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Article

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SPOUDAI - Journal of Economics and Business

Provided in Cooperation with:

University of Piraeus

Suggested Citation: Yusuf, Tajudeen Olalekan; Ajemunigbohun, Sunday Stephen; Alli, Gbenga Noah (2017) : A critical review of insurance claims management: A study of selected insurance companies in Nigeria, SPOUDAI - Journal of Economics and Business, ISSN 2241-424X, University of Piraeus, Piraeus, Vol. 67, Iss. 2, pp. 69-84

This Version is available at:

<https://hdl.handle.net/10419/195195>

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A Critical Review of Insurance Claims Management: A Study of Selected Insurance Companies in Nigeria

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Abstract

This study is an empirical investigation of insurance claims management among selected insurance companies in Nigeria. For this purpose, the researchers have been able to review critically the significant contribution of the claims processing in the management of insurance firms' claims. This study conducted in Lagos metropolis, employed a descriptive survey design using random sampling technique and thus gathered data through the use of structured questionnaire. The sample population consisted of 127 respondents made up of claims managers and other members of staff within the surveyed companies. One sample T-test was adopted in the analysis of collected data. Empirical assessment reveal that the various claims handling processing have significant effects in the claims management processes of insurance companies. The findings from study confirm the significance of the various claims handling processing in claims management of insurance companies in Nigeria. It therefore recommends that claims manager should put forward strategic plans to ensuring that insurance claims complaint files are properly kept, monitored and handled for needs that may warrant its usefulness in the future. Also, state-of-the-art training mechanism should be put in place to enhance and improve the working pattern of a claim officer which invariably might affect the organizational efficiency of insurance companies and lastly, Government should harmonize their resources and technical knowhow with the Nigerian insurance industry in ensuring that insurance claims are well designed to curtail fraudulent claims experienced in the past.

JEL Classification: M04, M19.

Keywords: claims, claims processing, claims management, insurance companies, Nigeria.

1. Introduction

Often times, situations that arise from loss events awake the insuring populace towards the need for protective measure. However, claims are noted as the most critical channels and a defining link that shape the overall perception of the customers towards their insurer (Crawford, 2007). According to Capgemini (2011a), the claims processing is the mirror to the customer that enable the insurers' drive at improving customers' acquisition, expectation, retention and business' insight for product enhancement and company's profitability. Therefore, the drive, accuracy, efficiency and effectiveness of claims managerial procedures is key for cost control, risk management and meeting expectation needed for proper portfolio underwriting (IBM, 2011).

Studies recently conducted in Nigeria among insurance experts within the academia had given quite a number of revelations with respect to insurance fraud; claims handling process; claim cost and insurer's profitability; among others (Ojikutu, Yusuf, & Obalola, 2011; Yusuf & Abass, 2013; Yusuf & Babalola, 2009; Yusuf & Dansu, 2014). However, Michael (2008) earlier stated that the core elements of a modern claim management system that can process all claim types should include: a component of case management along with the skill to calculating and processing complex reoccurring payments. TIBCO (2011) opined that for insurers to significantly enhance their claims management and promptly adapting to changing situations, they are required to make more profound infrastructural changes that align claims processing with organization objectives for customer service, operational cost and risk management.

Quite a number of recent studies such as Capgemini (2011b), Michael (2008) and Rose (2013), had revealed that insurance company's management of claims process is an integral link to its profitability and continuous survival, and also, mentioned that good claim management ought to be proactively conducted in acknowledging and paying claims legitimately; and then, evaluating accurately the claims reserve. According to the Association of Insurance and Risk Managers in Industry and Commerce (2009), paying claims legitimately is a representation of the delivery of the promise at the heart of the insurance contract, which in fact indicate excellent claims handling service that is considered as a differentiator that separate them from their competitors. An excellent claims handling service is an insurance company's competitive edge and thus, noted as a service that customer value greatly.

Capgemini (2011a) argued that a highly effective claims practice can be a vital contributor to attracting new customers and strengthening customer loyalty to produce a valuable customer experience. According to an earlier remark by the Organization for Economic Co-operation and Development (2004), a good insurance claim management process should involve: claims reporting; receipt of claims by the company; claims files and procedures; fraud detection and prevention; claims assessment; timely claim process; complaints and dispute settlement; and supervision of claims-related services.

1.1 Statement of research problems

In achieving a cost reduction in the claim management process and delivering on a value-added brand promise to customers, the focus seems to be effective and efficient managerial process in the claims function. In this regard, claims management process has been a daunting task because of its critical function that touches all aspects of the organization relating to service delivery, exposure to risk, positioning of competitiveness, fraud

management and infrastructural development. To some insureds, the belief is that the insurer is only interested in premium collection, and not settlement of claim. Singh (2012) points at certain inefficiencies that adversely affect customer's claims experience to include: aging technology, rising number of fraudulent claims and increasing complexity in the claims processes.

However, the increasing difficulties in the claims management processes are rationale for which this study is embarked upon, namely: inappropriateness in claims acknowledgement and assignment; ill-design of information systems to identifying existing claims; communication gap between insurers and customers; claims investigation and documentation time-consuming; insufficient professionalism in the determination of loss situation and amount; and inappropriate conclusion and monitoring of claim handling process. Capgemini and Efma (2011) noted that inefficiencies with related to claims could stem from environment, technical and organizational factor.

1.2 Objectives of the study

The core purposes of the study are to take cognate examination of the followings:

- To ascertain inappropriateness in claims acknowledgement and assignment;
- To find out if a well-designed information system is in place to identifying existing policies;
- To know if claims officiating have significantly improved insurer-customer relationship;
- To examine if claims investigation and documentation have been time-consuming;
- To find out if adequate professionalism is involved in the determination of loss situation and amount;
- To ascertain if claims handling process is appropriately concluded and monitored.

1.3 Relevant research questions

- In a bid to achieving the various objectives stated above, the followings are the relevant research questions that were set out:
- Are there inappropriateness in acknowledging and assigning claims whenever claims are reported?
- Are claims information systems well-designed for proper identification of existing policies?
- Of what significant is claims officiating to insurer-customer relationship in the claims management process?
- Are claims investigation and documentation considered time-consuming in the claims management process?
- Has there been involvement of professionalism in the determination of loss situation and amount?
- Is claim handling process appropriately concluded and monitored?

1.4 Research hypotheses

To provide answers to the questions highlighted above, the following testable hypothetical statements were considered:

Ho₁: Claims acknowledgement and assignment have no significant effect in the claims management process

Ho₂: Claims information systems in place have not significantly enhance proper identification of subsisting policies

Ho₃: Claims officiating have not significantly improved insurer-customers relationship in the claims management process

Ho₄: Time consumption in the claims investigation and documentation have no significant effect in the claims management process

Ho₅: Professional involvement in the determination of loss situation and amount have not yielded significant effect in the claims management process

Ho₆: Conclusion and monitoring of claims have not yielded significant effect in the claims management process

2. Meaning and concept of claim

A claim on an insurance policy, according to Krishman (2010), is a demand on an insurance company to fulfill its portion of the promise, committed to while writing the contract with the insured. Asokere and Nwankwo (2010) defined a claim as a demand made by the insured person to the insurer for the payment of benefits under a policy. Brooks, Popow and Hoopes (2005) earlier submitted that an insurance claim is also a demand by a person or an organization seeking to recover from an insurer for a loss that an insurance policy might cover. A claim, according to Vaughan and Vaughan (2008), is described as a notification to an amount is due under the terms of a policy.

However, Francis and Butler (2010) described claim as a defining moment in the relationship between an insurance company and its customer. Similarly, such relationship can become healthy if the insurers are able to address five key issues such as: taking greater control of the claim process; understanding their customer; choosing the right claims model for their business; developing a mutually beneficial relationship with other service providers; and gaining an information advantage. Singh (2012) opines that insurers can transform the claims processing by leveraging modern claims system that are aligned with robust business intelligence, document and content management system that will improve claims processing efficiency and effectiveness.

2.1 Claims management process

Jacob (2007) noted that the core challenges driving business costs in claims processing involve: responsiveness; flexibility and management of workflow; supply chain management; and business intelligence. Association of Insurance and Risk Managers in Industry and Commerce (2009) argued that the key components that must be in place in a bid to delivering excellence in insurance claims handling include: culture and philosophy, communication, people, claims management, infrastructure, data management, operations, and monitoring and

review. According to Esri (2012), the five steps for optimizing the insurance claims process involve: data organization; analysis and planning; mobility; management and customer engagement.

Goel (2013) was of the opinion that claims processing involves some tasks such as: following up with the claimant or third party for missing documentation and validating that all required claim information has been collected. It was arguably considered thus that claim managers ought to focus only on the most significant claim tasks that required their attention, and also optimizing the use of their time. According to Singh (2012), for insurers to attain operational efficiency and effectiveness in claim process, they must look directly at implementing modern claims system; leveraging advanced fraud detection technologies and creating innovation around their self-service claim processing activities. IBM (2007) expressed that those involved in the management of claims seek to achieve: increased efficiency in their claims handling process; improved control over the process with a view to managing and guaranteeing service levels; seamless integration across the end-to-end claims process; greater flexibility within the process to respond to changes within the market; and the ability to deliver this across multiple distribution channels to their customers and partners.

Benefits that have been alluded to effective claims management process, according to Capgemini (2011c), were noted as: improved customer service; reduced indemnity costs, improved claims handling and administration; reduction in allocated loss adjustment expresses; improved operational management; improved enterprise risk management; enhanced business agility; and core brand differentiation. According to an earlier submission by the Productive Commission (2002), a good claim management process is expected to include: proactiveness in recognising and paying legitimate claims; assessing exactly the reserve associated with each claim; reporting regularly; minimising unnecessary costs; avoiding protracted legit disputation; dealing with claimants carefully; and expediting claims handling.

Amorose (2011) opined that the key areas insurers should take critical look at in achieving operational excellence in claims management are: leveraging advanced analytics, supplier management, legal cost management, technology enablement, and fraud detection. According to Wilberforce (2015), claims process commences at underwriting function which is guided by structured losses experience data. An experiential revelation by Jacob (2007) noted that in addressing the various challenges in the insurance claims management process, a set of technology-related processing significant to enhancing claim have been identified as follows: (i) An integrated and flexible architecture; (ii) Business intelligence enable by more sophisticated data management, analysis and reporting throughout the enterprise; (iii) Deeper integration of business processes, as well as visibility provided by monitoring, alerts, and reporting; (iv) increased collaboration; (v) support for mobile workers; (vi) cost-effective migration from legacy systems; and (vii) industry and technology standards.

2.2 Insurance claims manual

The claims manual, according to the State of Louisiana Office of Risk Management (2011), is developed purposely to provide useful information on insurance language to use in agency contract with outside vendors, contractors or lessees. It is thus used as a guideline and to provide recommendations of limits and coverages. The insurance policy section of the claim manual usually contains brief description of individual insurance and not treated as a replacement for the relevant policy documents (Aon Risk Solution, 2013). Edward (2001)

opined that an insurer's claim manual is usually needful whenever there is a suit against insurance companies.

2.3 Insurance claims fraud

Quite a number of studies have established the relationship between insurers' claim managerial behaviour and insurance fraud (Crocker & Jennyson, 2002; D'Arcy, Derrig & Weisberg, (nd), Derrig, 2002; Derrig & Weisberg 2004; Dionne, Giuliano, & Picard, 2009; Loughran 2005; Shiller, 2006). Fraud, as cited in Brennan (2012), is seen as a deliberate act that is contrary to law, rule or policy with intent to obtain unauthorized financial benefit. Kuria and Moronse (2014) as cited in Yusuf and Ajemunigbohun (2015) described fraud as an act or omission with the intention to making one gain advantage illicitly or dishonestly in dealings that can be accomplished by intentionally concealing, suppressing, misrepresenting or nondisclosure of relevant fact significant to transactions of financial decision; misappropriating assets; and abusing fiduciary responsibility or position of trust. An earlier submission by Derrig (2002) opined insurance fraud as a criminal act which involves obtaining monetary gain from insurer or insured through misrepresentation of facts or false pretences. Coalition Against Insurance Fraud (1999) earlier proposed insurance fraud laws as essential to combating the increasing effect of fraud on the cost of insurance.

However, the studies of Roder and Jamieson (2005) and SAS (2012) noted two distinct types of fraudulent claims as: opportunistic and planned/professional. According to Yusuf and Babalola (2009), opportunistic fraud is categorized as the most prevalent insurance fraud within the insurance market. Insurance Europe (2013) argued that fraud affects every type of insurance, be it non-life, life and health insurance protection. According to Singh, Parekh, Indge, Bali, & Torpey (2011), the various types of fraud affecting insurance companies are: commission rebate, fake documentation, collusion between parties, and misspelling. Yusuf (2010) stated four classes of insurance fraud to include: internal fraud, intermediary fraud, policyholder fraud and insurer fraud.

Roder and Jamieson (2005) opined that the true economic cost of insurance is near impossible to quantify. To this end, Chartered Global Management Accountant (2012) had suggested effective anti-fraud strategy to include: prevention, detection, response and deterrence. Meanwhile, a combination of prevention, detection and response measures can assist to create an effective fraud deterrent. For further submission, while fraud prevention strategy is said to composed of: a sound ethical culture and sound internal control systems; the key tools for detecting fraud include: training and experience combined with the necessary mindset that fraud is always a possibility. Lexis-Nexis (2014) suggested that tactics to preventing insurance fraud must be integrated with insurers' operational activities to guaranteeing the following: ensuring secure information management; enhancing operational efficiency; improving investigative efficiency; minimizing false-positive results and promoting compliance with global regulations. Therefore, taking an assessment technique, according to IBM (2012), insurance companies are guaranteed with the following: preventing fraud at the time of policy submission; predicting fraud at the intake of claims; identifying fraud during adjudication; discovering fraud by examining patterns in data; investigating fraud more efficiently by reducing false positives and accelerating the investigation process; and visualizing trends to continuously enhancing antifraud efforts.

3. Research method

In achieving the purpose for which this study was set out, a descriptive survey research design was adopted. The choice of this survey technique was due to the fact that it observed what happened to sample subjects or variables without any attempt to manipulate or control them (Asika, 2008). Besides, it has potentials to predict behaviour and assist in collecting information identical regarding all cases in a sample (Bordens & Abbott, 2002). It assists in portraying an accurate profile of persons or events and thus establishes causal relationship between variables employed in the study (Robson, 2002, Saunders, Lewis, & Thornhill, 2009). Data gathering was conducted via the field survey among insurance companies with the aid of structured questionnaire comprised of two parts, Part A and Part B; while Part A consisted of personal data of respondents, Part B detailed statements related to constructs understudied. However, the respondents' views with respect to the understudied issues were coded to enhance the completion of the Questionnaire which was assisted using a Likert-type scale measurement of 'Strongly Agree', 'Agree', 'Disagree' and 'Strongly Disagree'. To this end, each response was assigned a numerical code before it entered into SPSS (Pallant, 2011). Accordingly, strongly agree = 4, agree = 3, disagree = 2 and strongly disagree = 1.

The population of the study consisted of 51 insurance companies operating in Nigeria. Among these insurance companies, 31 companies were surveyed consisting of 22 general insurance companies and 9 life insurance companies, giving a 61% of the industry capacity. The choice of these companies was as a result of their gross premium and market share capabilities as documented by the Nigeria Insurers Association (2014). The empirical research ground for the sample population was drawn from Lagos metropolis. The choice of Lagos was because it houses the largest number of insurance companies within the West-African region. A total of 155 copies of questionnaire were set out. 5 copies of the questionnaires provided for claims managers and other staff members within the respective surveyed company accompanied by a covering letter. A random sampling technique was adopted in the data gathering process. In order to ascertain the appropriateness of responses, frequent telephone calls, electronic mailing, and short visits were options to ensuring proper questionnaires' filling and returning. Also, questionnaire gathering was done via self and other research assistants employed. To the end, 142 copies retrieved while 127 were found validly completed and usable for analysis (that is, an 82% effective response rate).

On the validity of the study, construct and content validity were adopted. While the construct validity was conducted via measures of variables understudied from well-grounded literatures, the content validity was designed through the distribution of a set of drafted questionnaires to few selected top insurance claims officers and some members of the academia in the field of insurance. These experts considered the instrument and gave laudable suggestions, which assisted the researcher in being able to present the items on the instrument within the linguistic understanding of the respondents. On reliability, the Cronbach alpha on questionnaire administration is 0.7862; which shows that the instrument is above the standard requirement of 0.70.

4. Results and discussion

In a bid to analyzing the research hypotheses, the T-test statistical technique was employed for these purposes.

Hypothesis Testing

A hypothesis test, according to Gravetter and Wallnau (2000), has been described as a statistical technique that uses sample data to ascertain a hypothesis about the population parameter. The T-test sample non-parametric technique has been employed for this study.

4.1 Claims acknowledgement and assignment have no significant effect in the claims management process

Table 1

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Claims Acknowledgement and assignment in Claims Management Process	127	1.7953	.82941	.07360

Table 2

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Claims Acknowledgement and assignment in Claims Management Process	24.393	126	.000	1.79528	1.6496	1.9409

Survey report, 2016

Result in table 2 shows that the calculated value of 24.39 is greater than the p-value of 0.000 at 5% level of significance (i.e. $D_{cal} = 24.39 > p = 0.000$). Therefore, in consonance with the decision rule, the null hypothesis (H_0) that Claims acknowledgement and assignment have no significant effect in the claims management process is rejected. We then conclude that Claims acknowledgement and assignment have significant effect in the claims management process. This result corroborates the suggestion of Brook, Popow and Hoopes (2005), who noted the assignment of claims as an involvement of insurers' acknowledgment of the claim with the insured or the insured's representative before assigning it to a claim representative. This suggestion further confirms the earlier studies of IBM (2011) who noted efficiency and effectiveness of claims management procedures as key for cost control, risk management and meeting customers' expectation needs

4.2 Claims information systems in place have not significantly enhance proper identification of subsisting policies

Table 3

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Identification of Subsisting Policies in Claims Management Process	127	1.9528	.77519	.06879

Table 4

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Identification of Subsisting Policies in Claims Management Process	28.388	126	.000	1.95276	1.8166	2.0889

Survey report, 2016

The result in table 4 shows that the calculated value of 28.38 is greater than the p-value of 0.000 at 5% level of significance (i.e. $D_{cal} = 28.38 > p = 0.000$). Therefore, in consonance with the decision rule, the null hypothesis (H_0) that Claims information systems in place have not significantly enhance proper identification of subsisting policies is rejected. We therefore conclude that Claims information systems in place have significantly enhance proper identification of subsisting policies. This result is in consistent with the study of Asikhia (2010), who had opined that until companies are able to deliver their services in an efficient manner, with technology as key determinant, financial institutions may not be able to retain their customers. Amorose (2011) thus see technology enablement as one of the key areas insurers should take critical look at in achieving operational excellence in claims management.

4.3 Claims officiating have not significantly improved insurer-customers relationship in the claims management process

Table 5

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Claims officiating in insurer-customer relationship	127	1.9370	.79431	.07048

Table 6

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Claims officiating in insurer-customer relationship	27.482	126	.000	1.93701	1.7975	2.0765

Survey report, 2016

In table 6, the calculated value of 27.48 is greater than the p-value of 0.000 at 5% level of significance (i.e. $D_{cal} = 27.48 > p = 0.000$). Therefore, in consonance with the decision rule, the null hypothesis (H_0) that Claims officiating have not significantly improved insurer-customers relationship in the claims management process is rejected. We then conclude that Claims officiating have significantly improved insurer-customers relationship in the claims management process. To support the existing result, Association of Insurance and Risk Managers in Industry and Commerce (2009) suggested communication as a key component that must be in place in order to deliver excellent insurance claims handling. This, further, confirms the earlier studies of Ashturkar (2014), Dhanushkoti and Coates (2006), DiNapoli (2013), and Organisation for Economics Corporation and Development (2004), where it was noted that proactive process at claims handling will provide customers with better resolution and curtailing the entire cost of their claims, and thus giving insurers stake in claims handling, more commitment and better performance strategies.

4.4 Time consumption in the claims investigation and documentation have no significant effect in the claims management process

Table 7

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Claims Investigation and Documentation in Claims Management Process	127	1.9843	.88178	.07824

Table 8

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Claims Investigation and Documentation in Claims Management Process	25.360	126	.000	1.98425	1.8294	2.1391

Survey report, 2016

The result in table 8 shows that the calculated value of 25.36 is greater than the p-value of 0.000 at 5% level of significance (i.e. $D_{cal} = 25.36 > p = 0.000$). Therefore, in consonance with the decision rule, the null hypothesis (H_0) that time consumption in the claims investigation and documentation have no significant effect in the claims management process is rejected. We then conclude that time consumption in the claims investigation and documentation have significant effect in the claims management process. This, then, corroborate the earlier study of Goel (2013) who arguably considered that claim managers ought to focus only on the most significant claim tasks that required their attention, and also optimizing the use of their time.

4.5 Professional involvement in the determination of loss situation and amount have not yielded significant effect in the claims management process

Table 9

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Determination of Loss Situation and Amount in Claims Management Process	127	1.7559	.96541	.08567

Table 10

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Determination of Loss Situation and Amount in Claims Management Process	20.497	126	.000	1.75591	1.5864	1.9254

Survey report, 2016

The result in table 10 shows that the calculated value of 20.49 is greater than the p-value of 0.000 at 5% level of significance (i.e. $D_{cal} = 20.49 > p = 0.000$). Therefore, in consonance with the decision rule, the null hypothesis (H_0) that Professional involvements in the determination of loss situation and amount have not yielded significant effect in the claims management process is rejected. The researchers then concluded that Professional involvements in the determination of loss situation and amount have yielded significant effect in the claims management process. In support of the result, Singh (2012) opined that insurers must look directly at implementing modern claims system to attain operational efficiency and effectiveness in claim process. Capgemini (2011b) concurs that improved claims handling and administration can effectively streamline and accelerate the claims management lifecycle.

4.6 Claims handling process have not been significantly concluded and monitored

Table 11

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Conclusion of Monitoring of Claims Management Process	127	1.9921	.84041	.07457

Table 12

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Conclusion of Monitoring of Claims Management Process	26.713	126	.000	1.99213	1.8445	2.1397

Survey Report, 2016

The result in table 12 shows that the calculated value of 26.71 is greater than the p-value of 0.000 at 5% level of significance (i.e. $D_{cal} = 26.71 > p = 0.000$). Therefore, in consonance with the decision rule, the null hypothesis (H_0) that Claims handling process have not been significantly concluded and monitored is rejected. The researchers then concluded that Claims handling process have not been significantly concluded and monitored. In support of the result, Association of Insurance and Risk Managers in Industry and Commerce (2009) argued that claims monitoring and review are key components that must be in place in a bid to delivering excellence in insurance claims handling.

5. Conclusions, recommendations and further research

This study attempts to examine claims management processes with the Nigerian insurance industry as research ground for its empirical assessment. The findings of the study have shown the significance of the various processes in claims management. It has so far affirmed that good claim processing is key to insurers' profitability and long-term sustainability. Insurance companies are urged to set moral and legal defensible values to guide their claims procedures and also, to shape their dealings with both existing and prospective customers. To this extent possible, insurance companies should clarify their claims manual in a bid meeting with their firm's value and expectations in dealing with the insuring populace, as well as making effort to attracting and retaining customers who share and appreciate these identical values, as claim stands as the mirror through which the insuring public see the insurer.

On recommendation, claims manager should put forward strategic plans to ensuring that insurance claims complaint files are properly kept, monitored and handled for needs that may warrant its usefulness in the future. Secondly, state-of-the-art training mechanism should be put in place to enhance and improve the working pattern of a claim officer, which invariably might affect the organizational efficiency of insurance companies. Claims handling procedures should be promptly managed to avoid deficiency in organization's operational objectives. More so, regulators and other stakeholders, within the industry, should at regular interval intensify effort to ascertaining the claims handling procedural methods in use by insurance companies in Nigeria; and lastly, Government should ammonize their resources and technical knowhow with the Nigerian insurance industry in ensuring that insurance claims are well designed to curtail fraudulent claims experienced in the past.

The study suggests that future studies should focus efforts at gathering information from the insuring populace as related to customers' experience of insurance claims in Nigeria. Additionally, the various claims handling modes should be understudied to ascertain their acceptance level among the insurance companies and the use to which they are put. Research efforts could be drawn at designing insurance claims model for addressing the lingering perceived customer image related to insurance fraud in Nigeria. Lastly, future research could also attend to detecting and preventing insurance fraud through the insurers' claim settlement manuals.

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