The Claims Corner: Understanding The Claims Process

Description

â??Claimâ?• is not a welcome word within the lexicon of a title office. Without claims, there would be no need for title insurance, yet a claim is something that every title office seeks to avoid, is often panicked to learn about and is loath to admit has occurred. It generally arrives at an inconvenient time and is introduced by a customer or business source that wants or needs the matter resolved yesterday. When a claim arises, the one thing no one seems to have is the one thing that is needed for resolution â?? time. This article will explore and attempt to shed light upon the claims process and the role of time in its resolution.

In a perfect world, under the terms and conditions of a title policy a claim is the assertion by an insured under a title policy of the existence of a lien, encumbrance, defect or other matter that affects title to the estate or interest as insured. This is accomplished by written notification to an insurer, at the address specified in the policy, by an insured that reasonably apprises the insurer of the facts relating to the claim.

In the real world, this often takes the form of a telephone call or e-mail to the agent from either the insured or the insuredâ??s real estate agent, coupled with either a plea for help or a demand for resolution. The agent has two options â?? advising the customer or agent to communicate directly with the insurerâ??s claims office or communicating the claim on behalf of the title office customer to the Insurer. While the policy has an address for delivery of the notice of claim, most title insurers have a means of electronic transmission of a claim.

A title office should always choose the latter option. Why? Because of time. In Virginia a clock starts to run from the moment a claim is communicated to an insurer; an insurer must acknowledge receipt of the claim to the insured within 15 days of its receipt. Notice of a possible claim communicated to an agent of the insurer is considered communication to the insurer. The faster the claim is communicated, the faster the insurerâ??s claims department is able to begin the process of investigating and resolving the matter. Remember that it is not the agentâ??s responsibility to determine the validity of the claim. Rather, it is their responsibility to communicate it to the insurer so the insurerâ??s claims process can begin.

Time is also an issue for the title officeâ??s customer. Often a claim comes to light in the form of a summons, a violation notice, or an action by an adjoining owner. In other instances, a hitherto unrealized title defect serves to obstruct the closing on a sale or refinance of the property. In either instance, it is as important to alert the claims office to any deadlines as it is to address expectations of the claimants for resolution. This is because a claim runs through three stages â?? claim intake, claim review/investigation and claim resolution.

Claim Intake

When a claim is received by the insurerâ??s claims office, it receives an initial review as to the type of issue, the location of the claim and the complexity of the matter. It is set up in the claims system and

assigned to an individual charged with investigating the claim. A letter or acknowledgment of claim is sent to the insured and to the agent with any request for additional information. The notice to the agent is typically accompanied with a request for the file.

â??Why,â?• one asks, â??do they need the entire file? Why not just the portion dealing with the claim?â?• The answer lies in the differing knowledge levels of the agent and the claims investigator. The agent is intimately familiar with the transaction, having worked on the file, examined the title, interacted with the parties to the transaction and communicated with lenders, creditors and local officials. The investigator knows none of this, but needs to quickly step into the shoes of the agent in order to fully evaluate the claim. The fastest way to do that is by requesting the entire file.

Claim Review / Investigation

It may seem like forever between the time the claim is received and time the agent or its customer hear from the claims investigator. This is because review of the file is only part of the investigatorâ??s role in the claims process. The investigator may need to reach out to the agent or the insured for clarification or additional input on something found in the file or may need to request additional updates on title. Witnesses may need to be contacted and interviewed or experts such as surveyors, appraisers or local attorneys may need to be consulted. While this takes time, the insurer is under a requirement to respond to the insured as whether it will accept or deny a claim within 15 days of the receipt of a properly executed proof of claim. If additional time is needed to investigate the claim that fact must be communicated within that 15 day period. A final determination is required within 45 days; if more time is required, that reason must be communicated within the 45 days and every 45 days thereafter. Pending litigation may act to shorten this review period so it is important to communicate any known litigation or time limits for response to the investigator. The agentâ??s role is to respond as quickly and as fully as possible to requests of the investigator; while the 45 day window may seem insufficient to the investigator, it may be an eternity to an insured, especially if additional time is required for complete investigation.

It is in this stage that the agent can have the greatest impact. Once contacted, the sooner the information is transmitted to the investigator, the sooner the insurer can assess the matter. Any insight resulting from the agentâ??s knowledge of the file such as contact information for interested parties or local experts can be passed along at this point. Something as inadvertent as a note scribbled by an employee or an e-mail exchange between two parties may have a bearing on the resolution of a claim; unless the investigator is directed to that note, it may be missed.

Claim Resolution

Unless extended, the insurer is required to communicate to the insured its coverage decision within 45 days of the receipt of a properly executed proof of claim. A denial may result from the claim not being a matter covered under, or being a matter specifically excluded by, the terms and conditions of the policy, such as a zoning determination or an exercise of police powers. A denial may also result because the claim falls within one of the exceptions contained in Schedule B of the policy.

Acceptance and resolution of a claim may take the form of one or more of (i) a curative action to eliminate the defect, such as a confirmatory or corrective deed, (ii) a letter of indemnity to another insurer to allow that insurer to issue its policy without exception to the defect (while this may not be an actual cure, it may allow the insured to sell or refinance without a delay), (iii) payment of a loss, (iv)

defense of the insured or (v) prosecution of an action on behalf of the insured. As with the investigation, the agentâ??s timely input and insight, if sought, can assist in determining the best method of resolution. Resolution of a claim may be quick, like a letter of indemnity, or reimbursement or payment on behalf of a claimant, or lengthy such as any litigation involving title to the property. In the latter, participation or cooperation by the insured may be necessary to a successful outcome.

Conclusion

A claim is never an enjoyable event and not all claims may be resolved to the satisfaction of the insured. The insured are not always made whole for inconvenience and all costs suffered or incurred since the policy is designed only to compensate for actual loss up to the policy amounts and legal fees are paid only to the attorneys retained by the insurer for the insured. More often than not, resolution of a claim is by nature a deliberate process that takes longer than the insured originally anticipates.

Roles that the agent should resist are interpreter of the claim or ombudsman for the insured. It is a natural reaction (and good customer service) to want to assure a claimant that their issue will be taken care of expeditiously and to their satisfaction. The terms of the policy, exclusions or exceptions, however, may dictate otherwise. Unavailability of witnesses, lack of cooperation by the insured, or the need for additional investigation may extend timelines or lead to delays in response by the insurer. Unless it is to provide information that is helpful to the investigator, calls from the agent may not expedite any response. For the agent, assuming these roles, however well intentioned, may only make a difficult situation worse, because a promised response outside of the agentâ??s control is now being used against them.

A better practice may be, educating a customer on the steps in a claims process to temper expectations, referring them to the claims department for answers to their questions so they do not get what they may perceive as inconsistent answers and encouraging prompt answers to any inquiries from the insurer or any retained counsel. If both agent and insured maintain prompt and direct communication with the insurerâ??s claims department the result will be a smoother process for all involved.

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