FCA INFORMATION REQUEST – GENERAL INSURANCE VALUE MEASURES PILOT

Scope

General Insurance products
List of pilot products (excluding reinsurance contracts):

- Home (**combined** buildings and contents policies) - Contracts of insurance against loss of or damage to both the structure of domestic properties and contents of domestic properties and including cover against risks to the persons insured incurring liabilities to third parties arising out of injuries sustained within the boundary of a domestic property. **For the purposes of the pilot, this excludes contents-only policies and buildings-only policies.**

- Home emergency sold as a stand-alone product or as an add-on to home insurance - Contracts of insurance relating to household assistance which fall within class 18. For the avoidance of doubt, contracts of insurance which include an element of service fall within this category provided they relate to household assistance.

- Personal accident sold as an add-on to motor insurance and home insurance – contracts of insurance sold as an add-on which fall within classes 1 or 2 of the 2001 Regulated Activities Order and which are not medical expenses cover, healthcare cash plans, travel and creditor

- Key cover sold as an add-on to motor insurance – Contracts of insurance sold as an add-on to motor insurance and relating to cover for lost, stolen and/or broken keys.

Sales
Sales to individual consumers in the UK are within scope. Group policies are out of scope.

Reporting responsibility
Insurers will be responsible for reporting on the products that they underwrite, including where they have set up delegated underwriting authority arrangements.

Lloyd's managing agents will be responsible for reporting on the products where they manage the underwriting capacity of Lloyd's syndicates.

Reporting period
The reporting period for this information request is the year ended 31 August 2018.

Reporting thresholds
Insurers will be required to report data for each of the products in the pilot provided they meet for each product both thresholds set out below:

	Must meet both thresholds	
	Total retail premiums (written)	**Average policies in force during the relevant period**
Home (Buildings and contents)	> £1,000,000	> 3,000
Home emergency	> £400,000	> 3,000
Personal accident (add-on)	> £400,000	> 3,000
Key cover (add-on)	> £250,000	> 3,000

Scenario: If total retail premiums written for personal accident in the relevant period exceed £400,000 and there are over 3,000 average policies in force then the firm should complete the relevant rows of the attached spreadsheet for that product.

Notes on completing the proforma

PLEASE NOTE THAT THERE HAVE BEEN MINOR AMENDMENTS TO THE INFORMATION REQUEST AND GUIDANCE FROM THE 2017 PILOT DATA COLLECTION. THE CHANGES ARE IN BOLD, STRIKETHROUGH OR UNDERLINED**.**

Note	Proforma	Guidance (for the purposes of the pilot)
1	Add-on and stand-alone sales	For the purposes of the pilot an add-on is a general insurance policy with separate cover and premium sold alongside or in connection with a primary another policy or a non-insurance product or service. For example, as noted above, key cover can be sold as an add-on to motor insurance. Where cover is included within the core cover of a policy and not a separate policy, or part of the standard cover of home, the data for that product/cover should be included in the reporting for home. For the purposes of the pilot, accidental damage would not be treated as an add-on to home. **However, where firms have legal protection cover included in their core home product then they are permitted to report two sets of data for their home data;** • **one with the legal protection cover included; and** • **another with the legal protection cover excluded from the home data.** **Alternatively, firms (who have legal protection cover included in their core home product) can report one dataset for their home data with legal protection cover included.** Stand-alone = A general insurance policy not sold alongside or in connection with another policy.
2	Distributors and brands (list largest 5 for each reporting row)	For example list the largest (by level of retail premiums for that reporting row) five distributors/ brands for that reporting row. Some insurers operate a delegated authority model under which cover holders may vary the terms and conditions. If this applies, please list the largest five distributors or brands here, but provide consolidated figures for all sales when reporting elsewhere in the proforma. Please confirm in your answer to this question if you operate this type of model. Please note that all data requested elsewhere in the proforma is at product level for your firm and should not be split by distributor or brand. Nor should it be limited to the largest 5 distributors/ brands.
3	Number of policy sales to UK consumers	This would not include group policies, but is instead based on the number of individual policies sold to UK consumers. This includes renewals as well as new sales.

Note	Proforma	Guidance (for the purposes of the pilot)
		This will be the number of sales in the year ending 31 August 201**8** (regardless of the period covered by the sold policies).
4	Total retail premiums (written)	This is the total gross retail premiums, based on the premiums charged to the end consumer (net of IPT), for the policies sales to UK consumers (see note 3). The reported data should exclude adjustments to premiums resulting from mid-term adjustments or cancellations as well as excluding other income such as cancellation fees, change of address fees and other fees and charges related to the policies.
5	Average premium	Total retail premiums (written) (see note 4) divided by the number of policy sales to UK consumers (see note 3).
6	Number of claims registered	Number of claims registered in the year ended 31 August 201**8**. Claims registered means a report or communication from a retail customer to raise a claim on their insurance policy, where the insurer has registered the claim on their system. <u>*Scenarios*</u> Where an event covers multiple claim components this should be treated as a single claim. Where a customer contacts the firm to report an event as required under their insurance policy but does not wish to make a claim, this should not be treated as a registered claim. Enquiries should be excluded from the reported data. Where a customer initially calls to make a claim and is advised at that time that the loss is not covered or the claim is below the policy excess and decides not to pursue a potential claim further then this should be treated an enquiry and be excluded from the reported data. Where a claim is registered but not subsequently pursued (ie the customer does not contact the firm again) then the claim should be included within claims registered.
7	Average number of policies in force	Average policies in force (excluding group policies) during the year ended 31 August 201**8** – based on the number of policies in force at the end of each month during the year, and dividing the total by 12 to arrive at an average for the year.
8	Claims frequency Data for claims frequency will be published in bands.	Number of claims registered (see note 6) divided by the average number of policies in force (see note 7).
9	Number of claims where all or part of the claim has been accepted and a pay-out	This should include all claims where a firm has paid-out on a claim during the year ended 31 August 201**8** and there are no elements of the claim which are outstanding at the year-end (i.e. the claim is closed or settled). This will include claims which were registered in

Note	Proforma	Guidance (for the purposes of the pilot)
	has been made (and the claim is closed at the year-end (e.g. 31 August 201**8**)	previous reporting periods but paid-out in the year ended 31 August 201**8.** *Scenarios* If a firm pays out on one element of the claim, but is still investigating another element of the claim at the year-end (i.e. the claim is still open) then this claim acceptance would be captured in the year that the final pay-out has been made and the claim closed. If a firm pays out on one or more elements of a claim, but rejects other elements of the claim (and the claim is now closed) then these claims should be included in this data field. If a firm pays out on one or more elements of a claim and there are no outstanding elements of the claim at the year end, these claims should be included. If in the subsequent period, the claim is reopened then this subsequent element of the claim should not be included in this data field.
10	Number of claims that have been rejected in the year ended 31 August 201**8**	Claims rejected will include claims registered which are subsequently declined/rejected in the year ended 31 August 201**8** for the following reasons: - **Exclude from the figures** cases of proven fraud. For the purposes of the pilot, proven fraud will be cases meeting the Insurance Fraud Register definition of insurance fraud (http://www.theifr.org.uk/en/faqs/#1175). - **Include** claims rejected because of breach of condition of the policy (for example where a claimant failed to notify the insurer within an appropriate time period after an event that was likely to result in a claim) - **Include** claims rejected because there is no cover (for example, where there may be exclusions under the terms and conditions) This will include claims which were registered in previous reporting periods but rejected in the year ended 31 August 201**8.** *Scenarios* Where a firm rejects one element of the claim but other element(s) of the claim are still being investigated and are outstanding then this partial rejection should not be included in this data field for this year. However, if in the following year the remaining elements of the claim are rejected then the claim should then be included in this data field for that later year. Where a firm accepts one element of the claim but rejects another element of the claim, this should not be treated as a rejected claim. Where a claim has been rejected because the policy has been voided, this should be excluded from the rejected claims.

Note	Proforma	Guidance (for the purposes of the pilot)
		Where a customer has contacted the wrong insurer to make a claim – this should not be included in the registered and rejected claims data. Where a customer contacts the firm to enquire whether they are covered for a claim and are informed that they are not covered then this should be excluded from both rejected and registered claims (regardless of whether the enquiry has been recorded on the firm's system). Where an insurer is part of a panel and the panel provider may not record which of the insurers on the panel that a claim was rejected by or on behalf of – allocating a proportion of rejected claims in line with the insurer's share of the business could be reasonable basis for estimating the number of rejected claims.
11	Claims acceptance rate Data for claims acceptance rate will be published in bands.	= (Number of claims registered (see note 6) less the number of claims that have been rejected in the year (see note 10)) Divided by The number claims that have been registered (note 6).
12	Total claims pay-out Cost (for claims where all or part of the claim has been accepted and a pay-out has been made and the claim is closed at the year-end).	For the claims where all or part of the claim has been accepted and a pay-out has been made and the claim is closed at the year-end (note 9) the claims pay-out cost includes: - Total monetary value (£) of direct claim pay-outs to policy beneficiaries; - Other costs incurred by the firm which directly benefit the customer (e.g. the cost to repair a damaged wall for a home insurance claim or the cost of a home engineer for a home emergency claim); - Specific claims costs incurred handling of individual claims. This could include claims investigation costs; - Pay-out cost. These costs could include both internal and external outsourced costs, where relevant. For example loss assessment activities performed in-house could be included, including both the direct cost and an appropriate apportionment of overheads. <u>*Excluded costs*</u> - Expenses including costs associated with the general handling of claims - Other non-claims costs - Costs of providing a regular service element such as a helpline or a boiler service for home emergency. <u>*Scenarios*</u> Where part of the claim was paid-out in the previous year but part of the claim was still outstanding at the year end the final pay-out in

Note	Proforma	Guidance (for the purposes of the pilot)
		respect of the claim took place in the current period, then the claim pay-out that took place in the previous year should be included in the calculation for the current period. Where a claim has been closed/settled in the previous year but the claim has been reopened in the current year, any additional claim pay-out should be included in this field. Where firms subsequently receive recoveries from other firms these recoveries should be netted off against the relevant claim pay-outs. Where a claim is settled, but the settlement include a regular payment element then the settlement value as it is reported on the firm's system should be included in the cost.
13	Average claims pay-out Data for average claims pay-out will be published in bands.	Claims pay-out cost (see note 12) divided by the number of claims where all or part of the claim has been accepted and a pay-out has been made and the claim is closed at the year-end (see note 9).
14	List the top 10 reasons for claims being rejected	Provide the top 10 reasons for claims being rejected, using your own definitions, with the most common reason listed first and the least common reason listed last. If the data is readily available please provide the numbers of rejected claims for each of the 10 reasons for 2018.

Information request and guidance – additional Q&A to assist firms in reporting the data

Product reporting

1. **Where we have cover such as personal accident and home emergency embedded as part of the core home product, should we report premium and claims information for our full home product or just the buildings and contents sections of cover?**

   Where cover is embedded within your home product, the relevant data for that cover should be included in the submission for home and not be stripped out.

2. **Are you also collecting data for home contents-only policies and buildings-only policies?**

   No – for home reporting we are only collecting data for policies which include both contents and buildings insurance.

Data granularity

3. **Do you require the reported data to be split by the largest 5 distributors/ brands?**

   No – data should be reported at firm level capturing all the relevant business for that product rather than only capturing or reporting data for the largest 5 distributors/ brands. We requested information on the names of the largest distributors/ brands to help users understand the main distributors selling the pilot products underwritten by insurers. Hence, note 3 onwards refer to all business and not just the top 5 distributors/brands.

Rejected claims

4. **In a situation where a claim is closed and the only payment made is a supplier-investigation fee i.e. a call-out charge, should this be included here?**

   Yes – <u>If the claim is rejected following the investigation. However, if following the investigation, the customers walks away from the claim then the claim should not be treated as a rejected claim.</u>

5. **If a claim is registered and no elements are accepted but equally not all elements are rejected i.e. an element may be rejected and another element withdrawn would this be included?**

   This should be treated as a rejected claim for the purposes of the pilot.

Reporting periods

6. **Is it correct that the claims accepted and claims rejected for the current reporting period relate only to the claims that were registered in the current reporting period?**

   No - the claims accepted and the claims rejected figures should not only relate to the claims that were registered in the reporting period and accepted or rejected in the period, but should also capture claims which were registered in a previous period, but were rejected or accepted and paid out in the current reporting period.