SURAKSHA AUR BHAROSA DONO
Corporate Office: Fulcrum Building, 9th Floor, A & B Wing, Sahar Road, Andheri (East), Mumbai 400 099.

CLAIMS GUIDE

SIMPLE HOME INSURANCE POLICY

Notification of Loss

Preferred methods of Notification

- Customers will be encouraged to report losses to the Call Centre.
- However customers may notify a claim using one of the following communication channels:

  - Toll Free No. 1800 22 1111 / 1800 102 1111
  - Email notification to central email address– customer.care@sbigeneral.in
  - SMS CLAIMS to 561612
  - By letter/ Fax to any of our offices
  - By completing a manual claim form and mailing it to an SBIGIC Branch or corporate office or in person to any SBIGIC Branch.
  - Via the website www.sbigeneral.in

Minimum information required for Intimation

- We would need the below mentioned information to complete intimation –

  - Notifier details (first and last name/relationship to insured/contact details)
  - Insured's details (first and last name/relationship to insured/contact details)

Or

  - Policy Number

And

  - Asset information: (building and contents-Building name and address,)
  - Date of loss
  - Type of event

- A unique Intimation ID/Claim Reference number will be provided to the notifier and an estimated reserve will assigned based on the Cover type and Cause of loss.
- Where a policy or risk cannot be found, the notification will be taken as "Intimation Pending" and the notifier will be contacted to obtain further information. No reserve will be entered against the Intimation ID.
- Alerts and notifications will be sent to the relevant business areas upon notification of the claim by the Insured in the following circumstances:
  - Claims with estimated reserve in excess of Rs. 5,00,000/-or as appropriately defined for each product
  - Claims under Catastrophic events.
  - Any claim where the events or circumstances warrant referral & input from other areas within the business

.

Appointment of Third Party Service Providers

At the time of notification we may appoint Loss Assessors/Surveyors or any other service provider to make safe the risk and prevent or minimise further losses. Appointment of surveyors will comply with the guidelines prescribed by the IRDA.

Third party service providers will be allocated based on their certification (where required), experience and geographical suitability to ensure customers are serviced in a timely and efficient manner.

Third party service providers may be appointed at any stage throughout the claim to substantiate, repair, re-instate or recover the loss.

Service providers we may choose to appoint include, but are not limited to:

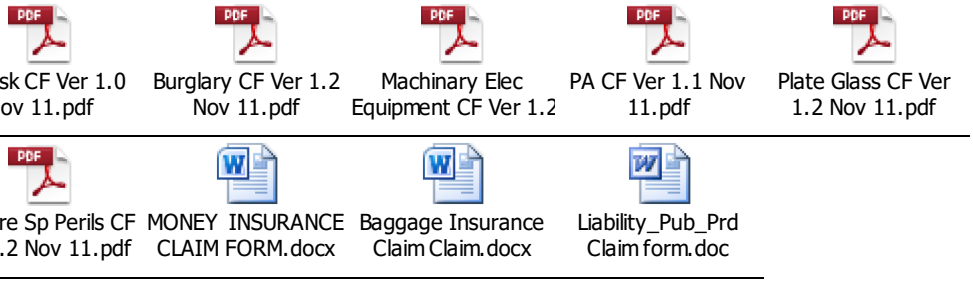
- External Loss Assessors
- Surveyors
- Investigators
- Legal Counsel
- Salvage Operator

Service providers will be reviewed regularly with penalties imposed in the event of breaches to MOU's, if any and if required removal from the panel. The number and geographical spread of service providers will be based on business needs and will be reviewed on a regular basis.

A master table of third party service providers will be maintained to ensure claims staff allocate only those service providers still empanelled with SBIGIC.

Claim Forms

Separate Claim form should be used for each section :



Assessment of Claim

After a claim has been notified the claims staff/officer/manager will validate the claim as follows:

- Policy in force at time of loss.
- Policy coverage including any extensions, exclusions, endorsements or add-ons.
- Risk address or property is noted on the policy.
- Details of incident/accident including time, date, location, other parties or witnesses.
- Hypothecation or other parties with a financial interest in the claim.
- Nature of damage or loss is consistent with details of the incident/accident
- Insured details including preferred method of communication and valid addresses (postal/email etc) and contact numbers.
- Supporting documentation required from the customer in order to assess and settle the claim.
- Perform fraud checks to ensure the claim is valid under the policy.
- Likely cost of claim.
- If required appoint loss assessor/surveyor/investigator

Upon appointment of a loss assessor/surveyor/investigator we will notify the insured of their details and co-ordinate survey/investigation. If an assessor/surveyor/investigator is not required to attend the scene immediately, this notification will include scheduling a date and time for the assessor/surveyor/investigator to attend the site.

A loss assessor/surveyor/investigator/ must report their initial findings within 7 days including reserve estimates. Thefinal report must be submitted no later than 30 calendar days after receipt of all requisite documents to assess the claim.It will be appropriate for some claims to fall outside these guidelines depending on severity & complexity of the loss/event. Upon receipt of the assessor/surveyor/investigator report the claim executive may either:

- Approve the claim for settlement,
- Refer the claim to underwriting/re-insurance - if the nature of the event or loss is unclear or if there is a re-insurance implication.
- Refer the claim for further investigation - in the event that there are inconsistencies with the information provided at the time of intimation and the surveyor report.
- Decline the claim – in this instance the claim will be referred to next level manager for a final decision.

At this stage reserves will be amended to reflect proposed claim cost and a review of the claim file will determine whether the claim can be settled (i.e. required documents received etc...)

If the claim is able to be settled by the claims executive, without any further delay or investigation, a payment will be prepared and dispatched to the insured/other party.
Where the claim has been referred to Underwriting or Investigations it will be allocated to the relevant underwriter/investigator.Upon receipt of the underwriter's decision or the investigator's report the claim will be settled accordingly.

Where a claim is declined the insured will be notified in writing as to the reasons for declinature and will be advised of our Grievance Redressal process .

Deficient Documentation

Where the insured is unable to provide the requisite documentation within 7 days of intimating the claim, we shall remind the customer advising the submission of the same at subsequent periodic intervals till complete submission.

The file will be reviewed to see if we are able to proceed with settlement of the claim and if so, we will settle.

Alternatively, if settlement cannot occur a final reminder will be sent to the customer advising a further 15 days grace, and stating that if documents are not received the claim/notification will be cancelled.

If after 30 days no documents are received a letter will be sent to the customer advising that the claim/notification has been closed.

For Personal Accident Claim

Every claim shall be disposed of in accordance to the Terms & Condition of the policy contract and the extant Regulations governing the settlement of claims. No Claims will be closed due to deficient documentation in our books.

Ex Gratia consideration

A claim may be considered for Ex Gratia settlement for a variety of reasons including customer loyalty or low claim loss ratio or like. The business may choose to settle a claim which is not valid under the policy on the basis of an Ex Gratia payment. This payment would need to be approved by the Manager/Officer vested with the authority and will be subject to escalation guidelines.

Claim Finalisation

Upon satisfactory completion of assessment and/or investigation a claim will be finalised by the Claims Executive. Wherever Reserve/ Claims Payments exceed the Branch Limits, the claim will be referred to a higher level authority for approval.

Once the payment is prepared by the claims department it will be approved by finance and remitted to the customer/claimant via their preferred payment method (e.g. cheque or NEFT). A letter will also be sent to the customer advising the payment details such as date of remittance and cheque number/transaction advice.

Once the final payment has been made to all parties involved in a claim the claim will then be considered closed. All reserves will be reversed to zero in this instance.

Declination

In the event that a claim is not valid under the policy the claim will be reviewed by the next level manager. In some instances the claim may be referred to regional underwriting prior to the final decision being taken. Once a decision has been reached to decline the claim, the customer will be notified in writing of our decision and reasons for doing so. Included in the letter, the customer will

also be advised of the Grievance Redressal process should they disagree with the decision to decline the claim.

Once a claim is declined a declinature reason will be recorded against the claim. (e.g.not covered under policy, annual benefit limits exceeded etc).

Financial Authority for Reserving and Approval


Claims Authority Matrix.xlsx

Grievance Redressal

In the first instance all grievances will be managed at a local claims branch level. In the event that the grievance cannot be resolved to the customer's satisfaction the matter will be escalated to the internal Grievance redressal team in the corporate office.

After consultation, the internal review outcome may be to pay the claim. In such instances the internal review team will notify the claims branch who will notify the customer & proceed to settlement. Should an internal review uphold the claims branch's original decision the customer will be informed of the outcome of the review and advised of the external grievance redressal process.

Should a customer prevail upon the use of mediation or litigation these matters will be managed, tracked and reported centrally through either the Grievance Redressal team (mediations) or locally through the Litigation Claims Team (Litigated matters).

Catastrophe Claims

In the event of a catastrophic event, all claims arising from the event will be allocated a catastrophe code to ensure accurate recording, reporting and management of these claims.

Catastrophic events will be monitored closely to ensure all stakeholders (internal & external) are managed appropriately.

Risk & Process Compliance

The entire Claim Processing, Reserving and Authorizing tasks will be subject to internal checks and controls on the maker and checker concept. Fraud checks will be performed on all claims at the time of lodgement. In the event that fraud indicators are triggered, the claim will be referred to an internal investigations team for review.
Should a more detailed investigation be required the Investigations team will engage an external investigator and allocate the claim to them.

A regular review of internal staff will review process and regulatory compliance by all staff. All reviews will be documented and remedial actions will be provided to the business unit manager to gain agreement and to implement. The effectiveness of the remedial actions in addressing non-conformance will be determined at the subsequent review period.

File and Document Management

All original paperwork/documentation submitted will be scanned and indexed against each claim. The physical documents will also be filed locally at the claims branch managing the claim in the event they are required for legal purposes.

Claim Documentation will be stored for a period of seven (7) years after which time it will be destroyed.

Service Standards and TAT's

Action	Timeframe
Intimation notification to insured	Within 24hrs of receipt of intimation if insured is identified
Allocation of Investigator, if required	Within 48 hours of Intimation
Claim Settlement	Within 7 days of receipt Investigator report and last relevant document
Declinature Letter	Within 7 days of receipt of final documentation including Investigator's report
Grievance Redressal – Notification	Immediately provide customer with grievance reference id and advise next steps
Grievance Redressal – acknowledgement	Within 10 days of receipt of the grievance
Keeping the Customer Informed	If customer contacts via telephone calls should be returned within 1 business day
	If customer contacts via email respond within a maximum of 2 working days for non-urgent queries, within same business day for urgent queries
	If customer contacts via letter or fax respond within a maximum of 7 working days or same business day if matter is urgent