RGA

Global Claims Views

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Tips for Clear Written Communications with Claimants

Introduction

Communication is a key skill for claims assessors. A significant portion of your daily workload is dedicated to communicating, orally or in writing, decisions and information with insureds, physicians, lawyers and health providers.

While both forms of communication are important, written communication often requires more thought and effort. Explaining a claims decision, a specific policy clause or simply requesting additional information can create confusion and frustration for the claimant if not done clearly.

Here are some simple suggestions for claims assessors to consider when communicating decisions in writing.

Plan your message

Letters to claimants, especially a decline or termination letter wherein the case manager has to explain his/her position, can be a daunting task. Before writing the letter, be mindful of the following:

- Your goal is to enable the claimant to understand your company's position and if necessary take action.
- Know what you want to say and how you want to say it. What information is your position or decision based on? Do you have all the supporting information you need?
- Be careful when using letter templates. Many insurers have them, but one size does not always fit all. Some prepopulated sentences or statements will not work in every situation.
- Be clear, precise and professional.
- Use plain language.
- If you are responding to a letter from the claimant, make sure you answer all points raised.

ABOUT THE AUTHOR

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Charles Deragon is Director GST North American Claims, working in the Global Claims Team for RGA. Utilizing his international experience and contacts, he brings support to RGA claims teams and their clients by developing alternative claim management practices and processes. Charles joined RGA Canada in November 2005 as Director, Group Claims. His major responsibilities included managing client relationships and assisting clients with various group claim issues. He has over 18 years of group claims experience in both the direct insurance and reinsurance markets. He is an MBA graduate of the Université du Québec à Montréal (UQAM) and the Université Paris-Dauphine.

Despite the warning about using templates, many insurers do use them. The following suggestions will help to ensure your letters are well-structured:

Use paragraph headings

Headings can help organize and communicate what you have to say and guide the reader to the information. Examples of possible headings include:

- Medical Information
- Benefit Calculation
- Policy Definitions
- Information Needed From You (that is, the claimant)
- Appeal Process

State your decision in the first paragraph

- Claimants want to know the status of their claim. It is best not to wait until the last paragraph to do so.

Decide how to present the information relied upon for the decision

- Many letters contain too much medical information, or information that is not presented in a chronological way, which confuses the reader. How much to include really depends on the particulars of a given case – perhaps more, for example, if the decline is due to a pre-existing condition, less if no medical data supports the disability. In either case, consider listing (in bullet form and in chronological order) only the key medical information pertaining to the claim.

Provide policy provision information

- Include all applicable policy provisions relied upon to reach the claims decision, including definitions of relevant terms found within those provisions. An attachment or addendum at the end of the letter can offer verbatim policy language.

Give the rationale for your decision

- Provide a clear and detailed explanation of how the facts of the claim related to the policy provisions outlined to reach the decision. This section should present a clear rationale for your decision, supported by the policy provisions. Statements must be factual, not subjective.

Next steps and what actions are needed from the claimant

- State clearly what is needed. Include a bullet-pointed list of specific information needed from the claimant in order to appeal the decision or pursue benefits beyond a certain period, as well as a timeline to provide the information.

Reservation statement (as required or used by local practice).

- Depending on local practice, such a statement usually explains that the insurer's rights and defenses under the policy have not been waived. These statements are usually drafted by the insurer's legal counsel and/or compliance department.

Closing sentence

- Conclude the letter with ways for the claimant to reach you or your company – for example, "If you have any questions or concerns regarding this matter, please feel free to contact me on the following direct number."

Regulatory Requirements

- Each jurisdiction may have regulatory requirements which must be included in the letter; e.g., contact details, registered office, information regarding the Ombudsman service etc.

Avoid industry jargon

Most people outside the industry (and even some insiders!) do not understand insurance jargon. Using unnecessarily complicated and/or technical language does not help you, your company or the claimant, and is likely to frustrate rather than inform. Although special terms can be useful shorthand in your company and might be the clearest way to communicate with your team, using such terms with claimants can cause misunderstandings, be confusing, and could even alienate the claimant, causing him or her to stop reading the letter entirely. Remember, terms that you know well may be meaningless to your audience.

We are not advocating leaving out necessary technical terms, but simply promoting the use of clear, plain language. When setting down your thoughts in writing, consider these suggestions:

Avoid acronyms

- Claimants might not understand them and could find them irritating. If, however, it is necessary to use an acronym, define it the first time you use it; e.g., "Total and Permanent Disability ("TPD")."

Define technical terms

- Technical terms should be as defined in the policy and explained. Use the Policy Definition section of your letter to define each term.

Be concise

- Stick to your points and keep them brief. The claimant does not want to read three paragraphs when the message could have been given in one. Use short sentences, delete unnecessary adjectives or filler words, and avoid repeating the same point.

Write once and check twice.

- Ensure you have proofread your letter. (Ask a co-worker to proofread your letter as well!) Any errors or typos, however small, could create unnecessary misunderstandings and confusion for a claimant. Always double-check genders, names, dates, specific periods mentioned, benefit calculations, and policy definitions (total disability, pre-existing condition, eligibility, etc.).

It might seem like more work, but focusing on these simple points will improve the quality and clarity of your written communications. The benefits of doing so are twofold: It will be easier to communicate your decisions and rationales; and claimants, although they might not always agree with your decisions, will be more likely to understand your rationales and know exactly what actions and next steps are needed. ■

NEW on GUM: Claims Best Practice Guide

By Peter Barrett, Global Head of Claims, RGA UK Services Limited

GUM's new online Best Practice Guide has been developed by RGA's Claims department to offer practical advice on all aspects of claims management for Critical Illness (CI) and Total and Permanent Disability (TPD) cover. Information about best practice when managing health, disability income and life claims will be added to the Guide over the course of this year.

How has the Guide been developed, and how will you be able to access it?

Development of the Guide

To ensure the Guide has a truly global feel, claims staff from RGA offices around the world formed working groups, each of which was tasked with writing Guidance Notes about the following key areas of claims handling:

- Claims assessment principles and processes
- Policy conditions
- Assessment tools and resources
- Claims challenges
- Claims management and communication
- Reporting and claims trends

These Guidance Notes were then finalized before being organized into an online Reference Guide.

The Guide contains the following features:

- Related sections are linked for easy cross-referencing
- Shows 'hidden' information to users when they click buttons and other interactive controls
- Plays videos and other media
- Tests a user's knowledge with interactive quizzes
- Provides users with access to other useful resources within GUM

Access

The Guide will be available on the Claims section of GUM at the end of March. To access, you will need to be a registered GUM user and accept the terms of use.

We hope you find the Guide a helpful and informative desktop reference tool. Please help us keep it current by emailing us at RGAclaimsBPG@rgare.com with your enhancement ideas.

For further details please contact:

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