Financial Conduct Authority

August 2025 update:
This review is historical. See What we publish for more information and current views.

Thematic Review TR14/8

Insurers' management of claims – household and retail travel

Report on the thematic project

May 2014

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1. Reasons for the project, its scope and format

Reasons for the project

In general insurance the point of claiming is the moment of truth when the consumer, as the policyholder (referred to as 'consumer' or 'policyholder' in this Report), finds out whether the claims service and claims outcomes an insurer delivers match what the consumer believes they bought. Consumer detriment can potentially occur in a number of ways including: unmerited rejection of the claim; a less than fair settlement; undue delays in the settlement occurring; and, an unsatisfactory process in handling the claim.

The last review in which claims were a major focus was in 2006. At that time the Financial Services Authority (FSA) carried out a review of how far the Insurance Conduct of Business (ICOB) requirements delivered against various consumer outcomes, including claims. It was concluded that insurers' processes were generally compliant.

The intention was that the current thematic project should be broader in nature than the previous one and would include consumer research among successful and unsuccessful claimants. The intention was not to test whether insurers are complying with our rules but to find out what consumers' experience is at the point of claiming. In assessing this, the criteria we applied included:

- Satisfaction levels among consumers making a claim, as revealed by the consumer research; this included consumers' views on what had gone well and what could be improved.
- Consumers' experiences as revealed by listening to live claims calls and reviewing closed files.
- How well firms are meeting their own aspirations about what they are seeking to deliver at the point of claim.
- Comparisons between firms.

In summary, the aim was that the project would enable the Financial Conduct Authority (FCA) to determine:

- The extent to which consumers as claimants are at the heart of general insurers' businesses, and the dimensions of how this varied between firms.
- How a sample of individual claims have been handled by each of the insurers in the project, for example, in not being unfairly repudiated according to the terms and conditions of the policy and Financial Ombudsman precedent.

- What processes insurers follow in handling claims. For example how much communication there was with consumers during a claim, and how supply chains are managed and incentivised.

- What is important for consumers in the handling of claims. And how the actual experience of consumers who have sought to make, or have actually made, a claim matches this.

- What balance insurers strike in dealing with potential fraud between, on the one hand, being vigilant and, on the other, not causing difficulties for honest policyholders in claiming.

Scope of the project

We focused attention on two products: household (both buildings and contents); and retail travel. Household was chosen because, after motor, it is the largest personal product line by premium volume. Travel was chosen because it is a very diverse market: there are many suppliers; and cover can be bought for a single trip, as an annual policy, or provided as part of a packaged bank account. A variety of sources, including our ongoing supervision and correspondence we have received, indicated that there might be problems in the extent of cover provided and its interpretation by consumers. Motor was not included in the project because of the attention it has received, first from the Office of Fair Trading and latterly from the Competition Commission.[1]

The project was confined to claims where the individual consumer has a contractual relationship with their insurer. So liability claims under household policies were out of scope, as were claims brought under group travel policies.

Ten insurers were involved in the project. They were selected against a range of criteria including: size; product range; and business model. The firms included London Market insurance companies and Lloyd's managing agents as they often delegate the underwriting of retail business and the handling of the claims to coverholders (such as brokers) and third party administrators (TPAs). We wanted to see how claims are handled across these chains of delegation.

As the focus of the project was on claims we did not explicitly look at sales-related matters such as how household and retail travel products are sold to the consumer, how the nature of the explanation of the product varies by distribution channel, and how consumers engage in this sales process. However, it became clear, from our consumer research and discussions with firms, that consumers' understanding of the products they bought influences their claims. So we do comment in the report on sales-related matters where these came to our attention as being particularly pertinent to claims and the outcomes for policyholders.

Format of the project

The project had five main strands:

- Investigative firm-facing work.

1 Competition Commission: Private Motor Insurance Market Investigation: http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-motor-insurance-market-investigation/provisional_findings_report.pdf

- Consumer and other research.
- Engagement with stakeholders.
- Feedback to individual firms and insurers generally.
- Publication of our report.

The **investigative firm-facing work**, which was undertaken between August and November 2013, comprised:

- An initial information request that was sent to each of the ten insurers.
- This was followed by interviews with the senior management, typically at CEO and Director of Claims level. A number of non-executive directors were also interviewed to find out what consideration there was of claims – particularly conduct-related aspects – at Board level.
- Visits to the claims operations of the insurers, including coverholders and TPAs in the case of the London Market firms. In total 18 sites were visited. These visits allowed us to talk to the managers running the claims operations, team leaders and individual claims handlers. We listened to in-bound and out-bound phone calls (about 170 in total). This was invaluable in showing the realities of claims, both for policyholders and claims handlers. We also reviewed a random selection of successful and declined claims at each of the insurers. More than 350 files were reviewed in total. Some examples of what we saw are provided in this report to illustrate the range of what consumers can experience.
- Accompanying both in-house and third party loss adjusters handling household claims. This allowed us to see at first hand a variety of claims – including fire, theft, escape of water, storm, subsidence – and how the adjusters engaged with consumers.
- Review of over 50 travel complaints to give us a deeper understanding of the problems consumers experience in relation to medical conditions.

The elements of the **consumer and other research** were:

- At the beginning of the project we commissioned a market research agency to conduct two focus groups with people who had recently made a claim – whether successful or unsuccessful – on their household or travel insurance. These groups were carried out to reveal what, in the light of the consumers' experience, was important for them in the handling of their claim, and what an 'ideal' experience would entail.
- The results of the focus groups were used to help form the questions for the quantitative research survey that followed. A total of 1,557 consumers who had claimed on their household or travel insurance were interviewed. People were chosen at random from lists of recent claimants supplied by the insurers. Of those interviewed, 1,028 had made a successful claim, 429 had had their claim rejected, and 100 had decided to withdraw their claim. One of the aims of the quantitative research was to enable comparisons to be made between firms. (We had also hoped to see whether claims results differed by distribution channel. However, configuring the research to capture this level of detail proved too complicated.[2])

2 This proved too complex as firms differed in their approach to capturing distribution method and some were unable to provide this level of information.

- The research agency also carried out detailed face-to-face interviews with 20 people who took part in the quantitative survey to bring to life the range of experiences identified.

- The Chartered Insurance Institute (CII), working in conjunction with the FCA, carried out a short on-line survey of its members. This elicited the views of insurance professionals in their private capacity, and so offered a different, albeit still an industry, perspective on industry practices to feed into our review. In total 804, CII members completed the survey on household insurance and 322 on travel insurance.

Detailed findings from the work undertaken by the market research agency and the survey of CII members can be found in appendices 1 and 2.

In the early stages of the project we **engaged with stakeholders** to carry out informal consultation to help define the exact scope of the project. Later, as findings began to emerge, we discussed these, their implications, and possible solutions, with stakeholders, some of which would have a role in taking forward the solutions. The stakeholders comprised trade associations (Association of British Insurers (ABI), British Bankers' Association (BBA), British Insurance Brokers Association (BIBA), London & International Insurance Brokers Association (LIIBA), Association of British Travel Agents (ABTA)), consumer organisations (Which?, Age UK, Citizens Advice) and also the Financial Ombudsman Service and the Corporation of Lloyd's. Ideas and views were also provided at various stages by a number of consultancies.

Feedback to insurers involved in the project was provided informally at the conclusion of the visits to claims operations, giving our immediate views on what we had seen. In a number of cases we required the firm to take action to correct problems. Later, more structured feedback was provided to the senior management of each of the ten insurers; this included the firm-specific results from the quantitative consumer research.

Previous thematic projects on topics such as motor legal expenses insurance and mobile phone insurance have shown the benefit of holding seminars for industry participants. These have enabled us to relay the findings of our project directly to firms, set out our expectations going forward, and allowed firms to comment. A seminar targeted at chief executives and directors of claims was held at the FCA on 9 April.

Our rules as they relate to claims – an overview

The FCA's rules on insurance claims handling, which are set out in the Insurance Conduct of Business Sourcebook (ICOBS), require (amongst other things) that insurers must:

- handle claims promptly and fairly
- provide reasonable guidance to help a policyholder make a claim and appropriate information on the progress of the claim
- not unreasonably reject a claim, and
- settle claims promptly once settlement terms are agreed[1]

More generally, FCA regulated firms are subject to certain High Level Standards, which include those rules set out in the Principles for Businesses Sourcebook (PRIN) and the Senior Management Arrangements, Systems and Controls Sourcebook (SYSC). For example, firms must:

- conduct their business with integrity, due skill, care and diligence
- take reasonable care to organise and control their affairs responsibly and effectively, with adequate risk management systems
- pay due regard to the interests of their customers and treat them fairly, and
- pay due regard to the information needs of their clients and communicate information to them in a way which is clear, fair and not misleading[2]

In addition, firms must take reasonable care to establish and maintain such systems and controls as are appropriate to their businesses.[3] The nature and extent of the systems and controls which a firm will need to maintain will depend on a variety of factors[4] and further guidance on some of the main issues which a firm is expected to consider in establishing and maintaining the systems and controls appropriate to its business is in the FCA Handbook[5] (including, for example, on external delegation or 'outsourcing'[6]). A firm must also take reasonable steps to establish and maintain adequate internal controls.[7] Guidance on internal controls is also in the FCA Handbook.[8]

Firms should ensure that lessons learned as a result of determinations by the ombudsman are effectively applied in future complaint handling.[9]

As is pointed out elsewhere, this thematic review has not given detailed consideration to whether rules such as those highlighted above are being met. The rules referred to here are not intended to be an exhaustive list of an insurer/firm's regulatory obligations and other regulatory provisions may also be relevant depending on the circumstances.

1 ICOBS 8.1.1 R
2 PRIN 2.1.1 R
3 SYSC 3.1.1 R
4 See further SYSC 3.1.2 G and the paragraphs which follow it.
5 SYSC 3.2
6 Note also SYSC 13.9
7 SYSC 14.1.27
8 SYSC 14.1
9 DISP 1.3

2. Claimant satisfaction levels and insurers' approach to claims

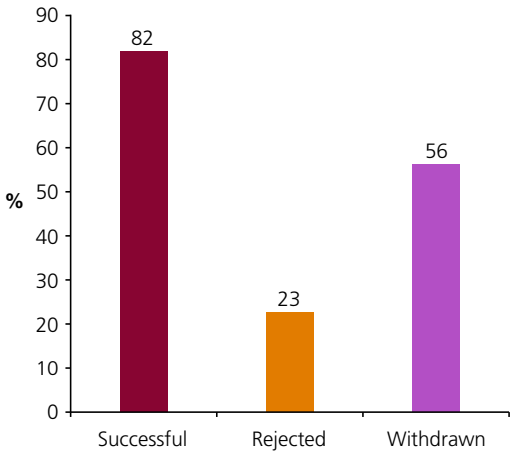
The results of our consumer research are broadly consistent with what emerged from the investigative firm-facing work. They show that insurers handle many claims to the satisfaction of policyholders. However, there are also areas where there is scope for insurers to enhance their claims service if they wish to increase satisfaction levels among consumers. These are both consumers who have been successful in making a claim, those whose claim is rejected by the insurer, and those where the consumer has decided to withdraw their claim.

Satisfaction levels

Three categories of claimants were covered in our research: successful, rejected and withdrawn. Across the three categories 64%[3] were 'satisfied' or 'very satisfied' with how their claim was handled overall.

Among policyholders who were successful in making a claim, a large proportion (82%) were satisfied with their experience. Not surprisingly, satisfaction levels among claimants who had their claim rejected, or decided to withdraw their claim, were much lower, as shown in Figure 1.

Figure 1: Percentage of consumers who said they were satisfied or very satisfied with the handling of their claim

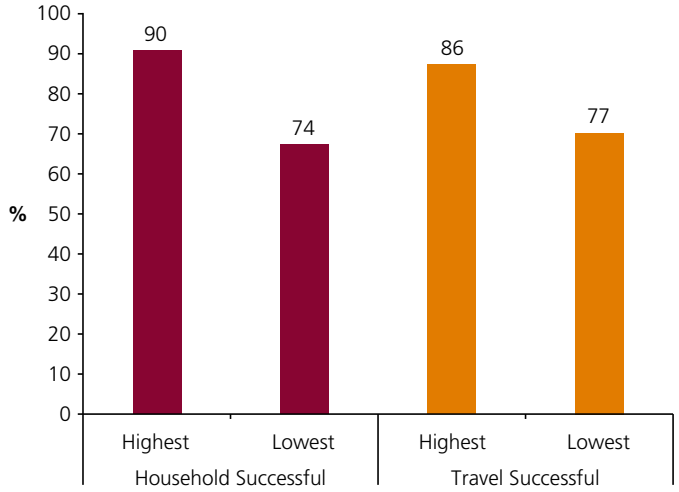


Base: All qualified respondents (excluding 'not sure'). Successful (1021), rejected (418), withdrawn (99)

3 This 64% is calculated based on all qualified respondents (excluding 'not sure'). Successful claimants (1,021), those who had their claim rejected (418) or withdrew their claim (99).

The consumer research also measured satisfaction levels for individual insurers, where sample sizes allowed this. Figure 2 shows the range of satisfaction levels for individual insurers. For household, satisfaction among successful claimants, ranged from 90% for the highest performing insurer to 74% for the lowest performing. For travel insurers, the range was 86% to 77%.

Figure 2: Comparison of the the highest and lowest performing firms in relation to the percentage of consumers who said they were satisfied or very satified with the handling of their claim



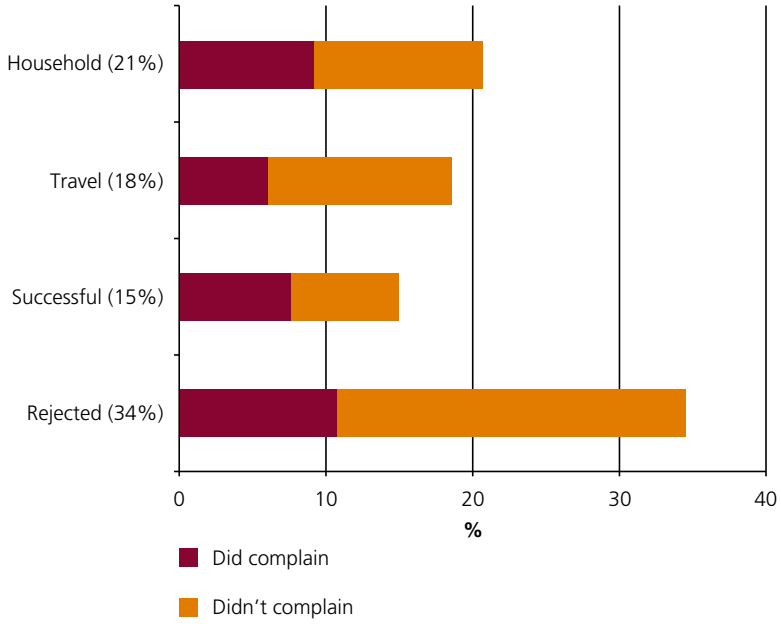
Base: All qualified respondents (excluding 'not sure'). Household highest (93), household lowest (92), travel highest (96), travel lowest (96 and 79).

In the research we asked people about the emotional and financial impact of claims on them. Not surprisingly, this showed that events, such as a fire or flooding, which can cause serious damage to a person's home, have a major emotional impact. However, the proportion of claimants who rated the emotional impact of their claim as 'High' was greater in relation to travel claims – at 46% – than household (39%) We can speculate that the reasons for this may be that people feel particularly vulnerable when they are abroad, and that people look forward to a holiday and so feel upset if it has to be cancelled. What these results show is that even what appear to be straightforward travel claims need to be handled sensitively by insurers.

Complaints

About 20% of claimants said they felt like complaining at some stage during the claims process. Yet only about one-third to one-half went on to make a formal complaint. This indicates that if insurers want to understand more about consumer's experiences – and their feelings – then they should collect information from a range of sources, both formal and informal, throughout the claims process.

Figure 3: Percentage of claimants who felt like making a complaint (and whether they did so)



Base: All qualified respondents. Household (976), travel (581), successful (1028), rejected (429)

Among those claimants who did make a formal complaint the majority were dissatisfied with how this was handled. This was true even among successful claimants – 52% of successful claimants who complained were dissatisfied. Perhaps not surprisingly dissatisfaction levels were even higher among unsuccessful claimants – at 76%. The principal reasons for dissatisfaction surrounded poor communication, delays, and nothing changing as a result of the complaint.[4]

Among CII members who completed the online survey, 65% agree that complaints are handled fairly with regard to household insurance, and 45% agree as regards to travel.

The insurers' approach to claims

In an initial information request to insurers we asked for details of their claims philosophies. In addition, three of the insurers provided us with claims strategies. We found these particularly useful because they set out formally what changes to its claims operations the insurer intends to make, typically over the next three years, the resources implications of this, and what these changes will mean for consumers as claimants.

We found virtually no evidence of insurers trying to push down aggregate claims costs by not settling valid claims, or systematically trying to squeeze the settlement cost. Nor did we see evidence of insurers deliberately delaying settlement, though in a good number of cases this took longer than it might otherwise have done because of poor management of the claim.

Firms pointed out that their interests and those of policyholders coincide. Claims settled quickly with the minimum number of 'touches' increase consumer satisfaction. They also keep

4 Note, bases sizes for claimants who made a complaint are as follows - successful (68), rejected (49).

the insurer's expenses down because the need to handle calls from policyholders chasing progress, and for reworking or corrective action, is avoided. If claims are handled expeditiously, indemnity spend is also kept down, for example because claimants are not housed in alternative accommodation longer than is necessary.

Insurers told us that the major affinity partners – especially those with a high street brand – are extremely protective of their reputation and exercise influence on insurers to treat their customers well. In one case this extended to the affinity partner being involved in interviewing people to be recruited to handle claims on their account; it rejected some candidates.

Even within the same insurer, policyholders' experience in the handling of their claims can be variable. In some cases it can be very poor. One householder had to endure five attempts by his insurer's supplier to fit the right replacement glazing. A number of the insurers articulated the same vision, especially on household, as to what policyholders' claims experience should be. This was that a policyholder should only have to make a single inbound call initially to report their claim. All subsequent calls would be outbound ones from the insurer or their suppliers – to arrange appointments, to discuss options for settlement etc. At present, insurers are a considerable way from consistently delivering a claims experience that meets the vision to which they aspire.

One of the factors that distinguished insurers in the project was the extent to which they are actively challenging themselves to enhance their claims performance. Particularly important in this is how rigorous they are about collecting data about consumers' experience throughout the claims process and feeding this back to improve products, sales and claims processes. This data can be formal, such as consumer research and complaints. Or it can be informal, such as what policyholders say over the telephone during claims-related calls or details of where things go wrong with suppliers – if an appointment is missed or workmanship is unsatisfactory.

Feedback of consumer information into clearer and wider policy coverage
In 2012 the household insurer changed its policy to provide cover for Trace and Access of water leaks, in relation to damage caused by Escape of Water. The change was made following analysis of customer complaints and feedback. The company decided that further water damage from leaks could cause greater damage and costs if not traced.

Organisation of the claims function

We saw a number of different models as to how firms organise their claims functions. Some have a single claims handler who, subject to holidays and cover being provided outside normal hours, 'owns' a claim; this is particularly the case with the emergency assistance activities of travel insurers. Other insurers allocate claims to teams rather than individuals because they feel that this is more robust during surge events such as floods and winter storms. One household insurer routes claims to teams based on the insured peril that has caused the loss. A number of insurers seek to resolve as many straightforward claims as possible during the first claims call (what insurers term the First Notification of Loss or FNOL).

Our investigative firm-facing work was undertaken between August and November 2013, before the recent winter storms and flooding. A theme in our discussion with household insurers was how they deal with the surge of claims that can follow extreme weather. Insurers'

contingency plans vary, in part depending on the magnitude of the surge. However, the plans typically have two elements. The first involves redeploying staff, who have been cross-trained in handling household claims, from other claims areas and/or from sales. The second involves the use of third party loss adjusters to provide overflow capacity.

Some of the larger household insurers have their own in-house force of loss adjusters. Having direct control of dedicated resources can, they believe, provide advantages during surge events in being able to ensure that there is an on-site presence. With ordinary, non-surge claims, it also allows the firm to send a representative to a policyholder's property where the age or vulnerability of the consumer indicates that an on-site presence will provide reassurance.

For travel insurers, the claims' peaks are more predictable, occurring during the summer holiday period and during the skiing season. Travel insurers plan the resources that will be required to meet the higher incidence of claims that will arise. In the case of one insurer, unexpected staff shortages had resulted in a backlog of claims over the summer of 2013. Evidence of the problems this had caused for some consumers came through in our research. Subsequently, the insurer had put in place plans to ensure that this problem did not recur.

Our consumer research found that insurers generally satisfy consumers in their handling of claims at FNOL, doing a good job of reducing stress and anxiety. While FNOL processes varied according to the structure of the claims operation, several insurers spoke of the importance of getting things right at the outset rather than having to correct compounded errors at a later stage.

Travel case study – the importance of handling the initial call well

"I was apprehensive, I had no experience of claiming before so I didn't know what to say, I was not sure because I felt it was my fault, but she was good, it was her manner, she made me feel better."

From what we saw, no one model of how to organise a household claims function appears to have obvious advantages over another. One observation however is that in some firms FNOL teams can exercise a mainly administrative function – taking down details of the claim and setting up a file – with the claim then being passed to a 'Day Two' team which takes over its handling. Our consumer research showed the importance of the interaction at FNOL for claimants, in providing reassurance and advice, and explaining what would happen next. FNOL teams that are configured to exercise a largely administrative role, in merely taking down details of the claim and telling the consumer when they will be contacted again, may not provide the service policyholders seek.

As regards travel, some of the insurers included in the project locate their emergency assistance operations and the handling of baggage and cancellation claims on the same site. Others have these claims functions at separate sites. Based on what we saw, co-location seems to have benefits in the handling of non-emergency claims. The medical expertise required to handle assistance claims is readily available for consultation on cancellation claims. There is more seamless handover between claims events that have occurred abroad and those where the policyholder is seeking to claim once they return home. Typically this is for out-patient medical expenses or incidental costs incurred as a result of hospitalisation.

Household compared with retail travel

Having two product lines in the project provided an illuminating contrast between household and retail travel. Household is a larger and more profitable market. There are competitive incentives to improve claims service to secure business, whether direct or through brokers and affinity partners. We saw substantial evidence of innovation and insurers challenging themselves to enhance their claims service. By contrast, few of the insurers demonstrated much enthusiasm for retail travel, which is generally not profitable. Insurers also talked less about innovation in their claims service.

A number of insurers are at the early stages of enabling consumers to notify claims, and send documentation to support a claim, electronically. This includes consumers being able to send images in real time of damage to a claims handler through their smart phone. This technology appears to be experiencing some teething problems – for example, in the size of files policyholders can send – but as it progresses it could speed up settlement times, particularly for more routine claims. Our research revealed effective communication to be important to consumers and a key driver of their satisfaction.

Some insurers are beginning to use email and SMS to keep policyholders informed about their claims. Use of these means of communication appears rather sporadic at the moment but may become more routine in future. Insurers are also beginning to send policyholders electronic communications in advance of potential claim events such as storms or floods to tell them what precautions to take to prevent damage.

3.
Issues emerging from the project

The key issues

The findings of this project are many and wide-ranging. Some were firm-specific. Seven of the issues can be regarded as key. These are:

- Recording and use of inbound claims calls (mainly household).
- Communication and ownership throughout the claim.
- Management of supply chains (household).
- The emergency assistance activities of travel insurers and the need for the right insurance.
- Insurance in relation to medical conditions (travel).
- Consumer outcomes in long chains of delegation.
- The clarity of product documentation.

Recording and use of inbound claims calls

Insurers receive high volumes of claims-related calls – particularly in household – which do not result in a claim. The call may be because the consumer wants to make a Buildings claim but only has Contents cover with the insurer. Or they may want to make a claim for Accidental Damage but do not have this in their policy. Or they may know they do not have cover but need help – because water is leaking through their ceiling. One insurer's figures show that 22% of calls in one month were 'Not Pursued'. (The calls 'Settled with Payment' were 60% and 'Declined' were 18%.)

Across insurers there is no consistency in how these in-bound calls and results are categorised. It was therefore not possible to get a picture across insurers of what proportion of calls, or claims consumers are seeking to make, result in settlement compared to how many are rejected and how many withdrawn.

Inbound call traffic is potentially an important source of information for insurers, if categorised and analysed carefully. It can reveal matters such as where consumers are confused about the terms of their cover, including excesses, and where this most commonly occurs. It can show whether this confusion is due to the complexity of the product itself or how it is sold. It can also provide information about needs that the insurer is not currently meeting, such as consumers seeking assistance to deal with damage to their property, even where they know there is no insurance in place.

Our discussions with household insurers showed that the degree to which individual firms recognise how important these inbound calls are – especially where they do not result in a successful claim – varied considerably. In addition some insurers are thinking actively about how they can assist consumers – and so not leaving them to fend for themselves – where there is no cover in place.

Given the variation between insurers as to how information is recorded, we considered whether this could extend to information recorded on industry databases such as the Claims Underwriting Exchange (CUE). We explored this topic with Insurance Database Services Limited, which is responsible for CUE. This discussion confirmed that there is variation among insurers as to what is recorded on CUE. Also insurers have varying approaches and procedures for using this information.

There is no common approach among insurers. As the industry moves towards increased use of databases at the quotation and underwriting stages, it may want to be mindful of the implications of the lack of a common approach and whether this has potential to cause harm to consumers.

Communication and ownership throughout the claim

Our consumer research showed that consumer satisfaction at first notification (FNOL) is reasonably high. 87% of successful claimants and 58% of unsuccessful claimants were satisfied with regard to the helpfulness of the person they first spoke to. FNOL was also particularly important in reducing their anxiety and stress.

Consumers who are 'very satisfied' or 'satisfied' regarding aspects of the subsequent handling of their claim was fairly high, particularly for those who had made a successful claim. However, during our review of claims files and when listening to claims calls, we saw a number of examples where things went wrong in the processes for the ongoing handling of the claim and keeping the claimant informed. Also, the consumer research revealed that good communication throughout the claim is an important driver of policyholders' overall satisfaction. The six aspects highlighted by the research are covered below:

Setting and managing expectations

Many insurers recognise the importance of clearly setting out for consumers what will happen during a claim and when this will take place. Equally, insurers told us of the need to re-evaluate progress throughout the claim, adjusting targets and consumer expectations accordingly. However, we saw a number of instances where this hadn't happened as effectively as it might have done. This caused delays and additional work for claims staff, and frustration or unexpected disruption for policyholders.

Handling claims for escape of water and flood exemplifies some of the ongoing challenges insurers face in setting and managing consumer expectations. Initially, consumers might not appreciate the severity of the damage or underestimate the time they will need to spend in alternative accommodation. Drying the property then takes time before repair to the buildings and replacement of contents can take place. The character of these claims requires ongoing monitoring of progress and careful, proactive management of consumer expectations throughout.

Household case studies involving loss adjusters – demonstrating that how the loss adjuster behaves has a critical impact on the claimant s experience

A good experience:
"The loss adjuster was very helpful and reassuring, very client centred. I felt a bit out of control of the situation but he was reassuring and said he would manage it all so not to worry. I felt I was in good hands. I had to move out for three weeks, so it was stressful but they didn't make it any more difficult than it had to be. They kept me fully informed and did everything they said they would. I was not made to feel a fool at any point and was allowed to choose the colours and the wallpaper. They settled all the bills. I got a call from the insurer at the end to make sure I was happy."

A bad experience:
"The assessor said I would have to wait for the insurance [company] to contact me, but he didn't say how long that would be. No one got in touch and when I called they said the adjuster was on holiday and it would be another three weeks. It felt like the insurance [company] was having to chase him. Meanwhile my house is still an absolute mess."

Keeping policyholders informed

A particular source of irritation for consumers was not being kept updated during the claim process. The consumer research indicates that two-thirds of consumers were satisfied, or very satisfied, about being updated about the progress of their claim. However, 20% of successful claimants and 34% of unsuccessful claimants were either very dissatisfied or dissatisfied.

Of CII members who completed the survey, a combined 29% for household and travel respondents disagreed with the statement that claimants are kept up-to-date throughout the claims process.

When visiting claims operations, we saw consumers making numerous inbound calls to check progress – particularly on household claims involving multiple suppliers. This was in stark contrast to our experiences of emergency assistance providers. Here, diary management is much more active, with regular calls to the policyholder in hospital overseas (or to the patient's family), for example to check wellbeing or to discuss the logistics of discharge from hospital and repatriation. While communication issues did arise on assistance claims, we observed generally high standards of communication with people in very distressing situations.

All parties knowing what is going on

On more complex claims, a policyholder might come into contact with a number of otherwise unconnected people or organisations besides staff at their insurer (e.g. engineers, builders and loss adjusters on a subsidence claim). 15% of successful claimants and 30% of unsuccessful claimants surveyed said that they were dissatisfied or very dissatisfied with the extent to which different people they spoke to knew what was going on. The survey of CII members also suggests room for improvement with a combined 26% for household and travel respondents disagreeing with the statement that 'claimants do not have to repeatedly explain their claim and provide the same information'.

On complex household claims some insurers take the approach of providing policyholders with a single document in the early stages of a claim. This sets out the respective roles and responsibilities of all of the parties that will be involved.

Clear explanation of the outcome

A key driver of consumer satisfaction is the quality of the insurer's explanation about the settlement – or reasons for repudiation. This can involve conveying complex information (e.g. excess amounts, inner limits, wear and tear deductions, policy wording interpretation etc.) in a clear and fair way. While most insurers had given thought to how they would clearly explain the basis of settlement, we saw some examples where there was little explanation as to how the settlement figure had been reached.

Our consumer research showed the importance of clearly explaining the claim outcome – particularly where the claim was repudiated or settled in part. 57% of consumers with rejected home claims – and 60% with rejected travel claims – were either dissatisfied or very dissatisfied with the explanation given.

Taking ownership

Various operational models are used by insurers to physically allocate and progress claims. But taking ownership goes beyond the physical allocation of a claims file within a process. It is the extent to which claims staff take personal or collective responsibility for key activities, including quickly getting things back on track (and learning from mistakes) when things do go wrong. The following simple example illustrates two different approaches. It is based on real claims we looked at with different insurers:

Case study – the difference between an insurer taking ownership during a claim and not doing so

Example scenario: Mr Y calls his insurer to say that a supplier has failed to turn up for an appointment for the second time – he is clearly not particularly happy.

Response by insurer 1: The claims handler apologises, books another appointment and moves on to the next claim.

Response by insurer 2: The claims handler apologises and assures Mr Y that she will sort things out. She notifies the supplier's manager, asking for a response, and arranges a new appointment. She arranges for her team leader to call Mr Y that day to further apologise, provide reassurance and deal with any complaint issues. The claims handler sets herself a diary reminder to check back with Mr Y that the appointment has taken place. A note of the response from the supplier is passed to the insurer's supply chain management team.

Follow-up call or visit

Consumers said that they valued follow-up at the conclusion of the claim to check that the claim has been resolved satisfactorily. This practice appears most common with repatriation claims handled by travel insurers. However, we also accompanied an insurer's inhouse home claims adjuster to a final site visit with an elderly couple. The adjuster demonstrated empathy and understanding, and made absolutely sure the consumers were happy with the situation. Routine follow-up on all claims may add extra costs for household and travel insurers. Against this the consumer research showed that it can have a significant impact on consumer satisfaction.

Case study – the benefit to the claimant of a follow up call at the conclusion of the claim
"I was very satisfied. It felt as though they cared. Everything was well organised and there was attention to detail. That call made it feel complete and finished."

Management of supply chains

Insurers with high claims volumes settle many household claims through third party suppliers – builders, providers of electrical goods, jewellers etc. And all household insurers use loss adjusters to some degree. Many suppliers can be involved in the resolution of large complex claims such as flooding, subsidence and fire damage. Whether listening to claims calls or reviewing files, we saw a large number of instances where things had gone wrong. Incorrect instructions had been sent to a supplier. An appointment for a supplier or loss adjuster to visit had been missed. Fire had resulted in damage to a cooker but when the supplier delivered a new one, they would not fit it, leaving the policyholder to find someone to do that. The repair of a garden wall had taken over a year because it was damaged again while repairs were awaited.

The potential detriment caused by providing incorrect policy information to a policyholder and a loss adjuster
The policyholder was making a claim for damage caused by escape of water. He was told by his insurance company on the phone that he did not have cover for Trace and Access. This was confirmed to the policyholder by the loss adjuster when we were on site with them. However, the policyholder referred to their documentation, which showed Trace and Access was covered. The adjuster had to call the insurance company to confirm this. On being told he was covered, the policyholder said "[the insurance company] seem to want to dispute everything just for the sake of it."

The larger household insurers are putting substantial effort into the management of their supply chains. Technology is being used so that instructions to the suppliers are sent electronically and the interactions the supplier has with the policyholder are increasingly visible to the insurer's claims handler. Despite this, we saw numerous instances of incorrect instructions being sent to suppliers, suppliers missing appointments to visit consumers in their property, and consumer dissatisfaction with workmanship or the replacement goods. Only a third of CII respondents agreed that third party household suppliers are proactively managed. All this suggests insurers still have a way to go to ensure that failure rates are very low and that consumers experience the minimum of stress in the resolution of their claims. As part of their forward planning firms may want to ask themselves what failure rate is acceptable and whether they have a plan to attain that rate.

The emergency assistance activities of travel insureres and the need for the right insurance

Emergency assistance services are provided by travel insurers to those who are ill, suffer bereavement, or are in other difficulties abroad. We saw the kind of traumatic situations that can occur. We also saw the expertise needed to secure the appropriate medical treatment and

repatriate the ill, injured or dead. These examples provided stark evidence of how important it is for consumers to have the right travel insurance when they go abroad. This applies even within the EU where travel insurers consider that public hospitals in some countries are not adequate and certainly not comparable to the NHS. 'Right' in this context means insurance that will cover people for the eventualities to which they are likely to be exposed when travelling, and for which they are prepared to pay the premium.

Emergency assistance is the one area of what we saw where claimants are at the heart of what insurers do. Their culture is to do whatever is in the best interest of the policyholder. Staff talk about 'cases' not 'claims'. And even where it turns out there is no insurance cover in place, because a pre-existing medical condition was not disclosed, the assistance operations said they will usually continue to provide support – for example, in ensuring a person is sent to the right medical facility for the treatment they need and in making the arrangements for repatriation, including Fit to Fly documentation. In these cases the costs, which can be very substantial, have to be borne by the sick person or their families.

Travel insurance in relation to medical conditions

Illness, accidents and death can lead to claims under the medical expenses, cancellation and curtailment sections of a travel insurance policy. One of the reasons that retail travel was included in the claims project was that correspondence we have received (including from MPs) and other evidence such as complaints to the Financial Ombudsman Service, indicated that a number of problems arise for consumers regarding coverage for medical conditions.

The cover travel insurers provide for medical conditions is varied. Consumers who seek to understand all the options available – as to cover, exclusions and price – will need to engage fully in the purchasing process. This may not always occur in all cases, for example, where insurance is bought close to departure or the consumer is heavily motivated by price. However, even with full engagement, there are still potential barriers to consumers understanding exactly which claims that arise from medical conditions will be covered. This may be relevant to decisions that firms make in the light of our rules to handle claims fairly, and not to unreasonably reject claims.

Based upon our findings, we have a number of observations about the way medical conditions are dealt with in travel insurance. These are most easily categorised under the headings of i) pre-existing medical conditions, and ii) changes in health after the contract has been concluded.

Pre-existing medical conditions

Our consumer research included questions about the extent to which consumers understood the need to disclose information about medical conditions. For example, claims can arise regarding medical conditions experienced not only by the policyholder, but also by travelling companions, 'others on whom the trip depends', and even business associates. The medical conditions of all these categories of people are relevant to the risks a travel insurer is accepting. Our consumer research showed that, of those surveyed, 88% said they knew they had to disclose their own medical conditions, 82% those of their travelling companions, and 74% in relation to 'others on whom the trip depends'.

Against this apparently reasonably high level of understanding, senior claims managers said that disclosure, especially around pre-existing medical conditions, is a significant problem. This view was echoed by the travel industry, based on research it has undertaken. It was further confirmed by the review we undertook of 50 complaints relating to cancellation and medical expenses claims (examples of some of the problems consumers have encountered are given overleaf).

At the highest level insurers have two broad approaches to dealing with pre-existing medical conditions. These are:

- A blanket exclusion of all claims arising from pre-existing medical conditions; or
- Consumers are required to disclose existing or previous medical conditions at the proposal stage. The risk is then underwritten based on medical screening. Premium loadings or exclusions may be applied depending on the condition, or cover may not be offered at all. Where a policyholder fails to disclose, the insurer may seek to reject a claim.

Our observations are that it is not currently clear to us:

- Whether insurers' requirements are expressed in language that most consumers can understand. In part, this may be to do with the complex nature of medical terminology, but there is also the question of whether insurers' information requirements are sufficiently clear.

Example - a consumer who misunderstood disclosure requirements because the word 'condition' was not explained
The consumer did not consider arthritis to be a 'condition' so did not disclose it. After his claim for cancellation was declined, he complained, also pointing out that a) most elderly people experience arthritis in some form, and b) it had never been a serious problem. In responding to the complaint, the insurer arranged a dummy screening. Had arthritis been disclosed, the insurer would have accepted the risk for a small additional premium. The insurer eventually offered to settle the claim.

- Whether, where exclusions are applied, consumers understand the implications of these and what cover they have in practice as a result. For example, there may be exclusions of claims arising 'directly or indirectly' as a result of a medical condition. The use of 'indirectly' may make it difficult for the consumer to know in advance exactly what medical eventualities they are covered for.

Example - a consumer who did not realise the implications of correctly disclosing his medical conditions
During the proposal stage, the consumer disclosed high cholesterol and fat. His cancellation claim following a heart attack was declined as this was related to the disclosed pre existing conditions. The claim was paid following a complaint – the sales team had failed to tell the consumer what policy endorsement was being applied and what this meant.

- Whether consumers – especially where they may be elderly and/or have a complex medical history – have enough knowledge of their medical history to be able to provide complete and accurate answers to disclosure questions. Some policies require disclosure of medical conditions that arose many years previously, and in some cases, of conditions which consumers have 'ever' suffered from.

- Whether it is insurers' intention that in some cases latent medical conditions are excluded. That is, conditions of which the consumer was not aware before taking out the insurance or which were not diagnosed, even if there was some awareness of the symptoms of the condition. And if they are excluded, the extent to which that is fair and/or clear to consumers.

Example – a consumer with a condition that was not thought to be serious at policy purchase
A consumer was referred to a specialist the day before booking a holiday and purchasing insurance. They were subsequently diagnosed with a serious medical condition and submitted a cancellation claim. This was declined on the basis that the consumer knew about the condition before booking the holiday. The consumer's GP confirmed that the consumer could not have known of the severity of the condition at the time of purchasing insurance. The claim was eventually settled, following the involvement of the ombudsman service.

Changes in health after the contract has been concluded

Many of the travel insurance policies we saw required consumers to disclose medical conditions that arose during the policy term. However, at least one insurer has no such requirement; in effect, it is accepting the risk presented at inception.

For policies containing such provisions, in addition to points raised in relation to pre-existing conditions that may also be relevant here, we consider that it is important that consumers are able to understand the precise scope and consequences of any such provisions. This allows them to make an informed decision. This includes allowing consumers to compare terms with the policies of other providers, which may not exclude cover in such circumstances. But it is also relevant to policyholders when it comes to making a claim.

Consumer outcomes in long chains of delegation

Insurers, particularly London Market insurers including Lloyd's syndicates, often delegate underwriting and handling of claims to brokers and third party administrators (TPAs). Authority can be further sub-delegated, so there can be three or four organisations between the insurer or managing agent, as risk carrier, and the policyholder.

The following diagrams are actual examples of the parties involved and the chains of delegation for a retail travel account underwritten by a firm that was within the scope of the project. They show the complexity of the organisational arrangements and the number of parties involved.

Diagram 1: Routes to market

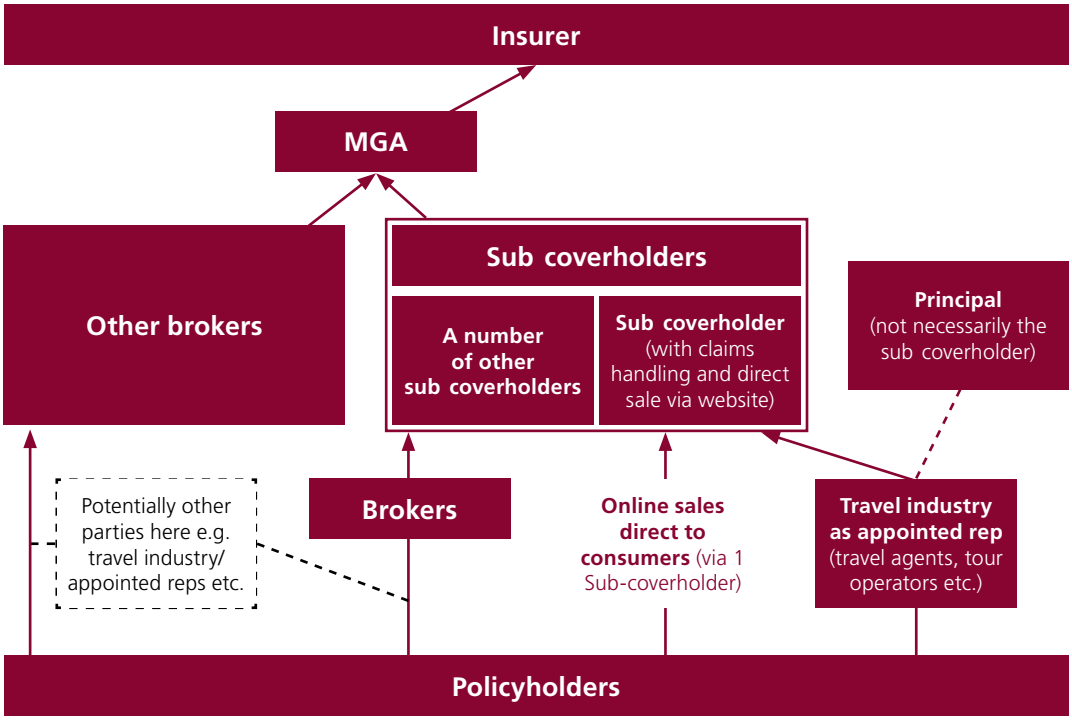
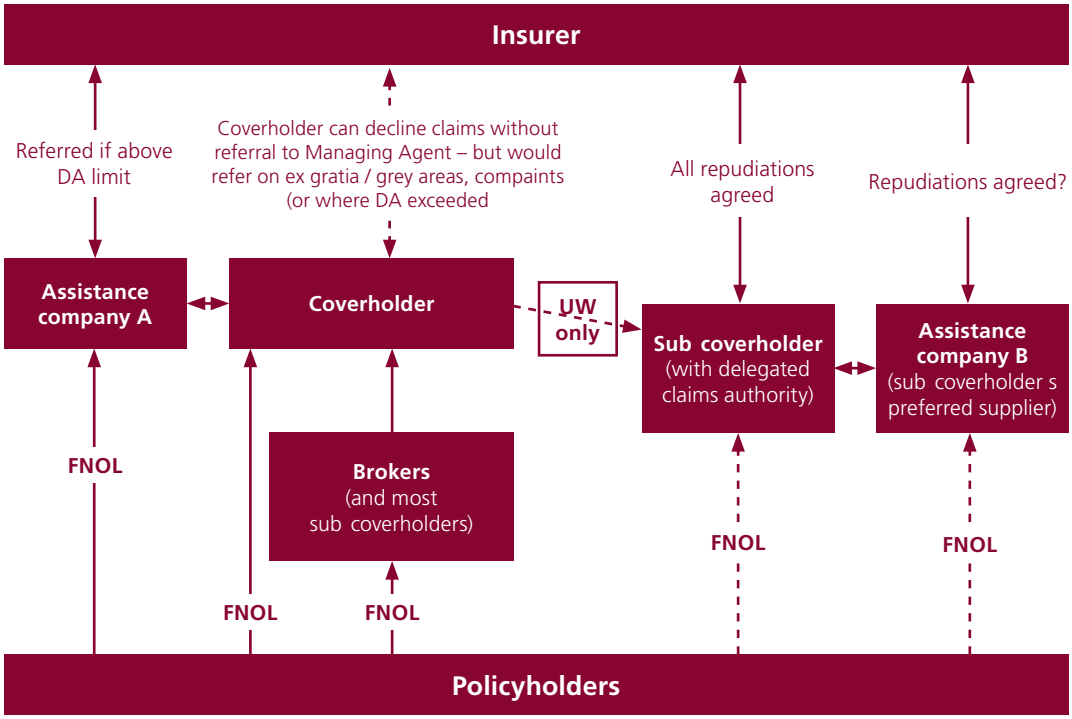


Diagram 2: Claims



We note earlier that major retail insurance companies collect a wide range of information about policyholders' experiences during the claims process. There are then feedback loops to improve products and services. In the long chains of delegation arrangements these processes do not seem to occur. For example, no consumer research was undertaken to gauge policyholders' satisfaction levels. Firms said one reason was that brokers were averse to this, regarding the policyholders as 'their' customers. The only measure of consumer outcomes that received any attention was formal complaints. However, for the reasons noted above, this is an imperfect measure of consumers' satisfaction.

We saw some evidence to suggest that the claims processes of coverholders or Third Party Administrators (TPAs) may not receive sufficient attention from the insurer or syndicate as risk carrier. In one case, the risk carrier had provided formal written guidance to coverholders and TPAs about how to deal with 'grey areas' in household claims. Yet no such guidance had been provided for TPAs' handling of travel claims. In another case we reviewed a sample of the claims handled by a broker with a retail travel account. This review raised concerns about whether the claims had been handled fairly, so we asked the risk carrier to review all claims that had been rejected or partially settled over the past two years to determine whether they had been handled fairly or not.

Retail insurance can be distributed by many means and claims handled directly by the risk carrier or delegated. What matters is that consumer outcomes do not vary depending how the insurance is bought or what are the administrative arrangements for the handling of the claim. At the moment it does not appear that insurers that delegate claims handling have the information, or the means to collect it, to show that consumer outcomes are being delivered which are comparable to those where claims are handled directly by the insurer.

The clarity of product documentation

One of the themes we explored in the focus groups held during the early stage of the project was the extent to which participants felt they understood the product they had bought and the cover it provided. What we heard was that the length and legalistic nature of policies and other documents (such as Key Facts) deterred consumers from reading them.

Case studies consumers find policy documents intimidating and legalistic

Household: "Someone said 'have you got accidental damage cover?', so I rooted around for the policy and looked at it. I found it quite difficult to read, there was a lot of small print, but it sounded like it should be covered"

Travel: "It's ridiculously long and complicated. It's all very well telling me to read the policy, but I had to print off 45 pages of it! I didn't bother reading it. There is a summary but that is more of a sales tool to make it sound better than it actually is."

For this reason we included questions about whether consumers considered they understood the cover they had bought in our quantitative consumer research. For household, 30% strongly agreed and 55% agreed that when purchasing the policy they were confident that they understood the cover they had bought. For travel, the figures were 26% strongly agreed and 59% agreed. Yet these results must be treated with caution. The qualitative research for this project revealed that on further detailed questioning this confidence tended to be misplaced. Also, other consumer research the FCA has carried out in general insurance has shown a number of people saying that they understood a product, but when their knowledge has been objectively tested, it has proved illusory.

The research for this project also showed that claimants who had their claim rejected were significantly less likely than successful claimants to state that their policy was clearly explained to them and that they understood their cover. They were also significantly less likely to state that they had read the policy documents at the point of purchase. This suggests that rejected claims may be reduced if consumers engage sufficiently at purchase and the importance of removing barriers to this engagement.

30% of CII members who completed our survey related to travel insurance, and 19% who completed our survey related to household insurance, did not agree that it is made clear to consumers what is and is not covered when they buy their policy.

The theme of the nature of much product documentation being a barrier to consumer engagement is a recurrent one. For example, it featured in the report Consumer Responsibility – Identifying and closing the gap commissioned by the FCA's Practitioner Panel (September 2013).[5] Also the Government's Insurance Growth Action Plan[6] includes the need to "ensure that consumers are given clear, concise and useable information so they better understand the product they are buying".

Some of the insurers we interviewed acknowledged that the industry had not yet achieved the right balance in its documentation, between setting out the legal basis of the contract with the policyholder and explaining easily and clearly what the main features of the cover are. Some interesting ideas emerged during our interviews with firms. One senior manager, responsible for product development, speculated about the implications of moving to a two-page policy document and whether an insurer would have the courage to do this. Another firm was considering including non-insurance people in the drafting of a wording.

During our feedback meetings with insurers a number said that they aspired to produce shorter product documentation. However, they equally do not want to fall foul of regulatory requirements. Documentation tended to grow in length and become more legalistic to minimise this risk, reflecting the influence of compliance and legal departments. There was also open discussion about how many consumers do – or would – read product documentation even if it was clearer and easier to read. While acknowledging this might be the case, we reiterated the point that the evidence, referred to above, suggests that the nature and appearance of product documentation currently tends to deter consumers.

5 Consumer Responsibility – Identifying and closing the gap: http://www.fs-pp.org.uk/documents/fca_practitioner_panel_consumer_responsibility_report_september_2013.pdf

6 The UK insurance growth action plan: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263148/the_UK_insurance_growth_action_plan.pdf

Other issues

Fraud

On claims fraud, the challenge for insurers is to strike an appropriate balance between vigilance – so protecting the interests of non-claiming policyholders and shareholders – and causing unnecessary difficulties for genuine claimants. We did not conduct a systematic deep dive to look at counter-fraud within the claims process. Rather, each firm's approach to fraud was a theme in our interviews with senior management. During our visits to claims operations, we spent time with counter fraud teams, in some cases seeing demonstrations of the detection tools they use.

In common with other areas, we found a distinct contrast between the position in household and in travel; a more structured approach prevails in household. A number of messages emerged fairly consistently from our discussions:

- The hurdle to proving fraud is a high one. Insurers may have very strong suspicions of fraud but if they are unable to prove it they will tend to settle the claim.

- In a considerable proportion of cases where fraud is suspected and further investigation is undertaken – such as a detailed conversation being held with the policyholder about the circumstances of the loss – the claim will be withdrawn or not pursued.

Most household insurers – especially the larger retail players – were able to articulate clearly their philosophy and how in practice they strike a balance in the treatment of potential fraud. Of particular importance is having a triage process to deal with cases flagged as potentially fraudulent. Typically a decision is made within a few days as to whether these cases – often referred to as 'false positives' – merit further investigation or not. The resources deployed to identify and combat fraud include: dedicated anti-fraud teams; the use of industry databases; and sophisticated fraud detection software.

Travel insurers told us that they believe the incidence of opportunistic fraud is high. However, unlike in household (and motor), there is no industry database of claims. Industry initiatives to build a claims database have, to date, foundered on not being able to achieve support from enough insurers to make the business case viable.

Proving a loss is very different in travel from household. In the case of household, a property can be inspected to see whether physical evidence supports a claim for burglary. With travel, a claim for theft or loss of belongings abroad needs to be substantiated by the policyholder and the burden of doing so can feel quite onerous.

Our consumer research showed that the most common reason policyholders do not pursue travel claims is because of the burden of proof/documentation they need to submit to substantiate a claim. This could include: confirmation from the airline that a flight had been cancelled and the reasons for this; obtaining police crime numbers for stolen items; providing receipts for bookings; providing receipts/proof of purchase for lost or stolen items.

31% of CII members who participated in the survey, as regards travel insurance, disagree that claimants "are not expected to provide unreasonable evidence to support their claim".

Insurers need to be vigilant against fraud. However, the findings of our consumer research may prompt travel insurers to ask themselves whether they have struck the right balance as to what documentation/proof of loss they required the policyholder to provide.

Case study – How an insurer s approach to fraud makes consumers feel

Positive experience travel claim for missing camera: "I was supposed to have got a number from the manager in the bar (where the camera went missing). I didn't know this. She said 'It says in the policy that you should get those details, but never mind, I'll put it through anyway'. Her manner was good and I felt relieved, she could have rejected my claim."

Negative experience - home claim where daughter spilled her drink on a laptop: "I felt they were looking at me as a fraudster and calling me a liar. I was very angry, I'd been with them ten years and this was the first time I'd claimed. I would be better off not having insurance."

Potential impact of a claim on the renewal premium

Our consumer research showed that the most common reason policyholders withdrew, or did not pursue, a household claim was because of concern about the potential impact of a claim on their renewal premium.

The rating of a particular policy can be affected by many factors including: i) general rate increases or reductions to reflect market conditions or the insurers' own profitability or lack of it; ii) the performance of a particular broker or affinity partner's account; iii) changes in the insurer's exposure to, and incidence of, certain types of claims; and, iv) the claim history of the individual policyholder. It can be difficult for insurers to be categorical about the impact of making a claim on renewal premiums. They need to be mindful of potentially deterring claimants through the provision of too little, too much or the wrong sort of information. However, we saw cases where claims handlers seemed uncertain about what they could say. Given how important this kind of information is to consumers, insurers may want to reflect on what claims staff can say to consumers to deal with queries effectively and consistently.

Use of own builder

The larger household insurers in the project all have their own nationwide network of building contractors. Insurers with a smaller customer base may have access to a repair network via their loss adjusting provider, but this tends to be with more complex repair work in mind. Where the damage is less severe, the policyholder is often asked to get a quote from a local builder, which the insurer can cash settle.

While repair networks are available in many cases, all household insurers in the project offer policyholders the opportunity to use a builder of their choice. It appears that a good proportion of claimants prefer to do this rather than use the insurer's approved builders. However, in doing this, the claimant may lose the benefit of any explicit guarantee of work (typically one or two years) which comes with use of the approved builder.

We agree with the principle that consumers should be able to choose from a variety of settlement options, according to what suits them best. However, we did not see many documented examples where the insurer had set out for consumers the implications of using their own builder or one approved by the insurer. This may be important information for consumers in allowing them to make an informed choice.

Matching pairs and sets

It is not unusual for home insurance policies to specifically limit the insurer's liability to the repair or replacement of damaged items only. This could cause problems, for example, where one item in a three piece suite is damaged but cannot be repaired or replaced to match the undamaged items. A similar problem might occur where a single kitchen unit is damaged. Policyholders can end up being dissatisfied because they are left with mismatched furniture or kitchen units. While the circumstances of each claim vary, the Financial Ombudsman Service's general approach is that the insurer should look to pay for the damaged item plus 50% of the rest of the matching set.

We found one instance where an insurer's Best Practice Guidance said that a payment of 50% (reflecting the Financial Ombudsman Service's decisions) should only be made if it was likely that the policyholder would make a formal complaint. In other words, the amount the policyholder received would depend on how likely they were to complain.

Insurers should settle claims in accordance with their contractual obligations, regulatory requirements and relevant Financial Ombudsman Service guidance or final determinations.[7] It is unacceptable for an insurer to arrange their claims process in such a way that policyholders have to lodge a formal complaint for a claim to be settled on this basis.

7 DISP 1.3 sets out the requirement whereby firms should ensure that lessons learned as a result of determinations by the ombudsman are effectively applied in future complaint handling, for example by analysing guidance produced by the FCA, other relevant regulators and the Financial Ombudsman Service. It also covers the need to identify and correct any root causes of complaints.

4.
The implications of our findings

For insurers

Firms within this project are generally settling most claims to the satisfaction of policyholders. However, there are a number of areas where changes to processes or approach could further enhance consumer satisfaction among both successful and unsuccessful claimants. These areas are identified in the report.

The findings of this project will have varying degrees of relevance to individual household and travel insurers depending on their exact business model. In some areas – such as how important some firms regard collecting as much information as possible about a policyholder's claim experience and using that information to improve products and processes – the findings of the project have relevance beyond the two product lines that were the focus of the project. They extend to other types of retail insurance. Equally, we recognise that a number of the issues raised in this report are not easy ones for firms. Deciding what can be said when people ask about the potential impact of making a claim on their household premium at renewal is one example. Another is achieving the appropriate balance between detail and clarity in product documentation.

It is likely that household and travel insurers – as a minimum – will want to reflect on the findings of this project and what it means for their business. Insurers should also expect that we are likely to want to discuss claims with them as part of our ongoing Pillar 1 supervisory work.

For the FCA

This project has given us an insight into the claims practices across a range of household and travel insurers. It has also shown what changes some individual insurers intend to make to their claims services in the near to medium term. Perhaps most important of all it has provided a benchmark as to consumer satisfaction levels. It has also identified areas where there is scope for insurers to improve, if they wish to provide more consistent outcomes for claimants and enhance satisfaction levels among consumers who are both successful and unsuccessful in making claims. In this, the project has provided a foundation for future supervisory work, whether as regards individual insurers or across a wider cross-section of insurers.

For travel insurance stakeholders

The medical and other emergencies that travel insurers deal with across the globe show how important travel insurance can be for people when they travel abroad. Against this, our earlier analysis identified some of the problems that can occur for consumers in relation to medical

conditions and travel insurance. If the position is to be improved, action both by individual insurers and also across the wider community of stakeholders in the travel insurance industry would be likely to have greatest effect.

As regards individual insurers, we may take up with them on a case-by-case basis the wording of their particular terms and conditions where we have observed that there may be scope for improvement. Beyond this we generally encourage insurers to review their terms regularly so that they remain in line with their obligations under contract law, the Unfair Terms in Consumer Contracts Regulations (1999) and regulatory requirements, including the requirement to treat their customers fairly and be clear and not misleading. Firms may also find that where improvements to terms and conditions can be made for future customers, this could help in relation to their determination of claims, especially in the light of requirements to handle claims fairly and not unreasonably reject claims. Firms may find our observations in this report helpful when conducting reviews of their terms and conditions.

We mentioned at the beginning of this report that the travel insurance market is very diverse. Consumers are faced with a wide range of product offerings and methods of obtaining travel insurance. There is also a wide range of stakeholders including insurers, insurance distributors (which includes banks because travel insurance often comes as part of packaged bank accounts), travel agents, and consumer groups. The key travel insurance stakeholders have agreed to work with us collectively to see what can be done to achieve greater understanding by consumers and greater clarity for them. One of the key actions for us following the conclusion of this thematic project will be to agree the organisational arrangements for taking this work forward.

Appendix 1
Experience of insurance claimants consumer research report

Harris Interactive was commissioned to undertake a programme of consumer research to inform the Financial Conduct Authority's (FCA) thematic review of insurers' management of claims. This research aimed to understand the expectations of consumers when making a claim, and measure experience and satisfaction with claims handling across the insurers involved in the thematic review.

www.fca.org.uk/tr14-08-consumer-research

Appendix 2
Perceptions of insurers' management of claims: findings from a survey of members of the Chartered Insurance Institute (CII)

This report summarises the results from two short online surveys, one relating to travel insurance claims and the other to household insurance claims, completed by members of the Chartered Insurance Institute (CII). The aim of these surveys was to record the perceptions of a range of insurance professionals regarding how claims are managed, areas where insurers perform well, and any areas for improvement.

www.fca.org.uk/tr14-08-cii-survey

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