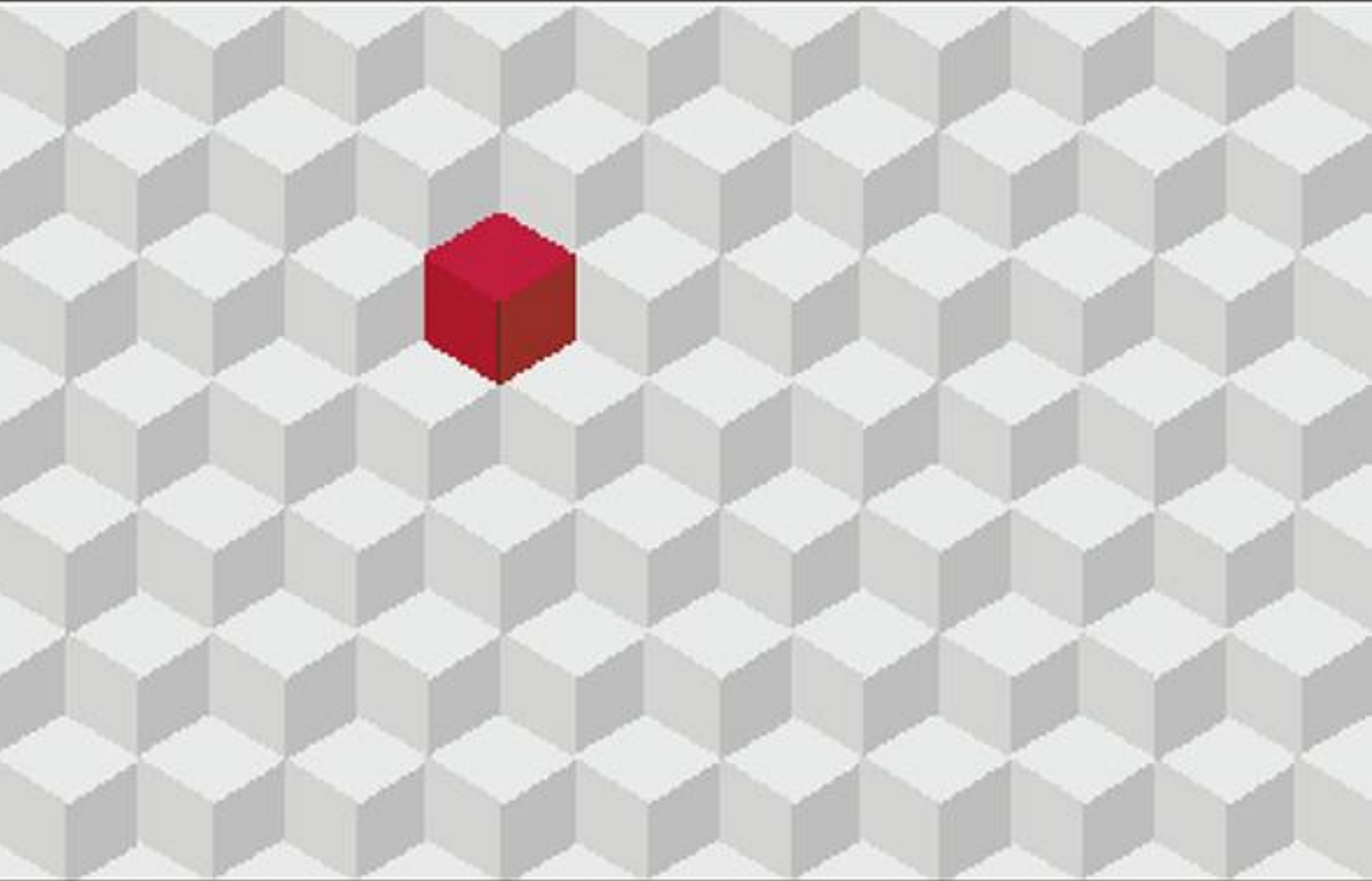


Facilitating a better future

lmalloyds.com



lma
Lloyd's market association



FCA Value Measures Reporting

Contents

Introduction	
Background	2
Requirements	
Claims Metrics	4
Product Governance	5
Timeline	
Timeline	7
FCA FAQs	
FCA FAQs	9
Appendices	
Appendix 1 - In scope products	13
Appendix 2 - Definitions	17
Appendix 3 - Report completion notes	21
Contact	
Contact	24

This guidance summarises the main elements of the FCA reporting requirements. However, managing agents should ensure that they are familiar with the details of the requirements as set out in the FCA Handbook.

Background

In September 2020, alongside a consultation on Pricing Practices, the FCA published [Policy Statement PS20/9](#) on General Insurance Value Measures Reporting and Publication.

The history of the FCA's value measures initiative can be traced back to 2013 when the FCA published a [Discussion Paper](#) on transparency which suggested the publication of claims ratios could improve transparency of insurance product value. That was followed in 2014, by [MS14/01](#) (General insurance add-ons: Provisional findings of market study and proposed remedies) which identified certain add-on products which the FCA to offer low value. MS14/01 set out a range of proposed remedies including the publication of claims metrics that it had previously discussed.

The [Final Report](#) of the Market Study confirmed the provisional findings and stated “*Add-on insurance often represents poor value for money, but we found many instances of poor value for standalone products too. We are concerned that there is currently no easily comparable measure of the value of an insurance product.*”

In 2015, the FCA published [DP15/4](#) specifically on the collation and publication of claims metrics. Again, the LMA submitted a substantive response and was invited, along with the IUA, ABI and several large consumer insurers, to participate in a series of round table discussions with the FCA.

Despite sustained push-back from industry, in 2016 the FCA launched a series of four annual pilot exercises involving a number of insurers and focused on four products: Home (combined buildings and contents); Home Emergency; Personal Accident and Key Cover. The FCA published the data it collected [here](#).

Following the pilot exercises and a further consultation, the FCA published [PS20/9](#), setting out its requirements for future value measures reporting. In addition to claims metrics reporting, all managing agents will be required to comply with new Product Governance rules. A summary of the requirements, which are extensive in terms of both products and granularity, are set out below.

Requirements

Requirements

Claims Metrics

Managing agents will be required to complete and submit an annual report on (or before) 28 February each year for the preceding calendar year (except the first report in February 2022 which covers the period 1 July to 31 December 2021).

The report covers effectively all GI products **sold to UK consumers**, excluding:

- Private Medical
- No claims discount protection
- Bloodstock
- Specie/fine art/antiques
- Products sold to commercial customers
- Products sold as part of a packaged bank account
- Group policies
- SME or other commercial policies

For subscription risks, reporting is by the lead only.

A full list of products in scope for reporting is provided as appendix 1.

Reporting threshold

The threshold for reporting is at least 3,000 policies **AND** £400,000 written premium.

****NOTE** – these are not pro-rated for the initial reporting period, so the threshold applies, in full, for that 6-month period******

High net worth policies are IN scope, but not as a separate reporting category. E.g. HNW property insurance would be included within the Home category.

Add-ons which are separate policies should be reported separately. When they are extensions within the same policy they should be reported as part of the main policy.

The data to be reported

The value measures data is:

1. the number of policy sales;
2. total gross retail premiums (written);
3. the number of claims registered;
4. average number of policies in force;
5. claims frequency;
6. the number of claims accepted;
7. the number of claims rejected;
8. claims acceptance rate;
9. total claims pay-out cost;
10. average claims pay-out;
11. the amount that the top 2% of claim pay-outs are above;

12. the names of the five largest distribution arrangements;
13. the number of claims walkaways;
14. the number of claims complaints; and
15. claims complaints as a percentage of claims.

Points to note

- Where a policyholder contacts a managing agent with an enquiry about policy coverage (or other general enquiries), that does not constitute a claim. However, if the policyholder contacts a managing agent to discuss a claimable or potentially claimable event that has actually taken place, that **SHOULD** be recorded as claim, regardless of whether that event would be covered.
- Claims which are rejected for insurance fraud, made against a voided or cancelled policy, and those directed towards the wrong insurer **SHOULD NOT** be reported as registered claims.
- Where a claimant chooses not to continue with a registered claim (a walkaway), that **SHOULD NOT** be treated as a rejected claim and should be deducted from the number of claims registered.
- Claims made below a policy excess **SHOULD** be treated as rejected claims.
- Reporting is based on activity taking place during the reporting period for each metric.

A full list of definitions is provided as appendix 2.

The draft report form can be found on page 54 of PS20/9. Notes on its completion are provided as appendix 3.

Product Governance

PS 20/9 introduces a requirement for firms to take value measures data into account when considering whether their products offer value to their customers. For managing agents, the value measures data includes data relating to other firms which has been published by the FCA and managing agents' own value measures data.

The rules do not prevent firms from using their own data to help assess the value of their products.

The above requirement comes into effect from 1 July 2021. PROD 4.5.4 R (1) (c) states that firms must take into account "the value measures information, within a reasonable period;" and so the extent to which firms can consider this information will be more limited at the start (i.e. July 2021), but once managing agents have started to pull together the value measures information to report they will be a better position to take account of the value measures information in their wider assessments.

A key point to note is that, setting aside the need to consider the value measures data – managing agents, as manufacturers, will already need to comply with the rest of PROD 4.5.4 R.

Timeline

Timeline

Date	Definition
01/01/21	Product Governance rules came into force
01/07/21	Reporting value measures comes into force
01/07/21	PROD 4.5.4 R (c) comes into force
28/02/22	Reporting begins for July 2021 onwards
2023 onwards	Annual reporting for the previous calendar year

FCA FAQs

FCA FAQs

The LMA put a series of questions to the FCA and their responses are provided in the FAQ section below.

Question	FCA Response
<p>1) It appears that the 1st report is due for submission by 28 February 2022 for the period 1 July 2021 to 31 December 2021. Are we correct in understanding that the requirement is for the reporting thresholds to be met for this 6 months' period only?</p>	<p>Yes – that is correct</p>
<p>Does this mean that in Q1 2023, we will have to report for the period 1 January 2022 to 31 December 2022?</p>	<p>Yes – that is correct</p>
<p>2) Where scenario 2 under the annual submission date and reporting period definition applies, must the reporting thresholds apply for that part of the reporting period or for the entire period the distribution arrangement is in place?</p> <p>For example, if a binder runs from 1 January 2022 to 31 January 2023, would we only need to report for the period 1 February 2022 to 31 December 2022? And meet the reporting thresholds for the period 1 February 2022 to 31 December 2022 and not to 31 January 2023?</p>	<p>The reporting thresholds are set at the product level e.g. 'Home – Buildings' for each managing agent based on activity during the reporting period (e.g. 1 January 2022 to 31 December 2022 and 1 January 2023 to 31 December 2023).</p> <p>Hence, the reporting thresholds are not set at the distribution arrangement level but rather at the managing agent level for that product, which could include multiple distribution arrangements. If the threshold is met then firms are required to report the aggregated data from all the distribution arrangements (regardless of size) into the reporting return.</p> <p>Assuming that the threshold for the managing agent is met, if a binder runs from 1 February 2022 to 31 January 2023 – then the reporting for the period 1 January 2022 to 31 December 2022 would include activity from that distribution arrangement that takes place between 1 February 2022 and 31 December 2022. The activity from that distribution arrangement that takes place between 1 January 2023 and 31 January 2023 would be reported within the data for the year ended 31 December 2023.</p>
<p>3) Where reference is made to “gross retail premiums written”, does that mean policies bound during that period, regardless of inception date? For example, a policy may be bound in December 2021 but incept in January 2022. Would the related premium be included in the first submission?</p>	<p>Firms should report premium data for policies sold during a particular reporting period.</p>

4) For the first submission, will the de-minimis reporting thresholds apply in full, or be pro-rated to reflect the reduced (6-month) reporting period?

The de-minimus reporting will apply in full. The thresholds are set out in SUP 16.27.10 R and are based on the total gross written premiums and number of policies in the reporting period. These thresholds are not adjusted for the initial period of 1 July 2021 to 31 December 2021.

5) What is the position for business written under line slips or consortia? Are they in scope, and if so, who should report?

The business that is captured are policies sold to consumers and the managing agents are responsible for reporting the contracts of insurance effected by them.

The rules set out that where different insurers underwrite different elements of the cover that form part of the same policy, then the insurer underwriting the main part of the cover (and in the event of any doubt, the first part of the cover recorded in the policy) must report the value measures data for all elements of the cover (SUP 16.27.9 R (1)). Where there are co-manufacturers for a contract of insurance then only one must report the value measures data and each firm must agree in writing with the others which firm is responsible.

Where there is the sharing of the risk we expect the lead managing agent to report the data. In the event of there being no lead firm we would expect firms to agree which firm is responsible for reporting the value measures data for those contracts of insurance.

6) Are group policies out of scope?

Yes – This is set out in SUP 16.27.4 R (5).

7) The requirement is for insurers to report the names of the firms and/or brands which represent the largest five distribution arrangements rather than providing the detailed data for these individual arrangements.

a) Does this mean then that on the return the data will be bulked together? For example, if a managing agent has seven coverholders writing the same business, would the managing agent need to show individually the names of the top five, each of which meets the reporting thresholds? Would the data then be aggregated as one single product?

The thresholds are set at Lloyds managing agent and product level rather than at coverholder level. The data is aggregated at managing agent level for each product.

The managing agent must also report the names of the largest 5 arrangements.

b) If a coverholder has multiple binding authority agreements none of which, on a stand-alone basis, meets the reporting thresholds, do we need to add the premium + number of policies for all agreements together in order to ascertain whether the coverholder is one of the top five distributors?

That is correct

8) Where different insurers are underwriting a main policy and associated add-ons, e.g. insurer A underwrites a home policy and insurer B underwrites home emergency add-on, whose responsibility is it to report for the home emergency element of cover?

Where the home emergency cover is a separate policy then the insurer B would report the home emergency product (and depending on the circumstances as an add-on or a stand-alone product).

Where the home emergency cover is not a separate policy then insurer A would be responsible for reporting the home emergency element of cover. Please see SUP 16.27.9 R (1).

9) Do the reporting requirements apply to run-off books?

Where a product is not being sold to new or existing customers then, providing it does not meet the reporting threshold for a period, then no reporting would be required.

For example, if firm A sold 4,000 annual policies (for £1m in total) for a product in the period January 2022 to March 2022 but ceased selling any policies to new or existing customers from that point forwards – then the firm would need to report for the year ending 31 December 2022 (as the reporting threshold is met), but would not need to report data for the year ended 31 December 2023 (as there would not have been any sales in that period).

If a product is not available to new customers, but can be renewed by existing customers, then any renewals in a period would count towards the reporting threshold.

10) Would it be possible for the FCA to provide a mock-up of the return so firms can make plans?

SUP 16 Annex 48 AR sets out the reporting form. Internally we are developing updates to our reporting systems to allow firms to report the value measures data to us. We will look to provide further information to assist firms in due course.

Appendices

APPENDIX 1 – in scope products

Reproduced from SUP 16.27.7R Annex 48R

Product	Product definition
Alloy wheel insurance	<i>contracts of insurance against the risks of loss in relation to vehicle alloy wheels.</i>
Breakdown insurance	<i>contracts of insurance under which benefits are provided in the event of an accident to or breakdown of a vehicle including those where the effecting and carrying out is excluded from article 10(1) or (2) of the <i>Regulated Activities Order</i> by article 12(1), but excluding parts and garage cover contracts of insurance.</i>
Dental cover	<i>contracts of insurance providing benefits in the nature of indemnity, with or without limit, or fixed pecuniary benefits (or a combination of both) against risks of loss to the persons insured attributable to their</i> <i>incurring the cost of dental work.</i>
Excess protection (for motor insurance)	<i>contracts of insurance to cover the risks of incurring an excess in the event of a motor insurance claim.</i>
Extended warranty – furniture	<i>contracts of insurance against the risks of loss attributable to damage to furniture and having the effect as if the manufacturer’s or vendor’s warranty on the furniture is extended for a period of time or is extended in scope.</i>
Extended warranty – electrical goods	<i>contracts of insurance against the risks of loss attributable to failure of an electrical product (excluding motor vehicles and personal gadgets) and having the effect as if the manufacturer’s or vendor’s warranty on the product is extended for a period of time or is extended in scope.</i>
Extended warranty – motor	<i>contracts of insurance against the risks of loss to the persons insured attributable to failure of a motor vehicle and having the effect as if the manufacturer’s or vendor’s warranty on the motor vehicle is extended for a period of time or is extended in scope.</i>
Gadget (including mobile phone)	<i>contracts of insurance against the risks of loss attributable to loss, breakdown or failure of a personal electronic gadget (including mobile phones).</i>
GAP contracts	<i>see Glossary definition.</i>
Healthcare cash plan	<i>contracts of insurance providing fixed pecuniary benefits against risks of the persons insured requiring health care for sickness, infirmity, dental work or injuries sustained.</i>
Home – buildings	<i>contracts of insurance against loss of or damage to the structure of (but not the contents of) domestic properties.</i>

Home – buildings and contents	<i>contracts of insurance against loss or damage to either the structure or contents of domestic properties and including cover against risks of incurring liabilities to third parties arising out of injuries sustained within the boundary of a domestic property.</i>	
Home – contents	<i>contracts of insurance against loss of or damage to the contents of (but not the structure of) domestic properties.</i>	
Home emergency	<i>contracts of insurance providing assistance in the event of home emergencies.</i>	
Identity theft	<i>contracts of insurance relating to assistance in the event of identity theft.</i>	
Key cover	<i>contracts of insurance to cover the risks of loss arising from lost, stolen and/or broken keys.</i>	
Legal expenses	<i>contracts of insurance (or cover within a policy) against the risks of loss to the persons insured attributable to their incurring legal expenses including costs of litigation.</i>	
Missed Event/Ticket insurance	<i>contracts of insurance against the risk of loss of use of the ticket (excludes travel policies).</i>	
Mortgage payment protection	<i>payment protection contracts enabling a policyholder to protect their ability to continue to make payments due to third parties in respect of mortgages.</i>	
Motor	<i>motor vehicle liability, where the vehicle has more than two wheels and is not a motorcycle with side-car and:</i>	
	(a)	<i>the primary purpose of each vehicle insured on the contract is to transport nine or fewer non-fare paying persons and each vehicle insured on the contract is individually rated;</i>
	(b)	<i>the primary purpose of each vehicle insured on the contracts is to transport nine or fewer non-fare paying persons the persons insured are not a body corporate or partnership, and the number of vehicles insured on the contract is three or less; or</i>
	(c)	<i>the primary purpose of each vehicle insured on the contracts is to transport ten or more non-fare paying persons, the persons insured are not a body corporate or partnership and each vehicle insured on the contract is individually rated.</i>
Motorcycle	<i>motor vehicle liability in respect of two-wheeled vehicles or motorcycles with a side car.</i>	
Parts and garage cover	<i>contracts of insurance to cover the risks of incurring parts and garage repair costs in the event of a motor vehicle breakdown, but excluding breakdown insurance.</i>	

Payment protection (including credit card, store cards and personal loans)	<i>payment protection contracts</i> enabling a <i>policyholder</i> to protect their ability to continue to make payments due to third parties other than in respect of mortgages.
Personal accident	<i>contracts of insurance</i> providing fixed pecuniary benefits and/or benefits in the nature of indemnity against the risks of a beneficiary:
	(a) sustaining injury as a result of an accident; or
	(b) dying as a result of an accident; or
	(c) becoming incapacitated in consequence of disease,
	but excluding healthcare cash plans and private medical products.
Pet – accident only policies	<i>contracts of insurance</i> against the risk of loss to the person insured attributable to accidents to domestic pets, providing for each accidental injury.
Pet – lifetime policies	<i>contracts of insurance</i> against risk of loss to the person insured attributable to new illness or injury to domestic pets, providing a set amount of cover each year the <i>policy</i> remains in force.
Pet – maximum benefit policies	<i>contracts of insurance</i> against risk of loss to the person insured attributable to sickness of or accidents to domestic pets providing a fixed maximum benefit for each illness or injury.
Pet – time-limited policies	<i>contracts of insurance</i> against risk of loss to the person insured attributable to sickness of or accidents to domestic pets to cover the treatment of each illness or injury and a set time period for which treatment of each illness or injury will be covered.
Single trip – travel	<i>contracts of insurance</i> against a risk of loss to the persons insured attributable to a travelling on single-trip or to their making of travel arrangements for a single trip.
Travel (annual) – EU	<i>contracts of insurance</i> against a risk of loss to the persons insured attributable to their travelling or to their making of travel arrangements, covering the <i>UK</i> and/or the <i>EU</i> for a year.
Travel (annual) – worldwide	<i>contracts of insurance</i> against a risk of loss to the persons insured attributable to their travelling or to their making of travel arrangements, covering worldwide travel (excluding European-only travel insurance) for a year.
Tyre insurance	<i>contracts of insurance</i> to cover the risks of loss arising from the need to repair or replace motor vehicle tyres.
Vehicle cosmetic insurance	<i>contracts of insurance</i> to cover the risks of loss arising from cosmetic damage to motor vehicles <i>such as minor scratches and dents</i> . (excludes motor and motorcycle insurance policies).

Vehicle misfuelling insurance	<i>contracts of insurance</i> to cover the risks of loss arising from putting the wrong fuel into motor vehicles.
Vehicle pothole insurance	<i>contracts of insurance</i> to cover risks of loss arising from vehicle damage caused by potholes.
Wedding and party insurance	<i>contracts of insurance</i> against the risk of loss arising from the cancellation of weddings or private parties.

APPENDIX 2 – Definitions

Reproduced from SUP 16.27.6 R

“add-on <i>policy</i> ” means	a <i>policy</i> that is sold in connection with, or alongside, another product.
“average claims pay-out” means	total claims pay-out cost divided by the number of claims where all or part of the claim has been accepted and a pay-out has been made and/or benefits provided and the claim is closed at the end of the reporting period.
“average number of <i>policies</i> in force” means	the average number of <i>policies</i> in force during the relevant reporting period, calculated by adding up the total <i>policies</i> in force at the end of each <i>month</i> and dividing by the total number of months in the reporting period
“claim” means	any claim made by a potential beneficiary, including queries in respect of a potentially claimable event or loss (which has taken place).
“claims acceptance rate” means	<p>(a) the number of claims registered; less</p> <p>(b) the number of claims rejected; divided by</p> <p>(c) the number of claims registered.</p>
“claims accepted” means	claims where all or part of the claim has been accepted and a pay-out has been made and/or benefit provided, and the claim is closed or settled during the reporting period.
“claims complaints” means	complaints of a type that are reported in column O of the <i>DISP</i> 1 Annex 1R Table 4 or would have been reported if the threshold of 500 opened complaints was disregarded.

“claims complaints as a percentage of claims” means	<p>the percentage calculated using the formula:</p> $A/B \times 100$ <p>where: A = claims complaints; B = claims registered</p>	
“claims frequency” means	the number of claims registered divided by the average number of <i>policies</i> in force.	
“claims pay-out cost” means	the total costs of providing benefits to <i>policy</i> beneficiaries in relation to claims accepted during the reporting period including:	
	(a)	the total monetary value (£) of claims pay-outs
	(b)	the total cost incurred by the provider <i>firm</i> in providing non-monetary benefits; and
	(c)	specific claims costs incurred by the provider <i>firm</i> in handling individual claims including claims investigation costs.
	all claims during the reporting period less the number of:	
	(a)	claims walkaways;
	(b)	claims in respect of which the potential beneficiary reports an event or loss giving rise to the claim but does not wish to make a claim;
	(c)	claims rejected for insurance fraud; and
	(d)	claim rejected because the <i>policy</i> has been lawfully voided by the <i>insurer</i> .
“claims rejected” means	claims by potential beneficiaries of the <i>policy</i> , declined or rejected in the reporting period, regardless of:	

	(a)	when the claim was registered;
	(b)	whether or not the claim is rejected at the first notification of loss;
	(c)	whether the claim is rejected for breach of a <i>policy</i> condition, pursuant to an applicable <i>policy</i> exclusion, due to the application of an excess or otherwise,
		but excluding claims rejected for insurance fraud or because the <i>policy</i> has been lawfully voided by the <i>insurer</i> .
“claims walkaways” means		claims closed during the reporting period due to the potential beneficiary not pursuing the claim.
“distribution arrangement” means		in relation to the relevant product, each distribution arrangement through which the product is sold, as identified by the consumer facing <i>firm</i> or brand.
“no claims bonus protection” means		a <i>contract of insurance</i> which will, in the event of a claim, within certain limits, protect the purchaser’s number of years during which a person is deemed not to have made a claim for the purposes of calculating the no claims bonus discount incorporated by a provider into the price of a motor insurance product.
“ <i>policy</i> sales” means		<i>policies</i> sold in the reporting period, including renewals, and regardless of the period covered by the contracts.
“reporting period” means	(a)	the period beginning on 1 January and ending on 31 December; or
	(b)	any shorter period in accordance with SUP 16.27.12 (2).

“stand-alone <i>policy</i> ” means	a <i>policy</i> that is not sold in connection with, or alongside, another product.
“total gross retail premiums (written)” means	the total amount of gross written premium, based on the premiums charged to the end consumer (excluding insurance premium tax) in relation to policies sold during the reporting period.
“value measures data” means	the data required to be included in a value measures report and set out in SUP 16.27.10R to 16.27.11R.
“value measures report” means	The report referred to in SUP 16.27.7R

APPENDIX 3 – report completion notes

Reproduced from SUP 16 Annex 48BG

Proforma Column	Proforma
B	Add-on policies and stand-alone policies sales
Guidance	<p>Where cover is included within the main <i>policy</i> or sold as an optional extra or a cover extension of the <i>policy (A)</i> and not a separate <i>policy</i> then that cover should be reported as part of the reporting for <i>policy (A)</i>. The only exception to this approach is the reporting of legal expenses cover which should be reported separately in any event.</p>
F	Number of claims registered
Guidance	<p>Examples of how the number of claims registered should be reported are set out below:</p> <p>Scenarios</p> <p>Where an event covers multiple claim components this should be reported as a single claim. This could include multiple treatments for a single condition for pet insurance, which would be treated as a single claim.</p> <p>Where a person contacts the <i>firm</i> to report an event as required under their insurance <i>policy</i> but does not wish to make a claim, this should not be reported as a claim registered.</p> <p>Where a customer initially calls, or contacts the <i>firm</i>, to make a claim and is advised at that time that the loss is not covered or the claim is below the <i>policy</i> excess and decides not to pursue a potential claim further then this should be reported as a claim registered and a rejected claim.</p> <p>Where a person rings the <i>firm</i> to ask a general or hypothetical question about their <i>policy</i> or the cover, or checks their <i>policy</i> coverage online then this should not be reported as a claim registered.</p> <p>Where a claim is registered but not subsequently pursued (including where the customer does not contact the <i>firm</i> again) and the <i>firm</i> closes the claim within a reasonable period then the claim should be removed from claims registered (in the period that the claim is closed) and treated as a claims walkaway in that period.</p>
I	Number of claims accepted
Guidance	<p>Examples of how the number of claims accepted should be reported are set out below:</p> <p>Scenarios</p> <p>If a firm pays out on one element of a claim, but is still investigating another element of the claim at the end of the relevant reporting period (i.e. the claim is still open) then this claim should only be reported as a claim accepted in the reporting period in which:</p> <p>(a) the final pay-out has been made; or</p> <p>(b) the claim is otherwise closed.</p>

	<p>If a firm pays out on one or more elements of a claim, but rejects other elements of the claim (and the claim is now closed by the end of the reporting period) then this claim acceptance should be reported in this data field.</p> <p>If a firm pays out on one or more elements of a claim and there are no outstanding elements of the claim at the year end and it is closed, these claims should be included. If in the subsequent period, the claim is reopened then this subsequent element of the claim should not be included in this data field</p>
J	Claims rejected
Guidance	<p>For the purposes of the report firms may use the description of insurance fraud in the Insurance Fraud Register (see http://www.theifr.org.uk/en/faqs/#1175).</p> <p>An example of a claim rejected because of breach of condition of the policy is where a claimant failed to notify the provider within an appropriate time period after an event that was likely to result in a claim.</p> <p>An example of a claim rejected because there is no cover is where the claim falls within an exclusion under the terms and conditions.</p> <p>Firms should include claims rejected at the first notification of loss.</p> <p>Firms should include claims whether or not they were registered in the same reporting period as they were rejected.</p> <p>Examples of how firms should report rejected claims are set out below:</p> <p>Scenarios</p> <p>Where a firm rejects one element of the claim but other element(s) of the claim are still being investigated and are outstanding then this partial rejection should not be included in this data field for this reporting period.</p> <p>However, if in the following period the remaining elements of the claim are rejected then the claim rejection should then be included in this data field for that later reporting period.</p> <p>Where a firm accepts one element of the claim but rejects another element of the claim, this should not be treated as a rejected claim.</p> <p>Where a claim has been rejected because the policy has been voided, this should not be treated as a rejected claim.</p> <p>Where a customer has contacted the wrong insurer or provider to make a claim – this should not be included in the registered and rejected claims data.</p> <p>Where a person contacts the firm to enquire whether they are covered for a claim (relating to an event that has taken place or loss that has occurred) and are informed that they are not covered, then this should be included in both claims rejected and claims registered.</p> <p>Where an insurer or provider is part of a panel and the panel provider may not record which insurer/providers on the panel rejected the claim – firms may estimate their number of rejected claims by calculating a proportion of rejected claims in line with the insurer/provider's share of the business.</p> <p>Where a claim is closed and the only cost incurred is an investigation fee or cost (e.g. a call-out charge) and the claim is rejected then this should be treated as a rejected claim. However, if following the investigation the customer walks away from the claim then the claim should not be treated as a rejected claim.</p>

	Where a claim is registered and some elements of the claim have been rejected, but the customer has walked away from the remaining elements of the claim then this should be treated as a rejected claim.
L	Total claims pay-out costs
Guidance	<p>These costs could include both internal and external outsourced costs, where relevant. For example, loss assessment activities performed in-house could be included, including both the direct cost and an appropriate apportionment of overheads.</p> <p>Excluded costs are:</p> <ul style="list-style-type: none"> • expenses including costs associated with the general handling of claims; • other non-claims costs; and • costs of providing a regular service element such as a helpline or a boiler service for home emergency. <p>Scenarios</p> <p>Where part of the claim was paid-out in the previous reporting period and part in the current reporting period, then the claim pay-out that took place in the previous period should be included in the calculation for the total pay-out in the current reporting period.</p> <p>Where a claim has been closed/settled in the previous period but the claim has been reopened in the current reporting period, any additional claim pay-out should be included in this field.</p> <p>Where firms subsequently receive recoveries from other firms these recoveries should be netted off against the relevant claim pay-outs.</p> <p>Where a claim is settled, but the settlement includes a regular payment element then the settlement value as it is reported on the firm's system should be included in the cost.</p>
N	Top 2% of claims
Guidance	<p>Firms should report the amount that the top 2% of claim pay-outs are above in the reporting period.</p> <p>For example, if you have 100 claims then the 2% column would be the total claim pay-out cost for the claim accepted with the 2nd highest claim.</p>
Q	Claims complaints as % of claims
Guidance	This may be calculated as the number of claims complaints divided by the number claims registered.

Contact

Steve Morrell
Head of Regulatory Affairs
Lloyd's Market Association

steve.morrell@lmalloyds.com
Tel: +44 (0) 203 789 3494