69

Table 4.7 illustrates the factors which influence the respondents' decision to investigate a claim. From the findings, when the circumstances of accident are unclear, the insurer is likely to investigate a claim as given by a mean of 4.4 and a standard deviation of 0.71. Other major factors included the client's vehicle not valued prior to commencement of cover as well as the accident being self-involving with mean of 3.6 and standard deviation of 0.92. Respondents also indicated they may investigate a claim if accident occurred close to inception of policy with a mean of 3.3 and standard deviation of 0.99. They can also investigate if insured had been involved in another accident in the recent past, with a mean of 3.3 and standard deviation of 0.69. However, all factors seem

significant, as each has a mean above 3. In addition, there is agreement among the respondents on all the factors, as they all have a standard deviation below 1.

Findings therefore indicate that, claims managers are normally prompted to investigate a claim when circumstances of the accident are unclear, as investigations would reveal the unclear aspects of the claim, or what the claimant may be trying to conceal. If the vehicle was not valued prior to commencement of cover, a claims officer would want to establish whether damage to the vehicle existed before commencement of cover. In the case of a claim for theft of a vehicle, a claims officer would want to establish whether the vehicle indeed existed before commencement of cover. Where accident was alleged to be self-involving, there were no witnesses, thus no one to support the insured's version of the circumstances of the accident. Insurers therefore find it necessary to investigate the claim. Fraud will more likely be suspected if there is a combination the three factors.

Claims Departments find it necessary to investigate, since if a fraudulent claim is paid, the insurer loses a lot of money to fraudsters. This may result to increase in premiums, which affects both the good and bad customers. In addition, if a fraudster gets away with the act, he may be tempted to continue this practice in the future (Roff, 2004). However, a lot of time and money is wasted in trying arrest the menace, thus the need for the insurance industry and the government to give it attention, with the intention of wiping it out.

On the other hand, it may not be necessary to investigate a claim if the circumstances are clear. In a case where the vehicle was valued prior to commencement of cover, the underwriter had the benefit of knowing the condition of the vehicle. Usually where

claim results from collision between two or more vehicles, no foul play is suspected, and it is unlikely that the claim will be investigated. Similarly, if the insured has been with the same insurer for a long time, he is likely to be trusted, thus there will be no need for an investigation.

Table 4.8: Extent to which various parties are involved in perpetrating fraud

Extent to which various parties are involved in perpetrating fraud			
	N	**Mean**	**Standard Deviation**
Claimant Advocate	23	2.2	1.24
Agents/Brokers	23	2.4	0.97
Insureds	23	2.5	1.10
Garages	23	2.5	1.31
Assessors	23	2.6	1.10
Investigators	23	3.0	0.95
Own advocate	23	3.4	0.77
Own employees	23	3.6	0.71

Table 4.8 illustrates the extent to which various parties are involved in perpetrating fraud. According to the findings, claimant advocate with a mean of 2.2 and standard deviation of 1.24, agents/brokers with a mean of 2.4 and standard deviation of 0.97, insured's with a mean of 2.5 and standard deviation of 1.10; and garages with a mean of 2.5 and standard deviation of 1.31 were highly used to perpetrate fraud. In addition, assessors with a mean of 2.6 and standard deviation of 1.10, investigators with a mean of 3.0 and standard deviation of 0.95 and own advocate with a mean of 3.4 and standard deviation of 0.77 were moderately used to perpetrate fraud. Own employees were used to perpetrate fraud, but to a low extent ,with a mean of 3.6 and standard deviation of 0.71.

Liability claims emanate from road traffic accidents, work related injuries, Public Liability, Professional Negligence, Owner's and Occupiers liability among others.

Persons intending to lodge liability claims usually do so with the assistance of advocates. These claimant advocates have a tendency of lodging fictitious claims, with or without the involvement of the claimants. They achieve this using false medical reports, lodging multiple claims, colluding with police among other vices. Ultimately, their intention is to maximize on the amount of money they extract from insurance companies. With a mean of 2.2, it is clear that claimant advocates are involved in perpetrating fraud to a large extent.

The research also reveals that agents and brokers are involved in perpetrating fraud. This is very unfortunate, considering that these intermediaries are the distribution channels for insurance, and insurance companies expect them to source for quality and profitable business on their behalf. Further, some insurers mandate intermediaries to underwrite policies and issue certificate of motor insurance on their behalf. Insurance companies therefore have the responsibility of vetting intermediaries, and ensure they only deal with credible ones.

Garages were also identified as major perpetrators of fraud. According to the principle of indemnity, after an insured suffers a loss following a motor accident, the insurer has a responsibility to put the insured back to where he was before the loss occurred. One of the ways of doing so is repairing the vehicle. In so doing, the insurer contracts a garage to do repairs on their behalf. It therefore follows that when the garage is carrying out repairs, they are doing so on behalf of the insurer. However, some garages are known to inflate cost of repairs, while others inflict additional damage to the vehicle after it is taken to them for repairs. Other garages carry out sub-standard repairs in order make a saving on the amount they are allowed for repairs, resulting to customer dissatisfaction and

complaints. Garages may also collude with the insured to repair pre-accident damage at the insurer's expense. This increases the cost of claims, ultimately resulting to financial difficulties for an insurance company. Detecting and blacklisting of such garages is necessary, in order avoid such challenges.

Insureds are also noted as involved in perpetrating fraud. Some unscrupulous clients of insurance companies lodge fictitious claims. They may also stage-manage an accident, in an attempt to get compensation from an insurer for a vehicle they wanted to get rid of. There are also clients who claim for theft of a vehicle when in actual fact they sold the vehicle. Collusion between the insured and garages is also experienced. Insurers find it necessary to investigate a claim in order to identify and arrest such malpractices. Investigations are time-consuming, and are not received positively by most clients, especially the unscrupulous ones.

Investigators were also identified as perpetrators of fraud, though to a lower extent. This is unfortunate for insurers, considering investigators are the ones expected to identify fraudsters. When they collude with the parties being investigated, whether the insured, garage, claimant advocates or any other suspect, the insurer never gets to unearth the fraud, and may end up paying fraudulent claims. This increases the cost of claims, and also perpetuates the vice. Insurers must therefore be careful in selection of their investigators, and should rely on referral of good investigators from peers in the insurance industry.

Respondents were in agreement that involvement of own advocates' involvement in fraud was minimal, with a mean of 3.4 and standard deviation of 0.77. This is good for the

insurers, in that the advocates are likely to defend them adequately in court, against the claimants' advocates who were identified as highly involved in fraud. Respondents were also in agreement that own employees were involved in fraud to a very low extent, with a mean of 3.6 and standard deviation of 0.71. Employees should therefore be in a position to identify and reduce or eliminate fraud, considering that most of them are qualified and experienced. It is therefore not clear why level of fraud in the insurance industry is high.

Table 4.9: Factors which contribute to delay in claim payment

Factors which contribute to delay in claim payment			
	N	**Mean**	**Standard Deviation**
Funds allocated not sufficient	23	3.2	1.27
Staff have a high work load	23	2.9	1.06
Delay in submission of investigation report	23	3.0	0.88
Delay in reporting claim	23	2.8	0.88
Delay in claim documentation	23	2.9	0.99

Factors which contributed to delay in claim payment were also analyzed using a five-point Likert scale. From the findings, delay in reporting claim with a mean of 2.8, standard deviation of 0.88, delay in claim documentation with a mean of 2.9, standard deviation of 0.99. Clients should realize that the sooner they report a claim and document their loss, the earlier they will be compensated, all other factors held constant. Staff having a high work load was also identified as a contributor to delay in claim payment, with a mean of 2.9 and standard deviation of 1.06. It was however noted that most claims departments have a large staff force. It is therefore possible that the optimal number of staff has not clearly been identified. Further, Finance employees are also involved in the claims payment process, in terms of printing of the cheque, ensuring it is signed and payment can be delayed at these stages. Respondents are in agreement that

delay in submission of investigation report contributes to a low extent, with a mean of 3.0 and standard deviation of 0.88. Insufficient allocation of funds was seen as the lowest contributor to delay in claim payment with a mean of 3.2. However, the respondents' views were varied on this issue, with a standard deviation of 1.27.

Table 4.10: Challenges experienced in relation to payment of claims

Challenges experienced in relation to payment of claims			
	N	**Mean**	**Standard Deviation**
Claims are paid on first come first pay basis	23	3.1	1.60
A pre-set budget of expenditure on claims is followed	23	2.4	1.14
Claims Department is in charge of the payment process	23	2.6	1.24

Table 4.10 is an illustration of the challenges experienced in relation to payment of claims. As indicated in the findings, a pre-set budget of expenditure on claims is most prevalent challenge, with a mean of 2.4, though views are varied, with a standard deviation of 1.14. Where claims managers are allocated a fixed budget for payment of claims irrespective of actual amount of claims ready for payment, it becomes a challenge. This is because clients who have suffered a loss expect to be paid promptly. The situation is worse when the department is not consulted when fixing this budget. Failure to pay claims when they fall due is a major contributor to negative publicity against insurance companies. Regarding the question whether claims department is in charge of the payment process, the responses gave a mean of 2.6 and a standard deviation of 1.24. It appears that the department is not always in charge of the payment process. Claims managers should take a lead role in deciding claims to be paid. Undue interference in the claims payment process reflects negatively to the clients and claims payees in general. To the payees, the impression created is that claims personnel are not willing to pay,

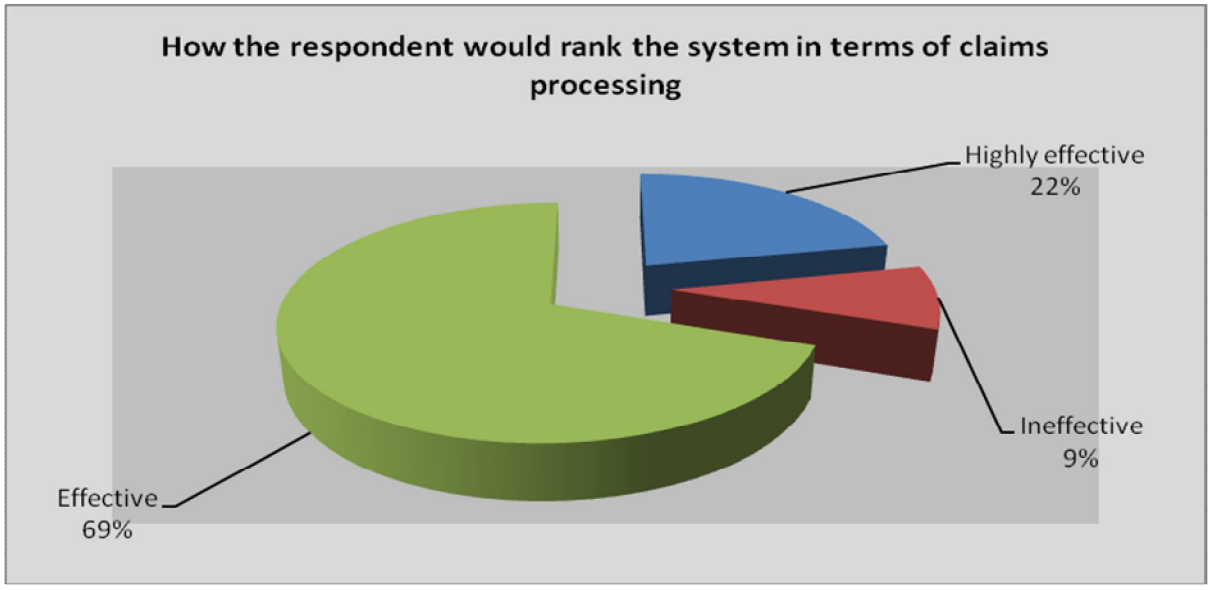
which is not necessarily the case. Most of the respondents are of the view that claims are never paid on a first come first pay basis, with a mean of 3.1 and standard deviation of 1.60. Majority of the respondents (34.8 percent) were of the view that claims are never paid on a first come first pay basis. This implies that claims are not queued in the order of occurrence, or even order of documentation. Recent claims are sometimes paid before older ones. This practice creates unfair treatment of clients. When this occurs, claims personnel are not sure which claims to give priority. The ideal situation is where all claims are paid expeditiously within set benchmarks, with very few variations.

Table 4.11: Whether there is a computer for claims processing at the respondents organization

Whether there is a computer for claims processing at the respondents organization		
	Frequency	**Percent**
Yes	21	91.3
No	2	8.7
Total	**23**	**100.0**

The research sought to know if there was a computer for claims processing at the respondents' organization. According to the findings, majority (91.3 percent) of the respondents said there was computer for processing claims while 8.7 percent said there was no computer for processing claims.

Figure 4.3: How the respondent would rank the system in terms of claims processing



Concerning how the respondents would rank the system in terms of claims processing, 22 percent of the respondents ranked the system as highly effective, 69 percent the system as effective, and 9 percent ranked it as ineffective.

Table 4.12: How the respondent would rank the system in terms of generation of required claims reports

How the respondent would rank the system in terms of generation of required claims reports		
	Frequency	**Percent**
Highly effective	3	13.0
Effective	16	69.6
Ineffective	3	13.0
I don't know	1	4.3
Total	**23**	**100.0**

Concerning how the respondents would rank the system in terms of generation of required claims, 13 percent ranked it as highly effective, 69.6 percent ranked it as

effective, 13 percent ranked it as ineffective and 4.3 percent did not know how to rank it. The above findings clearly show that majority of insurance companies have effective computer systems, both in terms of claims processing and generation of the required reports. If this is the case, the systems should assist claims staff to expeditiously process and settle claims. They should also be able to identify fraudulent trends, by making use of various reports in the systems. It is therefore possible that the computer systems are not optimally used. Further, workload of claims staff was seen as a challenge in payment of claims. This ought not to be so, if there is an effective computer system in place, coupled by experienced and qualified staff. Nyakomitta (2009) noted that ineffective IT governance and control is likely to be the main cause of the negative experiences many organizations and especially insurance firms have had with the use of IT.

Table 4.13: Challenges experienced when processing claims in relation to underwriting files

Challenges experienced in processing claims in relation to underwriting files			
	N	**Mean**	**Standard Deviation**
Policy document not issued	23	2.9	0.99
Relevant clauses not inserted in policy	23	3.0	1.00
Proposal form not completed	23	3.0	1.02
Proposal form filled by agent	23	2.4	0.87
Benefits listed in brokers slip are not endorsed in policy	23	2.4	0.92

Table 4.13 illustrates the challenges experienced when processing claims in relation to underwriting files. Most respondents were in agreement that proposal forms filled by agent was to be a major challenge, with a mean of 2.4 and a standard deviation of 0.87.

As had been observed earlier, agents were major contributors to perpetration of fraud. If they again complete proposal forms, the claims personnel have a difficult time trying to establish the subject of insurance. The law of agency bars an insurer from declining a claim on the basis of non-disclosure of material facts in the proposal form, if the proposal form was completed by an agent. Issue of benefits listed in brokers slip but not endorsed in policy was also identified as a challenge, with a mean of 2.4 and standard deviation of 0.92. Claims officers are guided by the policy document to determine basis of settling a claim. On the other hand, brokers indicate on their slips the extent of coverage they expect the policy to encompass. If the policy document is not in tandem with the broker's slip, claims officers may settle a claim at less than the broker and the insured expected. This results to customer and broker dissatisfaction, which reflects negatively against the claims department.

Respondents were in agreement that failure by underwriting departments to issue policy documents was a challenge, with a mean of 2.9 and standard deviation of 0.99. Where the insured had not been issued with a policy document, they are not receptive to claims officers relying on terms and conditions of the policy to interpret a claim, since they did not have the benefit of reading the policy. This can lead to customer dissatisfaction and attempts to resolve the complaints delays the claims processing. Respondents also noted that failure to insert relevant clauses in the policy poses a challenge, with a mean of 3.0 and standard deviation of 1.00. Similarly, the insured's failure to complete proposal form was identified as a challenge though to a lower extent and varied opinions among the respondents, with a mean of 3.0 and standard deviation of 1.02. The proposal forms the basis of the contract between the insured and the insurer. The proposal also contains

background information pertaining to the insured and also the subject matter of insurance. Where it is absent, claims officer may not have access to the information which is useful in adjusting the claim. However, it is noted that most respondents did not find this a major challenge, which is surprising.

Table 4.14: Challenges experienced in relation to legal claims

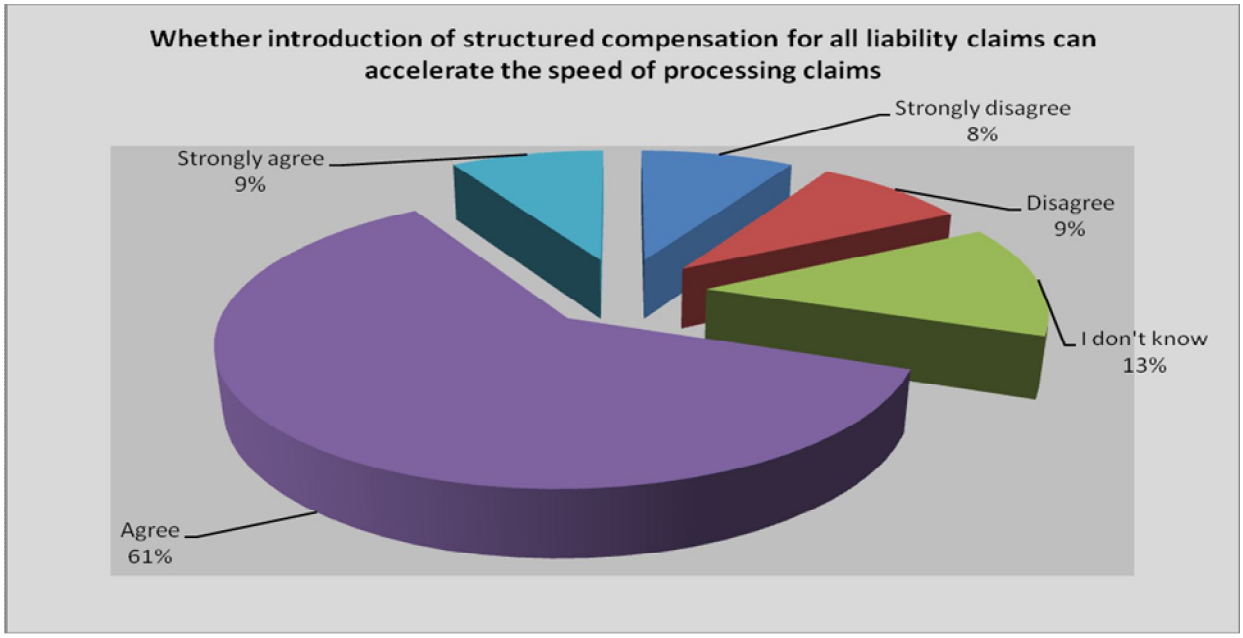
Challenges experienced in relation to legal claims			
	N	**Mean**	**Standard Deviation**
Judgments entered are consistent with nature of injuries	23	3.0	0.91
Judgments vary depending on the region in the country	23	2.0	1.00
Documents produced in court by plaintiff advocates to support a claim are authentic	23	2.8	0.59
There is collusion between plaintiff advocate and judge/magistrate to give high awards in court	23	2.4	0.71

Table 4.14 illustrates the challenges experienced in relation to legal claims. According to the findings on legal claims, judgments vary depending on the region in the country with a mean of 2.0, standard deviation of 1.00. Collusion between plaintiff advocate and judge/magistrate to give high awards in court was noted, with a mean of 2.4 and standard deviation of 0.71. Documents produced in court by plaintiff advocates to support a claim are sometimes not authentic with a mean of 2.8 and standard deviation of 0.59.

However, some of the respondents were of the view that judgments entered are consistent with nature of injuries with a mean of 3.0, standard deviation of 0.9. This finding seems to contradict the others above. If there is collusion between plaintiff advocate and judges/magistrates, awards differ from one region to another and documents plaintiff advocates produce in court in support of their claim are sometimes not authentic, one would expect that court awards are not consistent with nature of injuries. Whereas most

of the respondents responded “sometimes” and “rarely” (30.4 percent and 34.8 percent respectively), those who responded “very frequently” and “frequently” were 4.3 percent and 30.4 percent. Karau (2008) noted that insurance companies have complained that court awards are unrealistically high, and if courts continue making such awards, insurers may find themselves making losses. This observation also seems to contradict the views of the respondents on consistency of court awards with nature of injuries.

Figure 4.4: Structured compensation in liability claims and speed of processing claims



The research sought to know whether introduction of structured compensation for all liability claims could accelerate the speed of processing claims. According to the findings, 9 percent of the respondents strongly agreed that introduction of structured compensation for all liability claims could accelerate the speed of processing claims, 61 percent agreed, 13 percent said they did not know. Only 8 percent of the respondents strongly disagreed while 9 percent disagreed, that introduction of structured

compensation for all liability claims could accelerate the speed of processing claims. Structured compensation in liability claims means that the amount a claimant is to be paid is pre-determined, and is standard for all related injuries. A structured compensation system eliminates the need for court system and plaintiff advocates, since both the insurer and claimant are aware of amount payable based on nature of injuries. It is noted that 70 percent either agree or strongly agree that the system would accelerate payment of liability claims is an indication that it is recognized as a viable alternative to the court system in dealing with liability claims.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter presents a summary of the study findings and the conclusions arrived at. It also gives recommendations on some measures which can be taken to mitigate the challenges faced in management of General Insurance claims.

5.1 Summary of the Study

The objective of the study was to determine challenges experienced in management of General Insurance claims. The study was conducted among claims management staff in General Insurance companies. Out of the twenty-three (23) respondents who were interviewed, 73.9 percent were claims managers and 21.7 percent were assistant claims managers. 4.3% were claims clerks. 39.1 percent had held their positions for over 10 years, 13.0 percent for 6-10 years, and 21.7 percent for 4-6 years. All the respondents worked in claims department. Therefore, the respondents were deemed to have the knowledge and experience to appreciate the claims management process and challenges which may be experienced therein.

The study sought to establish the number of employees in claims departments of the respondent companies, their average working experience as well as their qualifications. Findings reveal that on average, claims departments of respondent companies are large. It also emerged that most of the employees had experience of more than five years. The number of employees in any claims department depends on a number of factors including product mix and market mix. However, the experience and qualifications of the

employees is important, as claims processing involves a lot of decision making, which should not be left to inexperienced or incompetent staff (Wedge & Handley, 2003). The study findings reveal that most employees in claims department possess the necessary qualifications and experience.

The study revealed that weak underwriting standards posed the biggest challenge in claims management. Most respondents cited failure of policy holders to complete proposal forms as a major concern. In addition, underwriters fail to endorse in the policies the benefits listed in broker's slip. Respondents also noted that failure by the underwriting department to issue policy documents, or failure to include the necessary clauses in the policies creates challenges in management of claims. Claims officers are guided in claims processing by the underwriting file, including proposal form and policy document. When the underwriting documents are not available or they are incorrect, claims officers may experience problems in processing the claim or they may interpret the policy in a manner which is not acceptable to the insured. This creates customer dissatisfaction, in addition to increasing time spent on a claim at the expense of other clients. Where the agent completes the proposal form on behalf of the client and information therein is either incorrect or deliberately misrepresented, the insurer is bound by law of agency to settle a claim which may arise by virtue of the law of agency, which binds insurer for actions committed by their agent.

Most respondents rated the level of fraud in the Kenyan Insurance industry as very high, with no respondent indicating as either low or non-existent, a clear indication that fraud in the insurance industry is rampant.. The reason why this vice may be growing is that it is perpetrated by parties working directly with the insurer. Incompetent and corrupt

service providers were identified as a challenge. This may be so, considering that garages, assessors, investigators and own advocates were identified by the respondents as some of the parties involved in perpetration of fraud, though to a lower extent than agents, brokers and own insureds.

Lack of effective information technology support, capacity of claims personnel, unpredictable court awards and cash flow constraints were not perceived by most respondents as major challenges. Most respondents (91.3 percent) noted that their organizations had computer systems which were efficient both in claims processing and generation of the required claim reports. The research showed that most claims departments were large, and the employees had both technical skills and relevant experience. Though respondents noted that courts in different regions gave varying court awards, most of them were of the view that judgments entered were consistent with nature of injuries. However, they also indicated that introduction of structured compensation for all liability claims could accelerate the speed of processing claims.

Most respondents attributed delay in processing of claims to delay in claim documentation, high workload of staff and delay in submission of investigation reports. Insufficient allocation of funds for payment of claims was not viewed as a major contributor to delay in claim payment. However, most respondents were of the view that payment of claims is hampered by adherence to a pre-set expenditure budget on claims, and the fact that claims are not paid on first come first pay basis. Majority were of the view that claims department is sometimes not in charge of the claims payment process. This should not be the case, as claims department should take a leading role in determining which claims are due for payment, as they are the ones who are in touch with

the process. Removing claims managers from the claims budgeting process and allocating inadequate funds for claims payment are self-defeating strategies which are likely to eventually lead to customer dissatisfaction and reduction of staff morale.

5.2 Conclusion

From the findings, weak underwriting standards form the highest challenge facing claims management of General insurance industry in Kenya. The underwriting department has a major responsibility of adhering to strict underwriting guidelines. This includes ensuring that the proposal form is completed by the insured and not the agent. Further, the underwriter should issue the insured with the relevant policy document, to eliminate any ambiguity at the time of a claim. The underwriter should also strictly vet the insureds, to ensure they are of high integrity. Further, underwriters should ensure that vehicles are valued before they are insured, to confirm that the vehicle existed at the time of insurance, and that it was in a good condition. This will reduce the need for claims officers to subject a claim which is later reported to investigations.

At the same time, research revealed that there is a high level of fraud in the Kenyan insurance industry. Apart from agents, brokers and insureds, claimant advocates, garages, assessors, investigators and own advocates were noted to be involved in perpetrating fraud, though to a lower extent. Claims departments have a major responsibility of vetting the service providers they appoint to handle claims on their behalf. It is however worth noting that own employees' involvement in perpetration of fraud was found to be minimal. In addition, employees in claims department of most companies had at least a diploma in insurance. Claims managers should train their

employees on fraud detection, in order to identify and expose fraudsters. Companies should also make use of the computer systems they already have to improve efficiency and generate reports which can point to areas of fraud.

The main causes of delay in processing of claims were found to be delay in documentation of claims, delay by investigators to submit their reports and high staff workload. Introduction of structured compensation for all liability claims could accelerate the speed of processing claims. Regarding payment of claims, following a pre-set budget of claims to be paid was found to be a major challenge.

However, capacity of claims personnel and IT support were not found to be major challenges. On the other hand, respondents attributed delay in payment of claims partly to high workload of staff. It would imply that though insurance companies have installed good IT systems, the use of the systems is not maximized in order to reduce claims processing cycle, thus enhancing efficiency and customer satisfaction. Further, it is necessary to enable interface between insurers and service providers, in order to improve claims tracking and enhance management information. The staff would also be expected to effectively deal with the challenges which have been identified, but this does not appear to be the case, thus the need to ensure that their training is geared towards dealing with the challenges.

5.3 Recommendations

Claims department plays a major role within the customer service delivery chain. It is therefore important that measures are taken to either eliminate, or minimize the challenges which may hamper its effectiveness.

Insurance companies should formulate and implement underwriting guidelines, in order to strengthen underwriting standards. In addition, underwriting officers should be trained on prudent underwriting. With the assistance of insurance industry players, the College of Insurance should also tailor-make courses to address the knowledge gap which may have caused underwriting standards to deteriorate. Policy makers in the insurance industry, including IRA as well as AKI should formulate and put into force valid policies that would effectively reduce or even completely eliminate weak underwriting standards. These policies should be formulated to ensure that the right procedures are followed by the insurance industry.

The insurance industry, either through AKI or individually need to educate the policyholders on the need to report claims immediately, as delay in reporting claim was noted to contribute to delay in claim processing. The insurance industry has a responsibility to report claimant advocates who are notorious for perpetrating fraud to the Law Society of Kenya (LSK) for disciplinary action. In addition, insurance companies should report agents and brokers who perpetrate fraud to IRA, who should withdraw their licenses.

Insurance companies should ensure that their claims departments have adequate number of employees who have the requisite skills to handle claims, in order to improve speed in claim payment. The staff should also be trained on fraud detection. A system should be installed in all claims departments to increase efficiency in processing and generating required claims reports, as well as detection of fraud. In addition, the company should allocate funds to pay claims when they fall due.

The insurance industry need to address the challenge of fraud as a united front. The use of an integrated computer system will assist the industry identify the perpetual claimants, and those with a tendency to defraud insurance companies. The industry needs to lobby for creation of a police unit to handle insurance fraud. They should also lobby for creation of special courts to listen to and determine insurance fraud-related charges. This will encourage insurance companies to press charges against fraudsters. The insurance industry may also lobby for creation of an anti-fraud unit within IRA, similar to the Kenya anti-fraud unit under Central Bank of Kenya, which deals with bank frauds.

Speed in processing of claims can be enhanced by sensitizing clients on need to document their claims promptly. It is also important to ensure that claims department has an optimum number of employees, in order to increase efficiency in claims processing. Insurers need to enter into service level agreements with service providers, to ensure the service providers operate within acceptable time lines on service delivery.

Structured compensation system can go a long way towards reducing the amount of liability claims. Through AKI, the insurance industry needs to lobby for its full implementation. It is noted that whereas the system was introduced for injuries to employees through implementation of WIBA, lawyers successfully filed a suit against it, thus re-introducing suits against employers for negligence. In the 2010 Budget speech, the Minister of Finance proposed to introduce structured compensation or motor claims. The insurance industry should lobby for its immediate implementation.

5.4 Suggestion for Further Studies

The study also suggested areas for further study:

i. A study should be carried out to determine the level of insurance fraud, and how to curb it.

ii. A study should be carried out to find out how the public's opinion of the claim processing and payment.

iii. A study to establish the role played by plaintiff advocates towards amount of court awards for liability claims.

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APPENDIX I: Letter of Introduction

September 16, 2010

TO WHOM IT MAY CONCERN

The bearer of this letter: **KIANA, MERCY WAIRIMU**

REGISTRATION NO: **D61/P/8720/2005**

Is a Master of Business Administration (MBA) student at the University of Nairobi.

She is required to submit a part of her coursework assessment a research project report on a management problem. We would like the students to do their projects on real problems affecting firms in Kenya. We would therefore appreciate if you assist her by allowing her to collect data in your organization for the research.

The results of this report will be used solely for academic purposes and a copy of the same will be availed to the interviewed organizations on request.

Thank you,

DR.W.N.IRAKI

CO-ORDINATOR, MBA PROGRAM

APPENDIX II: Questionnaire

SECTION A: Personal information

1. Name (optional) ……
2. Company (optional)……..
3. Position……..
4. Number of years experience in the current position (whether in current organization or from another organization ……..
5. Section/Department…….

SECTION B

1. Rank the following challenges in Claims Management, from highest to lowest (1 – 7).

Challenge	**Rank**
Cash flow constraint	
Capacity of Claims personnel	
Lack of effective information technology support	
Weak Underwriting standards	
Insurance fraud	
Unpredictable court awards	
Incompetent and corrupt service providers	
Any other?(Please specify)	

2) On a scale of 1 – 5, how would you rate the level of fraud in the Kenyan Insurance Industry?

(1) Non- existent ☐ (2) Low ☐ (3) Moderate ☐ (4) High ☐ (5) Very high ☐

3) Indicate the extent to which the following factors influence your decision to investigate a claim?

Factor	Never (1)	Rarely (2)	Moderate (3)	Highly (4)	Very highly (5)
Accident occurred close to inception date					
Vehicle not valued prior to commencement of cover					
Accident was self-involving					
Circumstances of accident are unclear					
Insured has been involved in another accident in the recent past					
Any other? (list below)					

4) Indicate the extent to which each of the following is involved in perpetrating fraud?

	Very highly (5)	Highly (4)	Moderately (3)	Low (2)	I don't know (1)
Garages					
Assessors					
Claimant Advocates					
Own advocates					
Investigators					

Agents/Brokers					
Insureds					
Own employees					
Any other (Please indicate)					

5) Indicate the extent to which the following factors contribute to delay in claim payment?

	Very greatly (5)	Greatly (4)	Moderately (3)	Rarely (2)	Never (1)
Funds allocated not sufficient					
Staff have a high workload					
Delay in submission of assessment report					
Delay in submission of investigation report					
Delay in reporting claim					
Delay in claim documentation					
Any other? (Please indicate below)					

6) Is there a computer system in your organization for claims processing? Yes ☐ No ☐

7) How would you rank the system, in terms of claims processing?
(1) Highly ineffective ☐ (2) Ineffective ☐ (3) I don't know ☐ (4) Effective ☐
(5) Highly effective ☐

8) How would you rank the system, in terms of generation of required claims reports?

(1) Highly ineffective ☐ (2) Ineffective ☐ (3) I don't know ☐ (4) Effective ☐ (5) Highly effective ☐

9) Indicate the extent to which you experience the following when processing claims, in relation to underwriting files?

	Very frequently (5)	Frequently (4)	Sometimes (3)	Rarely (2)	Never (1)
Policy document not issued					
Relevant clauses not inserted in policy					
Proposal form not completed					
Proposal form filled by agent					
Benefits listed in broker's slip are not endorsed in policy					

10) a) Indicate the extent to which you experience the following, in relation to legal claims?

	Very frequently (5)	Frequently (4)	Sometimes (3)	Rarely (4)	Never (5)
Judgments entered are consistent with nature of injuries					
Judgments vary depending on the region in the country					

Documents produced in court by plaintiff advocates to support a claim are authentic?					
There is collusion between plaintiff advocate and judge/magistrate to give high awards in court					

10b) Introduction of structured compensation for all liability claims can accelerate the speed of processing claims?

(1)Strongly disagree ☐ (2) Disagree ☐ (3) I don't know ☐(4) Agree ☐ (5) Strongly agree ☐

11) Indicate the extent to which the following apply, in relation to payment of claims in your organization?

	Very frequently	Frequently	Sometimes	Rarely	Never
Claims are paid on a first come first pay basis					
A pre-set budget of expenditure on claims is followed					
Claims Department is in charge of the payment process					
Payments are made as per set company benchmarks					

12) How large is your Claims Department?..... employees (number)

13) What is their average working experience?

(a) Less than 5 years …… (b) 5 – 10 years ……. (c) 11 – 15 years …… (d) over 15 years ……..

14) How many employees in Claims Department have the following as the highest qualifications:

(a) Secondary school ……(b) Diploma holder ……. (c) University graduate …….

Thank you.

APPENDIX III: Raw Scores

Challenges in claims management							
	1	**2**	**3**	**4**	**5**	**6**	**7**
Weak underwriting standards	21.7	17.4	21.7	21.7	8.7	8.7	-
Incompetent and corrupt service providers	34.8	13.0	4.3	26.1	8.7	4.3	8.7
Insurance fraud	21.7	21.7	13.0	17.4	4.3	4.3	17.4
Lack of effective information technology support	-	13.0	26.1	17.4	21.7	13.0	8.7
Capacity of claims personnel	4.3	17.4	17.4	4.3	26.1	21.7	8.7
Unpredictable court awards	8.7	13.0	17.4	4.3	21.7	17.4	17.4
Cash flow constraint	8.7	4.3	-	8.7	8.7	30.4	39.1

Challenges in claims management					
	Never	**Rarely**	**Moderate**	**Highly**	**Very highly**
Accident occurred close to inception date	4.3	17.4	34.8	34.8	8.7
Vehicle not valued prior to commencement of cover	-	13.0	30.4	39.1	17.4
Accident was self-involving	-	13.0	30.4	39.1	17.4
Circumstances of accident are unclear	-	4.3	-	43.5	52.2
Insured has been involved in another accident in the recent past	-	8.7	56.5	30.4	4.3

Factors which contribute to delay in claim payment					
	Very frequently	**Frequently**	**Sometimes**	**Rarely**	**Never**
Funds allocated not sufficient	8.7	30.4	13.0	30.4	17.4
Staff have a high work load	13.0	17.4	39.1	26.1	4.3
Delay in submission of investigation report	4.3	21.7	47.8	21.7	4.3
Delay in reporting claim	8.7	26.1	43.5	21.7	-
Delay in claim documentation	13.0	17.4	39.1	30.4	-

Extent to which various parties are involved in perpetrating fraud					
	Very highly	**Highly**	**Moderately**	**Low**	**I don't know**
Garages	30.4	21.7	30.4	4.3	13.0
Assessors	21.7	21.7	39.1	13.0	4.3
Claimant Advocate	39.1	26.1	21.7	4.3	8.7
Own advocate	-	13.0	34.8	47.8	4.3
Investigators	4.3	30.4	34.8	26.1	4.3
Agents/Brokers	17.4	39.1	34.8	4.3	4.3
Insured's	21.7	26.1	34.8	13.0	4.3
Own employees	-	8.7	30.4	56.5	4.3

Challenges experienced in relation to payment of claims					
	Very frequently	**Frequently**	**Sometimes**	**Rarely**	**Never**
Claims are paid on first come first pay basis	21.7	21.7	13.0	8.7	34.8
A pre-set budget of expenditure on claims is followed	26.1	30.4	17.4	26.1	-
Claims Department is in charge of the payment process	26.1	13.0	39.1	12.9	8.7

Challenges experienced in processing claims in relation to underwriting files					
	Very frequently	**Frequently**	**Sometimes**	**Rarely**	**Never**
Policy document not issued	13.0	17.4	39.1	30.4	-
Relevant clauses not inserted in policy	8.7	13.0	52.2	17.4	8.7
Proposal form not completed	13.0	8.7	47.8	26.1	4.3
Proposal form filled by agent	17.4	34.8	39.1	8.7	-
Benefits listed in brokers slip are not endorsed in policy	17.4	34.8	34.8	13.0	-

Challenges experienced in relation to legal claims					
	Very frequently	**Frequently**	**Sometimes**	**Rarely**	**Never**
Judgments entered are consistent with nature of injuries	4.3	30.4	30.4	34.8	-
Judgments vary depending on the region in the country	30.4	47.8	13.0	4.3	4.3
Documents produced in court by plaintiff advocates to support a claim are authentic	-	30.4	60.9	8.7	-
There is collusion between plaintiff advocate and judge/magistrate to give high awards in court	13.0	34.8	52.2	-	-

APPENDIX IV: General Insurance Companies

1. Africa Merchant Assurance Limited
2. APA Insurance Company Limited
3. Blue Shield Insurance Company Limited
4. British American Insurance Company Limited
5. Cannon Assurance Limited
6. Chartis Kenya Insurance Company Limited
7. Concord Insurace Limited
8. Co-operative Insurance Company Limited
9. Corporate Insurance Company Limited
10. CFC Life Insurance Company Limited
11. Directline Assurance Company Limited
12. Fidelity Shield Insurance Company Limited
13. First Assurance Company Limited
14. Gateway Insurance Company Limited
15. Geminia Insurance Company Limited
16. GA Insurance Company Limited
17. Heritage Insurance Company Limited
18. Insurance Company of East Africa Limited
19. Intra Africa Assurance Company Limited
20. Jubilee Insurance Company Limited
21. Kenindia Assurance Company Limited
22. Kenya Orient Insurance Limited
23. Kenyan Alliance Insurance Company Limited
24. Lion of Kenya Insurance Company Limited
25. Madison Insurance Company Limited
26. Mayfair Insurance Company Limited
27. Mercantile Insurance Company Limited
28. Occidental Insurance Company Limited
29. Pacis Insurance Company Limited

30. Phoenix of East Africa Assurance Company Limited
31. Real Insurance Company Limited
32. Tausi Insurance Company Limited
33. The Monarch Insurance Company Limited
34. Trident Insurance Company Limited
35. UAP Insurance Company Limited

Source: Association of Kenya Insurers Report, 2009