International Journal of Scientific Research and Engineering Development-– Volume 4 Issue 3, May -June 2021

Available at www.ijsred.com

RESEARCH ARTICLE OPEN ACCESS

Claim Management System: Overview

Abhishek Nagpal*,Atul Ranjan Shipu*, Sharadadevi Kaganurmath**

*(Department of Information Science and Engineering, Rashtriya Vidyalaya College of Engineering, Bengaluru
Email: abhisheknagpal6633@gmail.com. atulranjan10@gmail.com)

**(Department of Information Science and Engineering, Rashtriya Vidyalaya College of Engineering, Bengaluru
Email: sharadadeviks@rvce.edu.in)

----------**********----------

Abstract:

With the advancement in technology automation in the insurance industry has also grown over the years. While the field of banking and financial services has taken up this development since long ago, it was considerably slower to introduce automation in the insurance sector. With RPA and Intelligent Automation, insurance companies are starting to implement pilot automation initiatives. However, it is anticipated that these technologies will have a huge influence on the industry. The complete cycle of policy management activities, including policy issue and updates, is another popular insurance application for intelligent automation.Pre-writing checks were carried out at the policy issuing stage and the underwriting decision has already been taken. The policy must be issued and information must be updated and provided to the client in internal systems. There is a lot of manual labour involved in these operations. Digitalization of claims entails a redesign of the customer process flow and the use of technology to make every stage of the customer journey easier. This enables the insurers to respond more to consumer inquiries, automate transactions that are of little value and speed up the claim process.

----------**********----------

I. INTRODUCTION

Traditionally, with the aid of an insurance agent a general insurance plan could be bought. However, the insurance business increasingly tried to go digital with the onset of digitalisation. Life and non-life insurance are available online today, representing 1% of the internet insurance total market. Customers too like to get online insurance as it provides them better choices, better pricing and instruments to select the ideal coverage for themselves. Whole life insurance policy is most typically purchased online, auto, travel and health insurance are favoured for online purchase under non-life insurance. In addition to online purchases, there are numerous services available online, such as premiums payment, policy renewal and submitting claims. You have to call your insurance agent or ring the number of your customer to discover your claim status. You may now raise a claim online and monitor your home from within comfort. Digitization has resulted in speedier processing of claims, particularly in cash-free claims.If the insured person receives a pre-authorisation from the insurer

in a network hospital.Because everything is digitally processed,the hospital workers may submit the preauthorization to the insurance once all information is received from the assured.Likewise, within a few of hours the insurance might submit an authorisation.

Digitalization also minimises the likelihood of delays or errors because it is all more transparent.The processing of claims is one of insurance company's most important service tasks. The difficulty of managing a claims environment with numerous systems and manual handling may, however, lead to mistakes and delays that can irreparably affect client relations. Claims Management assists firms in simplifying customer, employee, agent and third-party claims processes. It gives a unique method for addressing a prevalent challenge in the business – enhancing the demand service and decreasing expenses. Claims Management is an integral system that ensures claim management and processing assistance for a range of sorts of claims in a single system.Claims Management The solution is designed to boost productivity and minimise operating expenses for financial services organisations, assure correct and consistent claims determinations, improve service levels and cut backlogs.

II. PRODUCT BACKGROUND

Any claim management application is intended to help insurance providers or insurers handle and analyse claims that come their way. As such the claim management system in question provides on the same requirement lines by enabling agents with automated workflows to administer claims processes to make sure that all claim targeted information is captured in a centralised system. The system should be able to communicate with policy databases and access the policy in question when enough searchable data is provided. The system is able to process the circumstances under which the claim is being made and verify if it meets the prior set conditions and that no flags are being raised. This leads to decreased false claims and increased customer experience. Management tools for Insurance claims can be deployed either as an independent solution, or as an integrated insurance package. There should also be support for all types in the single system that can provide options to improve productivity, decrease time to train. The flexibly configurable system permits increased accuracy and consistency with respect to claim decisions and calculation.

III. COMPONENTS OF CLAIMS

Every insurance claim consists of multiple parts: Summary, FNOL, Loss Details, Exposures, Financials and Litigation. Each of these have their own importance which is important to understand

A. Summary

Contains different details of the claim involving Claim Number, Policy Number, Insured Information, Type of Loss, Legal Information, Time and Date and Financial Information regarding that claim.

B. FNOL

The Initial Notice of loss (FNOL) is the insurance provider's first notice following the loss, theft or injury of an insured asset. The FNOL is normally the first step in the structured claims process, often known as the first loss notification. The first loss notice often precedes any formal, official claim. The process of producing a FNOL is commonly used by consumers and corporations.

C. Loss Details

The foundation of a damages claim in accordance with a policy. Loss of property due to pure risk. Widely classified, risk managers' forms of losses include personal loss, loss of property, loss of time and loss of legal liability.

D. Exposures

In insurance words, exposure refers to the vulnerability of an individual, business or institution to different losses or include personal loss, loss of property, loss of time and loss of legal liability.It essentially relates to the potential for accidents or other losses, such as crime, fire,

earthquakes, etc. The larger your risk of possible losses, the more you may expect that your premiums will be, as the insurer will have to charge you more to cover yourself profitably.

E. Financials

The operational statements of the company and related information include the balance sheet and the profit and loss statement. Buyers often seek financial information when both new business and renewal offers are provided. The financial position of an insured person is a significant element for evaluating insurance capacity, commitment to loss control programmes and ability to pay premium payments.

F. Litigation

Insurance litigation is the representation in disputes about the meaning, scope and effect of insurance policies or associated contracts, of insurers, policyholders and other parties. There are a number of substantive legal topics involved in insurance disputes.

IV. KEY USERS

The principal users of the application will be Adjusters, Supervisors, Internal Specialists, Administrators and External Vendors . These are individuals associated with the insurance agency's arrangement association who are overseeing the claim process consistently.

A. Adjusters

An adjuster analyses the degree of the liabilities of a corporation in order to decide insurance claims. Claim adjusters may deal with claims for property including structural damage and/or liability claims involving personal injury or property of third parties.

B. Supervisors

The insurance claims supervisors oversee the claims representatives of insurance companies and ensures that claims for personal, loss, or damages are reported accurately, that claims for personal, casualty, or property loss or harm are examined

C. Internal Specialists

In order to assess the validity of the claim, the investigator examines the facts of a claim. The scope and validity of the claim are determined and fraudulent claims are prevented by determining the validity of the claim.Claim investigators and forensic experts can be self-employed, can be employed by a number of public and government agencies or can be employed by insurance firms.

D. Administrators

An administrator from a third party (TPA) is a business that manages insurance claims or some components of a separate entity's employee benefit plan. It is also a phrase used to designate insurance companies that manage additional services, such as customer service and underwriting. This might be seen as an outsourcing of processing claims management because the TPA usually performs work carried out by the insurance company or the firm. For insurance claims, a TPA often processes the claims of employers who assure their workers themselves.

E. External Vendors

It continues uninterrupted and mostly uncontrolled the trend towards the employment of third party suppliers in the claims investigation. The sellers — engineers, mould repair services, arson investigators, accounts, computer software businesses, lawyers, etc. — are significantly involved in the investigation of claims and are frequently defendant when discrepancies between policyholders and their policyholders become litigation.

V. CLAIM MANAGEMENT PROCESS

These enterprises are challenged, in addition

to the fierce competition in which they operate, by rising compliance with the rules of the state and by rising customer expectations. The efficient administration of claims is essential for the success of both big and small insurance organisations. The main components of the claims process are establishing cost reduction and fraud reduction techniques while satisfying clients. In particular, small enterprises may benefit from tools and technology for claims administration.

Different benefits that can be acquired through this process are-

A. Detecting Frauds

The payment of false claims costs insurance firms money - the expenses are then paid to their clients by the insurance sector. As a result, the underwriting requirements are becoming harder and customers pay higher insurance prices. SAS data analytics businesses can use software solutions developed to assess payment history and assess trends in claim payment payments to help insurances detect fraud. For instance, how frequently an insurance claim may alert the same individual files of a person that a false claim may be submitted.

The settlement of claims unfortunately raises the chances for a corporation to pay more bogus claims too rapidly. In contrast to big corporations which may withstand some losses as part of a company, tiny enterprises are swiftly adversely affected by false claims in net income. Again the danger of losing unsatisfied consumers is increased by processing insurance claims too slowly. Small businesses cannot afford to lose consumers in a very competitive insurance market.

B. Lowering Costs

Cost monitoring throughout the claims management process affects how much the customer's premium rate is paid for the administrative expenditures of the insurance company. In general, it costs the insurance company more money when resolving a claim is delayed. The higher the expense of claims reduces profits.

Automation of portions of the claims management process can assist to reduce the operational expenses of a business, whether for small and big insurance businesses.One example is the higher expense of manually researching a claim. However, informatics systems promote efficiency through decreased claim mistakes, early detection of fraud, reduced processing and claims resolution time - all elements that reduce the cost of the insurance firm and boost profits.

Small businesses may be challenging even in a booming economy. Another key role in the process of managing claims that might minimise costs is to design prevention programmes before they take place and to avoid future claims.

C. Avoiding Litigation

When the consumer has a valid claim and may offer proof to support it, the insurance company ulteriorly agrees to pay a fair sum in most circumstances involving insurance claim disputes. Even if a claim may be rapidly resolved without litigation opportunities, the appropriate liability assessment is essential in order to resolve a claims disagreement promptly. Insurers are struggling to avoid legal disputes since the cost of resolving a claim has dramatically increased.

For example, it might be expensive for an insurance firm to establish it legally in case an insurer is misrepresenting facts about an insurance application. Another incentive to avoid the loss of a firm is litigation.Small insurance businesses are not exempt but are more and more susceptible to possible claims action.

VI .CLAIM CREATION SETUP

A. Intelligent case routing and assignment

- Register, adjudicate, track and manage requests effectively via a single interface
- Automated case routing depending on

workload of the adjudicator and expertise with the intricacy of the case

B. Self Service Portal for Customers

- An online application is the customer self-service portal.
- Recording clients' claims in real-time and status follow-ups.

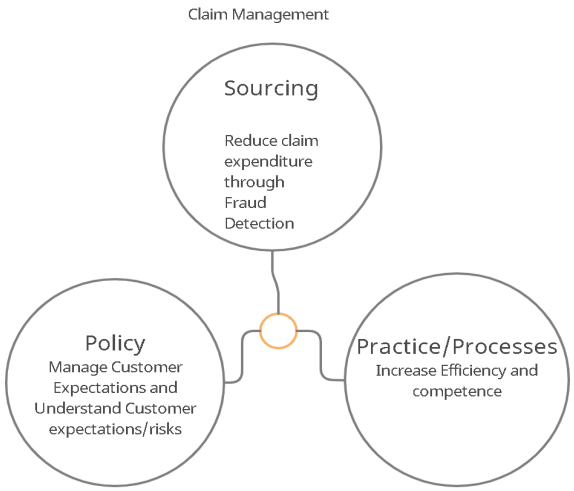

Fig 1. Data Flow of Claim Management

C. Retrieval and verification of policy information

- Policy information automatically retrieved when key indices are entered
- Checking duplicate entries and highlighting them to avoid mistakes.

D. Algorithms based on the rule

Integrated, comprehensive corporate standards to categorise claims automatically into "fast track" or "non fast track"Added or modified stakeholders flexibility—garages, appraisers, investigators and claim officers.

E. Comprehensive evaluation of claims

Detailed evaluation of each claim by supplying the assessor with an all-inclusive table.Additional information based on dynamic needs can be requested.

F. . Observation and Insights

Defined user efficiency monitoring and monitoring KPIsEscalation and surveillance reports for transparent and fast handling of claimsTracking payment and rescue and recovery.

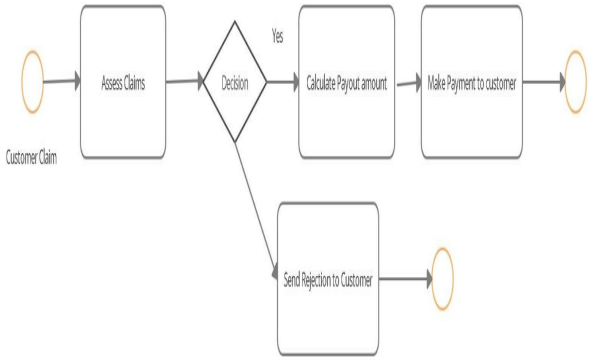

Fig 2. Claim Creation and Workflow

VII. CONCLUSION

In 'if-then,' the structure of the insurance company is woven. The owner of a policy must routinely pay a little premium but the insurer will bear a relatively bigger 'guaranteed amount' when the insured loss event takes place. Due to the minimal risk of the event, the model works. However, when the terrible occurrence occurs and the amount promised is claimed, the time of truth for insurers is. Since the sole reason why the insurance company exists is this event, the claims process must be easy, empathic and speedy.
Ideally, it must be easier than the premium payment procedure from the client's point of view.Nevertheless, most individuals are troubled, fearful and frustrated about the insurance claim procedure. Insurance carriers are certainly not deliberate about the challenges in the procedure, mostly because of the company's complexity. Unhappy and uncomfortable claimants, however, are significant encouragement that insurers begin to improve the process of managing their claims existingly.

ACKNOWLEDGEMENT

We are indebted to our guide , Prof. Sharadadevi Kaganurmath Assistant Professors, RV College of Engineering for the whole- hearted support, suggestions and invaluable advice through- out our project work and also helped in the preparation of this thesis We thank all the teaching staff and technical staff of the Information Science and Engineering department, RVCE for their help. Lastly, we take this occasion to thank our family members and friends who offered all the backup support during the project effort.

REFERENCES

[1]G. Shenoy, "Guidewire insurance suite: Claim center – an overview,"International Journal of Advanced Engineering Research and Studies,ISSN:2249–8974, pp. 121–127, 2015.
[2]M. Eling and M. Lehmann, "The impact of digitization on the insurance value chain and the insurability of risks,"The Geneva Papers on Risk and Insurance -Issues and Practice, vol. 43, no. 3, pp. 359–396, 2018.
[3]T. Aven, "Risk assessment and risk management: Review of recent advances on their foundation,"European Journal of Operational Research, vol. 253,no. 1, pp. 1–13,ISSN:0377-2217,2016,.
[4]S. Lin, Y. Liu, and Y. Xu, "Analysis on market segmentation of the medical insurance and pharmaceutical after the medical insurance reform," pp. 6545–6548, 2011.
[5] Revathi, P., "Technology and Innovation in Insurance – Present and Future Technology in Indian Insurance Industry",International Journal of Engineering and Management Research, Volume-10, Issue-1, February 2020.
[6] Ms.Babita Yadav, Dr. Anshuja Tiwari,"A Study on factors affecting customers investment towards life insurance policies",International Journal of Marketing, Financial Services & Management Research, ISSN 2277 3622, Vol.1 Issue 7, July 2012.
[7] Prinja S, Bahuguna P, Gupta I, Chowdhury S, Trivedi M ,"Role of insurance in determining utilization of healthcare and financial risk protection in India" ,PLoS ONE 14(2): e0211793,2019.
[8]R.Vijaya Naik , "A Study on Structure of Insurance Sector In India",International Journal of Business and Management Invention (IJBMI) ,Volume 7 Issue 9 Ver. 2,PP—01-08, September 2018.
[9]B.C. Lakshmanna, P. Jayarami Reddy, P. Sravan Kumar,"Operational Efficiency of Selected General Insurance Companies in India",International Journal of Innovative Technology and Exploring Engineering (IJITEE),ISSN: 2278-3075, Volume-9 Issue-2, December 2019
[10]Gopu Sowmiya, V. Selvam ,"Drive to digitalization in insurance a study on policyholders attitude towards using mobile banking",ISSN- 2394-5125,Vol 7, Issue 9, 2020.

