**THE EFFECTS OF SLOW CLAIMS SETTLEMENT ON THE SALES AND**

**MARKETING OF INSURANCE PRODUCTS; A CASE STUDY OF ENTERPRISE**

**INSURANCE CO. LTD (EIC)-TAKORADI BRANCH,**

KNUST

**By**

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the degree of

**COMMONWEALTH EXECUTIVE MASTER IN BUSINESS ADMINISTRATION**

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I hereby declare that the submission is my own work towards the Executive MBA and that , to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the university, except where due acknowledgement has been made in the text.

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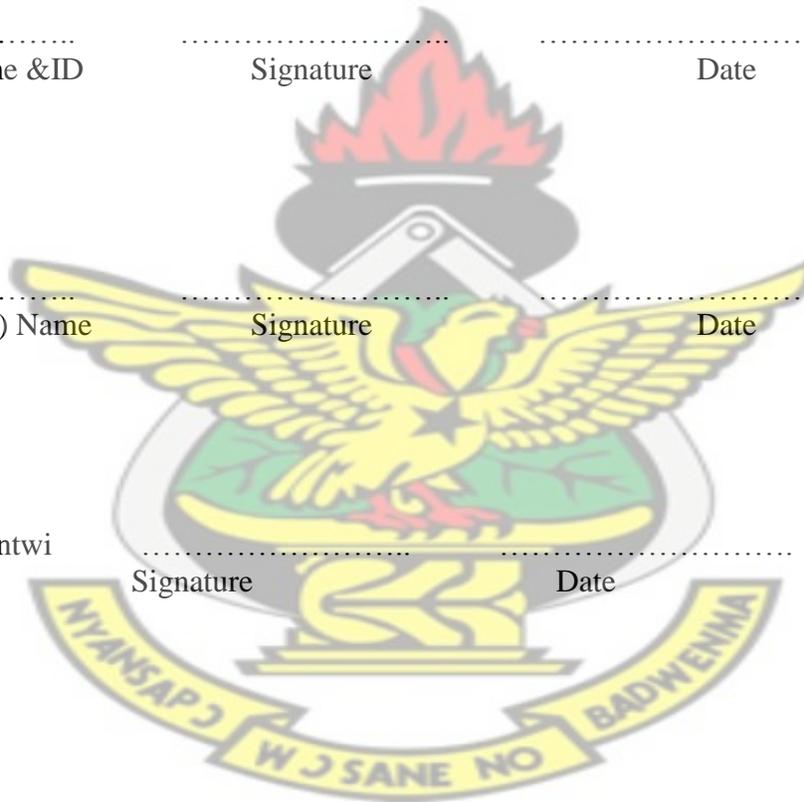
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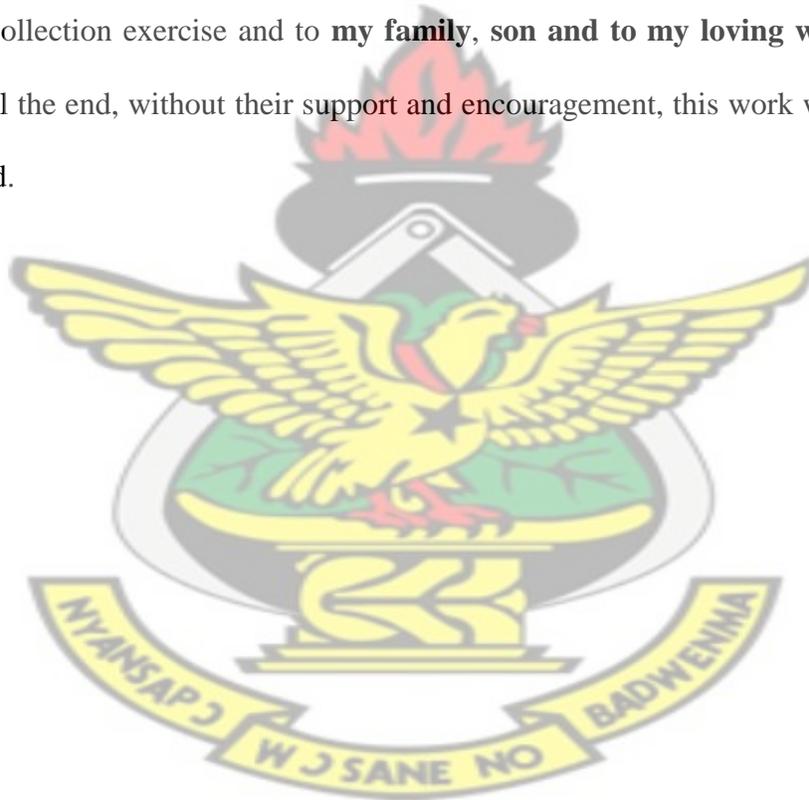
# DEDICATION

This thesis is dedicated to EMMA **OFORI-ATTAH (Mrs.)** my loving wife

**ABSTRACT**

Claims settlement, which dates as far back as the history of insurance, is the only reason the consumer (insured) buys an insurance product. The fast administration of Claims is therefore not only a legal obligation of an insurance firm, but a strong public relations and marketing strategy. The response to claims has rather been slow in Ghana and this is of great concern, since a thriving economy depends to a large extent on the guarantees and assurances received from insurance companies.

This research investigated the trends in the company's (Enterprise Insurance Company Ltd) claims settlement system and its effect on the sales and marketing of its insurance products. The objectives of the research was to; (1) Review current literature on marketing vis a vis literature on claims, (2) Determined the meaning of the word "Slow" from customer's point of view. (3) Established the relationship between the slow claims settlement and customer repurchase of insurance, (4) Examined the customer's perception of existing trends of claims settlement system in the company.

Data collection was conducted by administering questionnaires to both customers and staff of the company. The results obtained from the data collection were cross tabulated and subjected to descriptive analysis. The results obtained established the fact that prompt and satisfactory claims payment had positive effects on the sales and marketing of insurance products and vice versa.

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# CHAPTER ONE

## INTRODUCTION

### 1.1 BACKGROUND OF THE STUDY

Recent years have seen a significant increase in the awareness level of insurance in the economy of Ghana, and West Africa as a whole. Even though not encouraging, the latest observations indicate that insurance awareness is increasing but rather at a slow pace, (National insurance commission annual report,2009)

Unlike in developed countries like the United State of America (U.S.A) and United Kingdom (U.K) where insurance awareness is deemed to have reached its peak and is now concerned with the awareness of insurance operations on the Internet, Ghana may be said to be at its very elementary stage.

A survey conducted and published in the 24th September, 2000 edition of a leading U.K research organisation, Marketing & Opinion Research International (MORI) Financial Services, concluded that even though the awareness of insurance is at its peak, 56% of people have no insurance cover at all that will cover their financial interest should the worst happen . The research also stated that few people have adequate insurance cover due to misconceptions and slow claim processes of insurers.

The economy of Ghana has been marked for growth and it is expected that this growth would be faster than it has done over the past three decades.

The current growth statistics as reported in the publication of the African Economic Outlook and in the 3rd August, 2010 edition states that after about a decade of relatively strong economic performance with real gross domestic product (GDP) growing at an average of about 6% annually over the last five years, there was greater uncertainty about Ghana's economic growth prospects at the beginning of 2009.

Unsurprisingly, economic growth slowed in 2009, to a mere 4.7% – the lowest since 2002 – after rising to a two-decade high of 7.3% in 2008.

Economic growth is   expected to recover   modestly to 6.4% in 2010 and accelerate to 8.3% in 2011 on the   back of global recovery, exceptional public investment in the rising oil sector, and     revenues from anticipated new oil discoveries.

According to Aryeetey et al (2000), the performance of Ghana's economy and economic growth has been characterized by the non- attainment of macroeconomic targets. In particular, whereas the Gross Domestic Product (GDP) was expected to grow between 7.1% and 8.3% in the period 1996-2000, actual growth was between 4.2% and 5.0%. The significant deviation between targets and the actual was interpreted into low *per capita* GDP growth and poor growth of the economy.

The argument on slow growth of the Ghanaian economy cannot be exhausted without linking it to the worrying rate of growth in the service market especially the insurance industry.

Over the past years the insurance service sector has contributed immensely to the economy of Ghana. The industry can contribute even more if proper and better attention is given to the delivery of this sector.

"Clearly, if some measures are taken to decrease the financial losses and partly relieve the burden of losses associated with risks, it will facilitate the conduct of business and more people will be willing to do it" (Siddiqi, 1994).

The rising intricacy of the world economic system in today's industrial age has increased the importance of insurance in the process of manufacturing and profit-making dealings. The absence of insurance will constantly subject the individual/organization to the fear of a huge financial loss in the event of a tragedy and so will affect their decision making course of action in diverse ways. It is therefore apparent that a viable economy is dependent on insurance companies being swift in compensating victims of an insurance claim.

One of the principal functions of insurance is the settlement of claims. It is in fact the worry that a loss might occur that persuades individuals and economic institutions to take up insurance policies. Claims settlement is the monetary compensation that is paid to the policyholder in the event of a loss. (Parsons, 2005).

It used to be said that insurers would do anything possible to squirm out of paying claims. Insurers have been criticized for their marketing methods, based on cloudiness, twisting and mis-selling. If a company does not effectively handle its claims service, it can tarnish its image hence affect the sales and marketing of their insurance products. Insurance company's attitude to claims settlement has in the past provoked a lot of public criticism and even attracted the attention of governments.

In the past majority of insurers have persistently failed to recognize the need for qualified staff or claims specialists to enhance their claims service.

The typical claims department always seemed to be an afterthought, the last to get new equipment or staff. The focus was on sales, winning new business and retaining accounts. As the years passed there have been very few changes in the perception of claims (Burley, 2008)

It is in this light that most insurance regulatory bodies now seek to recognize the need for a thorough review of the role of the claims professionals in the insurance industry (Kelly, 2008).

Recently, however, in developed countries, the true value of the claims professional has come to the fore and now the claims operation is recognized as being the point where *"Treating Customers Fairly"* is tested and where the customer experience is molded. This increased focus on claims operation has brought its own benefits to claims professionals. Not only has their individual value enhanced but claim operation is now valued: it is the shop window of the insurance industry and has never been more tested (Burley, 2008).

In spite of these prevailing changes, the same cannot be said for the insurance industry in Ghana. The insurance industry in Ghana has been in a state of evolution for several years and is now in the process of reaching a new maturity.

In West Africa, especially Ghana, the response to these changes has rather been slow and this should be a source of great concern since the world is fast becoming a global village and in order for the insurance business in Ghana to thrive it needs to embrace these practices and philosophies.

However there are some prospective changes going on in the marketing environment in Ghana and other West African countries, which have also led to the decision to conduct this study, these include the following: changes in the composition of employees, changes in technology, Socio – cultural changes and economic changes particularly increased competition among operators.

Consequently, the reputation of any insurance company and consumers demand for insurance depends, to a large extent, on the sort of claims services provided by the company to its customers. Insurance companies in West Africa now wish to improve their public image, and retain the trust of their brokers (middlemen) and clients in order to meet their sales and marketing department projections.

Swift handling of claims is surely the way to do it. This being the case, it is imperative that these insurance companies make a commitment to claims handling. Firms in Ghana now conceive that an insurer's approach to the claims handling process is a good indicator as to its attitude towards its clients but do not have any strong empirical prove, hence this study.

## 1.2 STATEMENT OF THE PROBLEM

In Ghana, the insurance companies, just like other insurance companies in other parts of the world, do pay claims, yet they have a dented image in the eyes of the insuring public (Lijadu, 2002). The problem of running an effective claims administration that would satisfy the customers and earn their confidence as well as cause them to repurchase insurance products has remained too long in the insurance industry in the sub-region and the world at large.

Claims settlement is like a mirror through which the members of the public see an Insurance Company. A Company, which fails to settle claims to the satisfaction of customers, would definitely attract less business, as it is likely to discourage such clients to continue to insure with the company. Such clients might even advise their friends, colleagues and relations not to patronize such a company.

Prudent claims administration strategy promotes customer loyalty as it helps to develop a perception of 'membership' or belonging within a particular group of customers, thereby providing the company with opportunities to retain existing customers while attracting new ones and profitable ones (Braers, 2004)

The consequent effects of the above problem could lead to downward trends in sales and marketing figure, low premium income, low capital formation (savings and loans) and minimal contribution of an insurance company to the gross domestic product (GDP) of a country.

This project is therefore to look at the effects of slow insurance claims settlement on the sales and marketing of insurance products: situational analysis of Enterprise Insurance Company Ltd.plc (EIC). -Ghana

## 1.3 RESEARCH AIMS & OBJECTIVES

The purpose of this study was to investigate the trends in the company's claims settlement system and a thorough review of existing claims handling processes, The company would therefore be advised on the best way to settle claims that would ensure customer satisfaction. This will in turn redeem the image of the insurance company in the eyes of the insuring public, pave way for better performance in their sales and marketing growth figures and hence contribute to the economic development of the country –Ghana.

The objective of this study therefore was to critically examine the effect of efficient and prudent claim settlement procedures on the sales and marketing of insurance products in the company; Enterprise Insurance Company Ltd.plc (EIC)-Ghana.

More specifically, the study:

1. Reviewed current literature on service marketing vis-à-vis literature on claims settlement.

2. Determined the definition of the word "Slow" from the customer's point of view.

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3. Established the relationship between the slow claims settlement and customer repurchase of insurance.

4. Examined the customer's perception of existing trend of claims settlement system in the company through questionnaire and interviews to both the company's staff and their clientele.

5. Finally, gave recommendations on the best way to settle claims that would ensure customer satisfaction and increase premium growth.

## 1.4 RESEARCH QUESTIONS

The research exercise is set out to answer the following questions:

1. Does the payment or non-payment of insured's expected claim amount have any effect on the sales and marketing of insurance products?

2. Does prompt claims settlement have any effect on the sales and marketing of insurance products?

3. Does the settlement or non-settlement of claims have any effect on the sales and marketing of insurance products?

4. Are consumers' decisions and choices influenced by the company's claims handling process?

5. Does the Company have any structure in place to ensure customer satisfaction and to cater for customer complaints?

**1.5 SCOPE OF THE STUDY**

The study is based on the Ghanaian insurance market using EIC-Ghana as a scenario for the study. The research specifically investigated the company's claims service delivery vis-à-vis their customer services and corresponding effects on sales and marketing figures. It examined the effects of efficient and prudent claim settlement procedures on the sales and marketing of insurance products in the company.

**1.6 SIGNIFICANCE OF THE STUDY**

The payment of claims is not only a legal obligation but also a strong public relations instrument and a marketing strategy that has a lot of bearing on the sale of insurance products. This study aimed at identifying whether claims settlement affect the demand for the company's insurance products and customers choices.

This study will help EIC-Ghana identify and adopt the best ways to settle claims that will ensure customer satisfaction, which will have the positive effect of improving the image of the insurance company in the sub-region. This improved image will, in turn, increase demand for their insurance products and increase premium income generation/sales and marketing figures, capital formation and contribution to the economy of the country in the sub-region.

The study analyzed claim settlement process of the insurance company and its effect on their sales and marketing performance. The establishment of the existence of a relationship or not of these two variables will then be used to make appropriate recommendations to a goal oriented claims management that will ensure the double benefits of cost efficiency and customer satisfaction in EIC-Ghana.

## 1.7 LIMITATION OF THE STUDY

A major constraint was imposed by the time available for the study, which was limiting. This therefore forced the researcher to limit the study to just only one insurance company in the Western Region only, notably the Branch Office.

Again lack of spread of insurance awareness within the study area – Ghana accounted for the low response rate recorded and also limited the scope of coverage of the survey. This is because even in the urban centres most of the people are ignorant of insurance.

Another vital limiting factor was the three months duration allocated to the dissertation by the school authorities. This therefore barred the researcher from conducting a detailed research work.

## 1.8 STRUCTURE

As already noted the first chapter briefly gives a brief background study of the insurance market in Ghana specifically the current state of the claim administration in developed and developing countries. It goes further to state the problem, aims and objective of the study.

- Chapter two provides the theoretical basis for this research by reviewing the distinguishing characteristics of service marketing from physical products.

- Chapter three describes the methodology used in the research study.

- Chapter four details the primary data collected for the research as the findings and the analysis of these data.

- Finally, the fifth chapter presents the summary, conclusion and recommendation from the researcher.
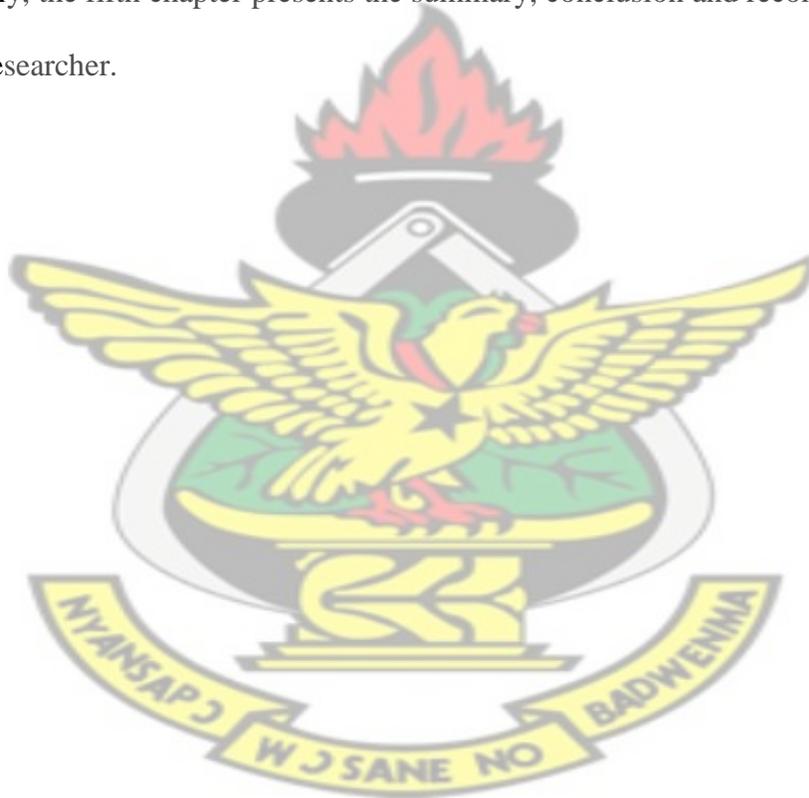
**CHAPTER TWO**

**LITERATURE REVIEW**

## 2.1 INTRODUCTION

The services literature highlights the nature of service marketing. It tries to position some of the differences in the nature of services versus physical products, which are believed to create special challenges for services marketers and for consumers buying goods.

In addition, it examines the importance of the four characteristics of services to consumers; Intangibility, Inseparability, Heterogeneity and Perishability.

While there have been several discussions on the effectiveness of these four characteristics in distinguishing between products and services, these are nevertheless widely accepted by scholars and used both as the basis for examining services buyer behaviour and developing services marketing strategies.

## 2.2 SERVICE MARKETING DEFINED

Service is an intangible product involving a deed, performance or effort that cannot be physically possessed. Service marketing has been defined as an economic activity that does not result in ownership (Jobber, 2004).

Services are unusual type of products, which require extra understanding and efforts to deliver. This is basically due to the fact that services are not as tangible as other physical products. A customer can only derive satisfaction from a service by fulfilment.

There is no single commonly accepted definition of the term however Gabbot and Hogg, (1993) as referred to by Manyo-Plange (2004), states that "Services are a series of deeds, processes and performances".

On the other hand Gronroos, (1984) defined service as an activity or series of activities of more or less intangible nature that normally, but not necessarily, take place in interactions between customer and service employees and/or physical resources and/or systems of the service provider, which are provided as solutions to customer problems.

Conventional marketing concepts cannot easily be applied to services because of the characteristics of services, which make them distinctive. More importantly, services cannot be produced in independent processes, that is, processes that are conducted and fully controlled by the service provider. In order to produce a service, the production process involves the customer, example, the customer must be present when their hair is being cut, and the customer's money is involved when using the services of a bank and the customer's car is involved in a car wash service.

Services account for a greater proportion of the economies in developed countries. (Kotler *et al*, 2001)

## 2.3 CHARACTERISTICS OF SERVICEMARKETING

## 2.3.1  INTANGIBILITY

Consumer goods are described as intangible because they cannot be tasted, seen, touched or smelled before they are bought. Since a service is an act, presentation or effort, not an object, device or thing, it makes it difficult for the customer to weigh up a service before paying for it.

For example, it is not easy to judge how thorough a car servicing has been, immediately afterwards. You cannot hold or touch a service unlike a product. As a result of this, the experience consumers obtain from the service has an impact on how they will perceive it.

This can cause lack of confidence on the part of the consumer in considering pricing and services marketing. It is often difficult for the consumer to measure service value and quality. To overcome this, consumers tend to look for evidence of quality and other attributes from the qualifications and professional standing of the service provider.

The suggested strategies for problems stemming from intangibility of services include creating and stressing tangible features (Berry 1980), to make the service more conspicuous. An example in the insurance industry is making it easier for consumers to perceive what is being sold by associating the insurance intangibles with tangible items such as *"Time Tested, Truly Trusted…. Since 1924*".

Other strategies to overcome intangibility of service include creating a strong organizational image, engaging in post-purchase communication, using cost accounting to set prices (Zeithaml, 1981) and replicating word of mouth communications (Berry, 1980).

The level of intangibility has been proposed as a means of distinguishing between products and services (Levitt, 1981). Zeithaml (1981) stresses the fact that the level of intangibility has implication for the ease with which consumers can evaluate services and products.

Additional research claims that intangibility cannot be used to differentiate clearly between all products and services. However Bowen (1990) suggests that this intangible notion is difficult for people to grasp. Onkvisit and Shaw (1991) also feel that the significance of intangibility is exaggerated.

**2.3.2 INSEPERABILITY**

Contrary to physical goods, services are produced and consumed simultaneously, for example, haircut, pop music, holiday, insurance, among others are produced and consumed at the same time. Consumer goods are produced, stored, distributed through intermediaries before being bought and consumed. In such cases, the service must be provided not only at the right time and at the right place but also in the right way. Services cannot be separated from the service providers. A product when produced can be taken away from the producer. However a service is produced at or near the point of purchase. (Jobber, 2004)

Take insurance claims settlement, for example, you lodge a claim, the waiting and delivery of the compensation to the claimant, the service provided by the insurer is all part of the service production process and is inseparable, the staff in a claims department are a part of

the process as well as the quality of compensation provided.

The client also participates to some extent in the service, and can affect the outcome of the service. People can be part of the service itself, and this can be an advantage for services marketers.

This notion of inseparability between production and consumption gave rise to the idea of relationship marketing. The salesperson's ability to reduce perceived uncertainty determines relationship quality from the consumer's perspective (Zeithaml, 1981).

Shelton, (1995) argues that most insurance and industries have failed in the development of long-term positive relationships with customers over the life of their policies; that an effective customer-related distribution strategy has clearly been lacking by reason of the distribution strategy, which focuses more on remuneration. This system has resulted in a set of behaviours in the sales situation which has led to pressure on the salesman to sell, pressure on the customer to buy, over-concentration on new business, the sale of inappropriate products, less interest in customer servicing and repeat business, and a dreadful reputation for many companies and the industry overall.

Researchers in service marketing as; (Engwall, 1984; Grönroos, 1979; Zeithaml *et al.*, 1985) have thus stressed the significance of buyer-seller interactions and long-term relationships.

Copulsky and Wolf, (1990) therefore defines relationship marketing as "an organization's effort to develop a long-term, cost effective link with individual customers for mutual benefit.

**2.3.4 HETEROGENEITY/VARIABILITY**

It is very difficult to make each service experience identical. For instance, a concert performed by a group on two nights may differ in slight ways because it is very difficult to standardize every dance move.

Generally, systems and procedures are put into place to make sure the service provided is consistent all the time, training in service organizations is essential for this, however in saying this there will always be delicate differences because a service is produced and consumed simultaneously, and because individual people make up part of the service offering, it can be argued that a service is always unique; it only exists once, and is never exactly repeated.

This can give rise to concern about service quality and uniformity issues. Personnel training and careful monitoring of customer satisfaction and feedback can help to maintain high standards. This is a particular difficulty for services with a high labour content, as different people deliver the service performance and the performance of people can vary from day to day (Rathmell, 1966).

Onkvisit and Shaw (1991) consider heterogeneity to offer the opportunity to provide a degree of flexibility and customization of the service. Wyckham et al (1975) suggest that heterogeneity can be introduced as a benefit and point of differentiation.

### 2.3.4 PERISHABILITY

In general, services cannot be stored and because of this time constraint consumers demand more. Services are perishable; they cannot be stored and carried forward to a future time period Rathmell, (1966). Onkvisit and Shaw (1991) suggest that services are "time

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dependent" and "time important" which make them very perishable. Therefore an empty seat on a plane, for example, is a lost opportunity forever. Restaurants are now charging for reservations, which are not kept, charges may be made for missed appointments at the dental clinic. Hartman and Lindgren, (1993) claim that the "issue of perishability is primarily the concern of the service producer" and that the consumer only becomes aware of the issue when there is insufficient supply and they have to wait for the service.

Perishability does not pose too much of a problem when demand for a service is steady, but in times of unusually high or low demand service organizations can have severe difficulties.

Conversely, during periods of low demand, the service firm may encourage trial of its products or services through promotions, add new and innovative services, make the working hours and location more convenient and even offer price promotions.

## 2.4 MANAGING SERVICE QUALITY

A service provider can principally distinguish itself from its competitors by improving service quality, which will eventually increase customer satisfaction leading to sales and profits.

"In the UK, local councils are facing increasing pressure to deliver higher quality services to the local communities they serve."(Jobber, 2004)

Exceptional quality services which will pay-off must aim at greater customer satisfaction, which will lead to increased retention and sales.

To meet quality targets, the service providers need to identify the expectations of target customers concerning service quality.

Jobber (2004) argues that most companies have been eluded on the issue of high standard of service quality because of the four causes of poor perceived quality. He further says that these barriers separate the perception of service quality from what customers expect, and to manage services well, they must be overcome. These four causes are;

**Misconception barrier** talks about the disparity in understanding from management and what the customer expects. This can only be resolved by marketing research.

**Inadequate resources barrier** highlights on the fact that managers may understand what customers expect but might be unwilling to provide the resources to meet that because of cost reduction policies.

**Inadequate delivery barrier** positions the manager understands of what the customers expect and provide adequate resources to meet that but fail to select, train and reward staff adequately resulting in poor and inconsistent service.

**Exaggerated promises barrier** emphasizes that even though all the above barriers are overcome, a gap between customer expectation and perceptions still remain through exaggerated promises.

## 2.5 MEETING CUSTOMER ORIENTATION/EXPECTATION

**Customer Orientation** can be seen as the set of beliefs in sales that says that customer needs and satisfaction are the priority of an organization. It focuses on dynamic interactions between the organization and customers as well as competitors in the market and its internal stakeholders. (www.wilkipedia.org)

A customer orientation reflects an organization's ability to understand customer needs vis-à-vis competitive offerings and translate this knowledge into superior products and services. This orientation is a key to leveraging organizational creativity, satisfying customer needs and improving long-run business performance.

Customer satisfaction has little meaning or effect unless it is embraced by and embedded within an organization.

Without an understanding of the process inhibitors or "choke points" that limit an organization's ability to focus on customers, quality improvements are inherently limited to those achievable under existing strategic plans, measurement and quality improvement systems, and implementation processes." (Anders et al, 2004).

## 2.5.1PHASES OF CUSTOMER ORIENTATION

As a process, Customer Orientation includes all of the activities involved in acquiring

information about customers, communicating that information through an Organization and

using the information for both strategic planning and more specific quality improvements.

However, it is not the concept of a customer orientation per se that drives a company's

performance in the eyes of its customers.

Rather, it is the day to- day, week-to-week and month-to-month processes, activities and

tools by which the concept is actually implemented. Johnson, (1994)


The Phases of Customer Orientation as indicated by Johnson, (1994) in Figure 1 is a process

framework that identifies the "leverage" points that improve customer focus or "choke"

points that keep companies from taking their customer satisfaction and loyalty to a new level.
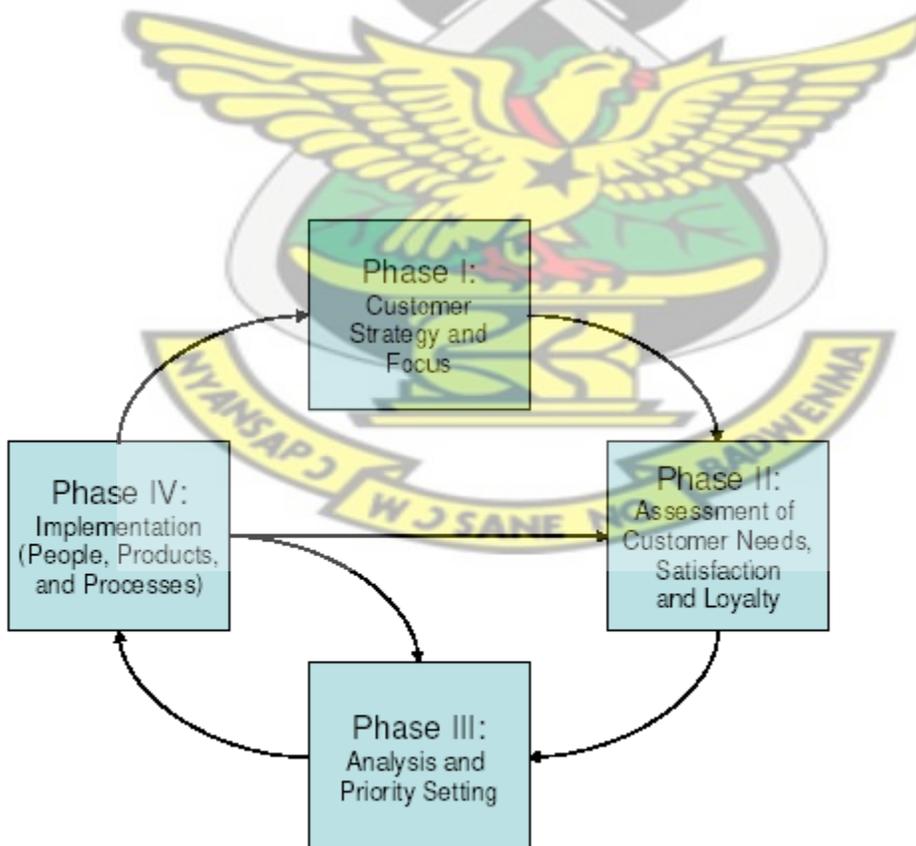


Figure 1. Four Phases of Customer Orientation

Source :( Johnson, 1994)

Phase I is the customer strategy and focus phase where companies explicitly balance customer goals (as with respect to customer satisfaction, loyalty, profitability and/or sales) vis-à-vis other business performance goals within. An important consideration at this phase is the overall level of organizational commitment or buy-in to customer goals. Strategic market planning decisions are also required at this stage, including how the firm should segment the market and what market segments they should focus on given their capabilities or competencies.

Phase II moves the process to the assessment of customer needs, satisfaction and loyalty. This phase often involves a period of "customer immersion," where companies immerse themselves in their customers using qualitative research (site visits, interviews, focus groups, observations, and subsequent surveys) to understand their customers' needs, the problems they are trying to solve, and how different products and services solve customer problems or provide particular benefits.

Phase III is a process of analysis and priority setting to set priorities for removing things-gone-wrong, improving things-gone-right, or finding innovative ways to meet customer needs. Moving from information to decisions requires certain inputs. One is the relative importance of improving product or service attributes and the customer benefits they provide.

An example is, what is the estimated impact of these improvements on customer satisfaction, loyalty and subsequent profits?

Phase IV is the implementation of the customer priorities established in phase III.This involves a process of "bridging the gap" between internal (company) quality and external (customer) perceptions. One traditional method employed at this phase is quality function deployment (QFD) and its "house of quality." The main purpose of QFD is to translate the voice of the customer into product and process change within an organization. The QFD process starts with an input list of desired product or service attributes (the voice of the customer).

The Four Phases of Customer Orientation provide a process view of how Organizations measure, monitor and use customer information.

## 2.5.2 3C'S OF COMPETITOR ANALYSIS

The diagram in Figure 2 according to Anders et al (2004), applies to a specific market segment and competitor. The three circles represent your customers' needs, what your company offers, and what your competitor offers respectively. Considering the areas where the circles overlap, it can be said that the measurement systems described under phase II of the customer orientation process should highlight these competitive advantages, competitor advantages, and basics. Customer needs that are provided by both a company and the competition are considered basic, where customers come to expect these qualities in a product or service.

While important to customers in a general sense, they fail to differentiate between competitors.
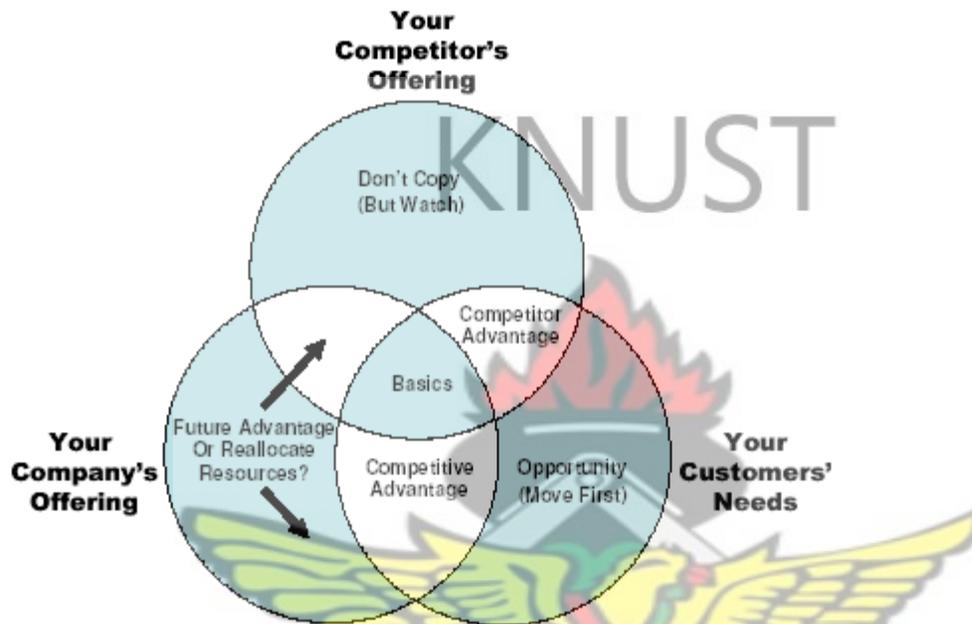


Figure 2.  3C's Analysis

Source: (Anders, Nilsson March 2004)

Performance areas of importance to customers where a company exhibit strong performance versus competitors are the company's sources of competitive advantage. These are the reasons why the company's customers choose the company over competitors. Performance areas important to customers that exhibit relatively weak performance are likely to be the company's competitor's advantage.

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The unoverlapping areas is reflects customer needs that are not currently provided for and which can be referred to as opportunities. A company that recognizes this and makes the first move creates a competitive advantage for itself. Understanding these unmet needs is a major benefit of the customer immersion described earlier, where companies focus more generally on what problems customers are trying to solve or experiences customers are trying to achieve than just focusing on continuously improving existing products or service processes.

Those areas where either the company or its competitor is providing things that customers don't currently use or want are additional candidates for possible reallocation, unless there is reason to believe that customer needs are moving in the direction of these capabilities. This is why it makes sense to monitor competitors' activities but not necessarily copy them.

The insurance sector is of particular interest from a market orientation viewpoint, as it works with intangible commodities in which service, quality, and customer orientation are crucial elements. The competitive characteristics generated by the global environment provide an additional interest in studying market orientation in this area.

## *2.6 CUSTOMER ORIENTATION, PROFITABILITY AND CORPORATE REPUTATION*

Corporate reputation has been considered to be one of the most sustainable drivers of business success and the most important competitive advantages of a business organization (Dunbar & Schwalbach, 2001).

Corporate reputation is an effective means to promote customer retention, and to strengthen competitive advantages when confronting rivals in a dynamic and competitive global market (Schwaiger, 2004). Previous studies have shown that firms that have strong corporate reputation are able to recruit quality employees and foster retention, thus reducing production costs and service costs (Caminti, 1992; Nakra, 2000; Preece et al, 1995).

In summary, these studies have shown that via a strong corporate reputation, companies can foster customer retention, maintain relatively low-cost production, and finally achieve a high profitability against their rivals in a competitive market environment.

Given that corporate reputation might positively lead to good financial performance, it is important to understand what means can be used by firms to improve their corporate reputation throughout all business endeavours. One could consider Customer orientation as the cornerstone of a process that would influence a firm's decisions in improving the quality of its products and services, ultimately leading to a high corporate reputation. Such a result would strengthen a firm's belief on implementing customer orientation, thus completing an ongoing, recursive corporate reputation enhancement process. (Schwaiger, 2004).

Although previous studies have established a link between customer orientation and performance outcomes, little research has addressed the effect of insurance claims administration on corporate performance results.

The management literature has long argued that firms with customer orientation and focus on consumers' need are more likely to achieve long-term success than are companies without (Deshpandé, Farley, & Webster 1993; Kotler, 2006).

A firm's customer orientation can be evaluated by examining the quality and product and services their customers received. Customer orientation provides a firm with a better understanding of its customers in any given business environment, and thus leads to a high customer satisfaction, which in turn results in a positive effect on its financial performance as well as a favourable corporate reputation perceived by the consumers.

In summary, these studies have shown that through a strong corporate reputation, companies can foster customer retention, maintain relatively low-cost production, and finally achieve a high profitability against their rivals in a competitive market environment.

## 2.7 THE SERVICE MARKETING MIX

According to Plange (2004), to compete in the 20th Century, firms have to market themselves effectively. The ability to devise and implement an effective marketing strategy is central to a firm's ability to compete. Marketing strategies are implemented through the marketing mix. The marketing mix is the combination of variables, which must be managed in order to meet the organization's marketing objectives. The services marketing mix as explained below consists of four physical goods variables plus an additional three: product, price, promotion, place, people, process and physical evidence, effectively known as the Seven P's.

**Product** is the key element in the marketing mix firstly because all other elements of the marketing mix revolve around the product and secondly because it is the firm's 'raison d'etre'. (Kotler 2004 as cited by Manyo-Plange 2004) defines a product "anything that can be offered to a market for attention, acquisition, use or consumption – it includes physical objects, services, persons, places, organizations and ideas." Insurance and for that matter life insurance services are therefore products since they fall within this context.

**Price is** variously called fee, interest rate, charge, fare, commission and in the case of insurance, premium. Pricing is the only element in the marketing mix used to generate income while all the other elements are costs. Price does not only help position the product in its desired segment or competitive spectrum, but aids in the attainment of profitability and strategic objectives.

**Promotion** has been defined as "the coordination of all seller-initiated efforts to set up channels of information and persuasion to sell goods and services or promote an idea" (Ray, 1982). Belch and Belch (2001) observes that traditionally, the promotional mix has been made up of advertising, sales promotion, publicity/public relations and personal selling, and that modern-day marketers employ direct marketing and interactive media to communicate with their target markets.

**Place** decisions are concerned with the distribution strategy, and are targeted at making goods and services available in the right quantities and locations when customers want them.

Insurers in contemplating distribution channels need to make decisions concerning the balance and use of; direct sales force (DSF), direct marketing and intermediaries i.e. brokers and tied agents, (CII, 1996). Tied sales representatives called agents supported by company marketing staff, newspapers, television and radio primarily sell insurance products in Ghana.

**People:** An essential ingredient to any service provision is the use of appropriate staff and people. Recruiting the right staff and training them appropriately in the delivery of their service is essential if the organisation wants to obtain a form of competitive advantage. Consumers make judgements and deliver perceptions of the service based on the employees they interact with.

**Process** refers to the systems used to assist the organisation in delivering the service. What was the process that allowed you to obtain an efficient service delivery? The process helps foster consumer loyalty and confidence in the company, help to ensure proper delivery of the product by routinizing the way the product is delivered. Where is the service being delivered?

**Physical Evidence** is the elements of the service mix which allows the consumer again to make judgements on the organisation. Physical evidence is an essential ingredient of the service mix; consumers will make perceptions based on their sight of the service provision, which will have an impact on the organisations perceptual plan of the service is very important in services. Imagine a dental surgery with blood on the floor: very unpleasant. A

dirty plate in a restaurant would put you off and make it difficult for you to experience the service as was intended {Kotler, 2006)

**2.8    CHALLENGES OF SERVICE MAKETING**

Challenges of service marketing as stipulated by Schultz and Doerr (2008), below are some of the most common and difficult challenges of growing and managing consulting, professional, or technology service businesses that don't necessary apply to product businesses.

1. **Clients cannot see or touch services before they purchase them.** This makes services difficult to conceptualize and evaluate from the client perspective, creating increased uncertainty and perception of risk. From the firm's perspective, service intangibility can make services difficult to promote, control quality, and set price.

2. **Services are often produced and consumed simultaneously.** This creates special challenges in service quality management that product companies do not even consider. Unlike service, products are tested before they go out the door but service production happens with the customer present, creating a very different and challenging dynamic.

3. **Trust is necessary.** Some level of trust in the service organization and its people must be established before clients will engage services.

4. **Competition is often not who you think.** Competitions for product companies are other product companies. Competitions for service companies are often the clients themselves. Sometimes you find yourself in a competitive shootout (some firms more than others), but often the client is asking 'should we engage this service at all'?

5. **Service deliverers often do the selling.** Many product companies have dedicated sales forces. For services, the selling is often split between sales, marketing, professional, and management staff.

6. **Marketing and sales lose momentum.** Most product companies have dedicated marketers and sellers. They market and sell continuously, regardless of the revenue levels they generate. In many services companies the marketers and sellers also must manage and deliver. This can often lead to the wide swings between revenue and extra work, and revenue and work deficiency.

7. **Passion is necessary, yet elusive.** The more passion, spirit, hustle, and desire your staff brings to the organization every day, the more revenue and success you will have. The correlation between staff passion and financial success is direct and measurable (as is the correlation between lack-of-passion and organizational failure

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## 2.9 OVERVIEW OF INSURANCE IN GHANA

This segment focuses on the specifics of the insurance industry in Ghana. It establishes the historical antecedence of insurance in Ghana, highlights on the effect of insurance claims settlement on the demand of insurance products in Anglophone West Africa with particular reference to The Republic of Ghana.

The literature also relates the historical background of insurance claims settlement to the current trend of insurance claims settlement in the market.

The discussion then narrows down into the history, profile and activities of the subject company; the Enterprise Insurance Company Limited, plc (EIC) - Ghana.

### 2.9.1 HISTORICAL BACKGROUND OF INSURANCE AND INSURANCE CLAIMS IN GHANA

Insurance has developed in response to a demand for risk protection. This demand has arisen out of the creation of liabilities by statute like Employers Liabilities Act (1880) and the Workmen's Compensation Act (1897 as amended in 1906).

Claims settlement or compensation for a loss dates as far back as the history of insurance. In fact, it is the only reason the consumer (insured) buys an insurance product. Man's first experience with insurance was in the field of marine. Records, however, show that modern marine insurance was practiced in 1347. In this early form, vessel or cargo would be pledged against a loan and should the vessel not successfully complete the journey; the loan would not be repayable. (Iruku, 1977)

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Another ancient maritime practice that has survived many generations virtually unchanged is that of "general average."

The mode of its operation is when certain cargo is jettisoned (thrown overboard) during a journey in an attempt to save the voyage. If the journey proves successful; the owners of the cargo that was not jettisoned and was saved will contribute proportionately towards a fund out of which the unfortunate ones who lost their cargo would be paid a claim (Fisher, et al, 2005).

In West Africa, methods of spreading risk by the extended family system, age, groups, clans, religious groups among other social devices is called *Susu* or *Esor* which dates back to the pre colonial era (Coker, 2006).

However, due to developments and modernization, this state of affairs is no longer ideal and adequate hence the need for more acceptable form of compensation.

As early as the 1920s, the British, representing agencies for insurance companies then operating in Great Britain, introduced conventional insurance to the West Africa sub region.

These agencies later were transformed into insurance companies whiles for example in the case of Ghana, the government formed their own indigenous insurance company to take care of their growing insurance needs after independence. Based on this principle above, the various classes of insurance then developed due to occurrence of unforeseen losses hence the need for financial protection against losses. (Iruku, 1977).

Today, Ghana has quite a bit of vibrancy in the insurance industry serving the needs of both local and foreign stakeholders, thus the need to uphold the customer in high esteem and

attend to their requirements with speed and efficiency. The customer in this age of globalization is hailed as "The King" thus satisfying their requirements means an organization will continue to stay in business and *vice versa.*

Insurance has even been hailed as a possible solution to the catastrophic food crises affecting third world nations like Ghana.

Gormley (2008) in an article titled "*Industry can help avert price disaster* " published in the *"Insurance Day"* stated that a study by the French Agricultural Research Centre for International Devevelopment, said, "insurance industry could play a major part in solving the underlying problems causing rising food prices. According to them the lack of access to risk management services and insurance for farmers in some of the worlds poorest countries has been a major factor stifling growth and crop productivity". In this article, he referred to the United Nations (UN) as saying that "the environment does not favour their operations and does not provide any security for the risks they would take in investing more in the sector. Increased availability of insurance, among other services could curb rocketing food prices".

## 2.9.2   INSURANCE, CLAIMS SETTLEMENT AND THE GHANAIAN ECONOMY

An economy is a configuration of different components with direct and indirect relationships, which are dynamic in nature.   A positive state of affairs may be neutralized if other components are experiencing negative occurrences (Ogedengbe, 2002).   An economy, according to Ogedengbe, can be divided into three components namely, agriculture, manufacturing, and servicing sectors.   The relationship among these sectors varies but an economy is better integrated with one complementing and supplementing another.

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He also stated that modern trends go to show that structural transformation, in the modern economic growth, includes the shift away from agriculture to non-agricultural activities and from industry to services.

Ghana is mainly an agriculture country with majority of its workers engaged in farming cash crops consisting primarily of cocoa products, which typically provide about two-thirds of export revenues, timber products, coconuts and shea nuts, which produce an edible fat, and coffee .Ghana also has established a successful program for non-traditional agricultural products for export, including pineapples, cashews, pepper, cassava, yams, plantains, maize, rice, peanuts, millet, and sorghum. Fish, poultry, and meat also are important dietary staples. Ghana has an estimated population of twenty four million people.

Minerals such as gold, diamonds, manganese ore, and bauxite are also produced and exported by Ghana. Import-substitution industries in Ghana include textiles, steel (using scrap), tires, oil refining, flour milling, beverages, tobacco, simple consumer goods; and car, truck, and bus assembly. Tourism has become one of Ghana's largest foreign income earners (ranking third in 1997), and the Ghanaian Government has placed great emphasis upon further tourism support and development {UNFPA 2005}

The New Insurance Act 2006 forms the basis for insurance regulation in   Ghana,   which   is enforced by the National Insurance Commission ("NIC"). Besides  establishing a minimum paid up capital level of US$1m (including reserves), insurers are also required to maintain an adequate total assets to total  liabilities  ratio ,which  is  currently  set  at  150%.  Further guidelines are  stipulated with regards to the quality of assets, with investments required to

equate to a minimum 55% of total assets by December 2010, whilst investments inequities and properties are limited to 30% and 20% of total investments respectively.

The non-life insurance market remains relatively small, with industry Gross Written Premium (GWP) totalling GH¢226.8m (or US$156m in 2009. Given that 23 registered insurers compete in this market (with further entrants expected in the medium term), competition is intense, with market share predominantly contested via premium reductions. Owing to low disposable income levels and a relatively underdeveloped insurance culture amongst individuals, scope in the personal segment remains limited, which implies a considerable dependence on representation, accounting for an estimated 50% of gross premiums in 2009.    Other challenges include:

- The lack of economic diversification and resultant focus on motor business, accompanied by significant rates undercutting and high business churn.

- The comparatively low minimum capital requirement of US$1m, which fails to discourage the entrants of new players, to the detriment of overall profitability.

- The poor enforcement of minimum motor rates, which exacerbates overall margin pressure.

- The continuous escalation in vehicle repair costs, ascribed to a heightened degree of insurance fraud and exposure to exchange rate fluctuations.

- The collection of outstanding premiums and high level of indebtedness of some insurers largely ascribed to the delayed premium transfer from brokers.

In an effort to better address the latter challenge, the NIC recently issued new guidelines, which took effect in September 2010. These include a strict cash collection of premiums below GH¢500. For annual premiums in excess of this amount, insurers are to receive a 40% deposit, with the balance paid within 90 days, failing which the company should decline cover.

Furthermore, insurers are required to charge interest where no deposit is received (at a uniform rate), with the period of credit limited to 3- 6 months. On the back of this, the high level of indebtedness is likely to improve, although success ultimately hinges on successful regulatory enforcement.

In addition, the further raising of the minimum capital level is currently being discussed, although no conclusion has been reached with respect to the timing and extent of the adjustment. Further improvements are expected from the adjustment of the minimum motor rates, which will be approved during the course of 2010.

Driven by the large scale exploration of oil and gas reserves, risk diversification is expected to improve. All market players have agreed to establish an insurance pool, which will represent the industry's interests. Each insurer is required to raise 5% of their respective For Year Ending (FYE) FYE09 capital as a capital contribution, with profits of the pool shared in accordance with insurers' respective capital contributions.

However, given the limited capacity in the local market, only a very small portion of the direct business will remain in Ghana (around non-life industry GWP grew by an estimated 22% to GH¢226.1m in 2009, which remained below the 32% recorded previously, attributed to lower public spending and a subdued FDI environment). Driven by rising vehicle repair

costs (resulting from a marked depreciation of the Cedi against the US$ in 1H F09), the net claims to Net Written Premium (NWP) ratio for the industry rose to 32% from 24% in 2008.

This, together with a 34% rise in management expenses constrained underwriting profitability, with the underwriting margin (net of UPR movements) reported at a markedly lower 2.4% (2008: 13.4%).

EIC's delivery cost ratio compares favourably to that of most of its peers. This, however, is in stark contrast to its earned loss ratio, which is substantially higher than the peer group average. Given the magnitude of claims (particularly in motor), EIC was the only insurer in the peer group to post a loss for the year, of GH¢1.8m. Cognisance is, however, taken of EIC's strong solvency which remains above that of its peers, although significantly supported by cumulative fair value gains.

The insurance industry does not produce a tangible, physical product but it rather renders services. Insurance is among the most complicated and least understood services in today Ghana's economy. The major factor, which contributes to this misunderstanding, is the highly complicated nature of the insurance policy itself. Individual policyholders remain confused by the small prints and its legality hence poor response in lowly educated areas like Ghana.

The contribution of the insurance industry to economic growth and development can be viewed from two perspectives namely:

1. The services that are produced add directly to national income; and

2. The industry makes an indirect contribution by supporting the agricultural, manufacturing and other service sectors with risk protection and helping to increase their output and employment.

## 2.9.3 CLAIMS SETTLEMENT PROCEDURE

According to Iruku, (1977), it may be pertinent to identify the underlying claim settlement procedure involved as follows:

*Notification*: All insurance policies require notification in writing "immediately" or "as soon as practicable" after a loss has occurred. Notification may be made through an agent or broker or directly to the insurance company. Some policies stipulate that the notice must be sent to the insurers within a specified number of days. Failure to give the notice within the stipulated number of days is a breach of the terms of the policy, which might entitle the insurer to repudiate liability.

*Verification*: Verification of records is to ensure that there was cover at the time of the loss against the peril that caused the loss. This involves an examination of records in the insurer's office to ascertain that the relevant policy was in force at that material time and that the policy covers the event that led to the loss.

*Proof of Loss*: The onus is on the insured to prove his loss. The claimant has to convince the Insurer not only that a loss has occurred, but that the loss was caused by an 'insured

peril.' If the Insured fails to prove their loss, the claim may fail. The policyholder must also prove the quantum or the extent of their loss.

*Negotiation:* Most claims are settled by means of negotiation between the parties without the need for such formal procedures as arbitration or litigation.  This is, of course, the fastest and most economical method of adjustment.  In most claims, there may be nothing over which to negotiate and the claim may be paid almost immediately. When negotiation does not work out, the contract may itself prescribe some other procedure to be followed, such as arbitration and litigation.

I.   *Arbitration:* Where negotiations break down or fail to achieve the desired objectives, the other option available is Arbitration. It is the settlement of a dispute by the decision of one or more persons called Arbitrators. The decision of an Arbitrator is called an Award and it can be enforced by legal process in the same way the judgment of a law court could be enforced.

II.  *Litigation* is another method of settling insurance dispute where the aggrieved party goes to the law court to seek redress. This option is chosen where Negotiation and Arbitration fails. In practice, insurers are reluctant in going to court so as to protect their image. In most cases, insurers always strive to get problems solved before it gets out of hand or resort to litigation.

*Payment of Claims:* When all activities associated with adjustment of the loss are completed and the amount of loss is determined and agreed upon, the insured is entitled to receive payment. There are at least four methods of payment, which insurers can employ in providing claim settlements. They are as follows:

- Cash Payments

- Repair

- Replacement

- Reinstatement

The option as to which method is to be employed is normally given to the insured by wording of the policy.

In spite of the above, the insurer, in paying claims must balance the interest of the claimant and all other policyholders who have contributed to the fund. Although the claimant is entitled to be paid in accordance with the promise of the insurance contract, the fund should be protected against payment of unearned claims. There are certain prohibiting factors like Average and Excess/franchise/deductibles inherent in the practice of the insurance that makes it possible for clients not to receive their full payment.

*Average* is a condition in the policy which provides that where the amount of premium paid by the insured is only for a smaller proportion of the total value at risk, since that is what has been disclosed by the insured, any claims settlement under this policy will recognize this fact and the amount payable to the insured will be proportionately reduced.

***Excess/Franchise/Deductibles*** are amounts of money (decided at inception of the policy) that are subtracted from each claim to be settled. It is immediately observed that should the total amount of the claim be less than the amount of the excess/franchise/deductibles the claim will not be paid (Wildman, et al, 2005).

***Ex-gratia*** occurs when a client suffers a loss or incurs some liability for which the insurer cannot be held liable, under the policy. This client may be a valued client to the insurer and the insurer may want to identify with him during his misfortune. In such situations the practice of insurance allow for the payment "out of grace" (ex-gratia) of monies to the insured. Therefore, this is a claim payment made by the insurer out of favour even though there is no legal obligation (Chiejina, 2004).

### *2.9.4*   **THE IMAGE OF CLAIMS IN THE INSURANCE INDUSTRY**

There is a general agreement even amongst insurance practitioners throughout West African countries, that the insurance industry today does not enjoy a favourable public image unlike in other parts of the world.  Insurance men and women are regarded in some areas as mere parasites who exploit society without giving much in return except for the occasional claims which they are compelled to pay either out of fear of being taken to court and discredited or exposed, or out of fear of losing their customers to another company (Irukwu, 1977).

" To all intents and purposes, the claim department can be seen as the 'shop window' of the insurance company. It does not matter how cheap an insurance company's premiums are, or

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how efficiently they conduct their underwriting administration if a claim is not properly and fairly dealt with, this is where an insurer will be judged." (Roff, 2004)

Lijadu (2002) stated that the insurance industry in Nigeria and of course in the West African sub-region is bogged down by unwholesome public perception. He stated that the insurance industry is aware of the public's misconstrued image of the insurance sub-sector. He emphasized this by saying that the insurance industry is perceived as quick to collect premium, slow to pay claims, using small prints to confuse you, providing poor services and engaging in sharp practices.

It is interesting to note that this perception still lingers on in Ghana whiles the story remains different for other parts of the world.

### 2.9.5  THE EVOLUTION OF CLAIMS

Claims are evolving in Europe. The Chartered Insurance Institute Claims faculty reports, "over recent years there have been many changes to the way in which claims are handled, viewed and managed. These changes are incremental and accumulative, rather than sudden and dramatic and this has created an ever-changing and evolving claims environment.

It is agreed that claims is much closer to the heart of the industry than ever before and in many cases is believed to be the biggest trigger to an organizations profits and loss. So it is not surprising that in this ever-competitive industry, a claim has a greater presence. (Claims Faculty, CII 2007).

### 2.9.6 CLAIMS ADMINISTATION AND E-COMMERCE

The utilization of new and better technology, better business process and off shoring have all been contributing factors in the evolution of claims. The much reported but none-the-less outstanding emergence of the Internet is playing a major part in enabling reduction in cost and expenses and more innovative and responsive customer service.

For example, on-line claims tracking and rapid communications through standardized formats for requesting for information enables insurers to differentiate their brand from their competitors and to provide a better service to their customers. (Collins, 1997)

Claims processing is designed to allow claims to be recorded within the insurer's records and for a reserve to be set up for the potential liabilities involved in the claims as quickly and as smoothly as possible. A function, which for many years was a purely manual, one or one, which had the assistance of certain accounting machines, has now been taken over to a large extent by computers. The reliance of technology has been given a great boost by the coming into being of technology where there is reliance of telephone and the necessity for giving of service which is both quick and efficient, is of prime importance. (Collins, 1997)

The e-business revolution is gaining committed converts among increasing numbers of insurance companies and brokers world over. According to Brian, (2000), a research conducted on over 60 leading insurance and financial organizations in, the UK identified that a staggering 90% of processing today in commercial insurance remains paper based. The

subsequent cost of this with other expenses amounted to as much as 35% of the net premium, in the main, due to duplication of administration between parties.

### 2.9.7 THE OUTSOURCING OF CLAIMS SERVICES

More insurers are putting their claims service in the hands of third parties today more than ever before in the developed world. This according to Gordon (2000) is a revolution in claims handling.

Claims management is considered to be one of the most valuable possessions of any insurer and the question to ask is whether he will be ready to trust an outsider with it. It seems many insurers are prepared to do just that, as they allow outside companies to look after their customers.

Claims outsourcing means an insurance company uses an external company to handle its claims. The outsource company is paid a fee and can handle the claim from start to finish but customer loyalty is the key to insurer. It costs far more to win business than to retain an existing client. So is outsourcing really such a good idea, and why is it growing so rapidly?

Cost, according to Gordon (2000), is a major factor. In her words, "It is far cheaper to use outside firms than employ vast numbers of people in-house which involves salary bills and overheads. But it is not purely the bottom-line. The outsource providers would agree they are able to offer better service which will lead to greater customer loyalty."

While claims outsourcing is considered viable, when it comes to signing the cheques, there is still some caution. While the assistance companies say they are prepared to take over claims validation, insurers are reluctant to relinquish control.

There is always the fear that doubtful claims might be paid. And at the same time, if an outsource company were to become too tough when negotiating a claim settlement, that all-important customer loyalty could be at stake.

It seems therefore that outsourcing is an unstoppable force in the insurance industry, as the need to cut costs and offer improved services becomes vital to survival. For the insurance industry in West Africa with particular reference to Ghana, claims outsourcing is an area that is yet to be considered for a wide spread adoption.

### 2.9.9  INSURANCE CLAIMS FRAUD

Insurance fraud remains an issue, but even though it is becoming more effective at detecting the cheats, this is not an image it wants to project.

The Association of British Insurers report, June 2003, estimates such fraud costs in the insurance industry to be in excess of £1 billion per year. The report states that insurance fraud arises not only when individuals make false claim for an accident\event that has not occurred, but also when individuals inflate claims for genuine incidents. This highlights the importance of putting in place effective strategies to detect fraud but also raises some interesting issues around prevention. (Stears, 2003).

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Below are facts and figures of the official view of costs and impacts of fraud crime as quoted by the Tenth Annual Review Report (2007-2008) of the Fraud Advisory Panel-UK;

"Financial crime costs at least £13.9 billion, increasing to £20 billion when income tax and EU related fraud are taken into account. This amounts to £330 for every man; woman and child in the UK. Individuals lost at least £2.75 billion whereas businesses lost £3.7 billion in 2005.The public sector was defrauded at least £6.8 billion in 2005-2006." (Association of Police Officers, March 2007).

"Fraud is a hidden tax on everyone. It increases the cost of goods and services, impoverishes small as well as corporate shareholders, strikes at the future of private pension holders, and jeopardizes jobs and saps faith in the country's unique standing at home and abroad. It damages business growth and investment'. (Fraud Review, June 2006)

"In monetary terms the harm [fraud] causes is on a par with Class A drugs" {Lord Goldsmith QC (February, 2007)}.

The leadership of fraud-dominated countries describes trans-national organized crime and fraud as a threat to national security, which reflects in the statement from the cabinet office below;

"The potential effects include: undermining legitimate cross-border trade; threatening the integrity of financial markets through large scale money-laundering; and threatening business

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and individuals through cyber-crime."(National Security Strategy of the United Kingdom Cabinet Office, March 2008)

Although insurance Companies are joining with other bodies to launch a major crackdown on fraudulent insurance proposals and claims such as false theft reports, staged accidents, arson claims for personal profit, multiple claims on same property and material falsehood at the proposal stage. Needless to say, sometimes even the most honest claims may have been refused their compensation because of difficulty in telling whether the claim was genuine.
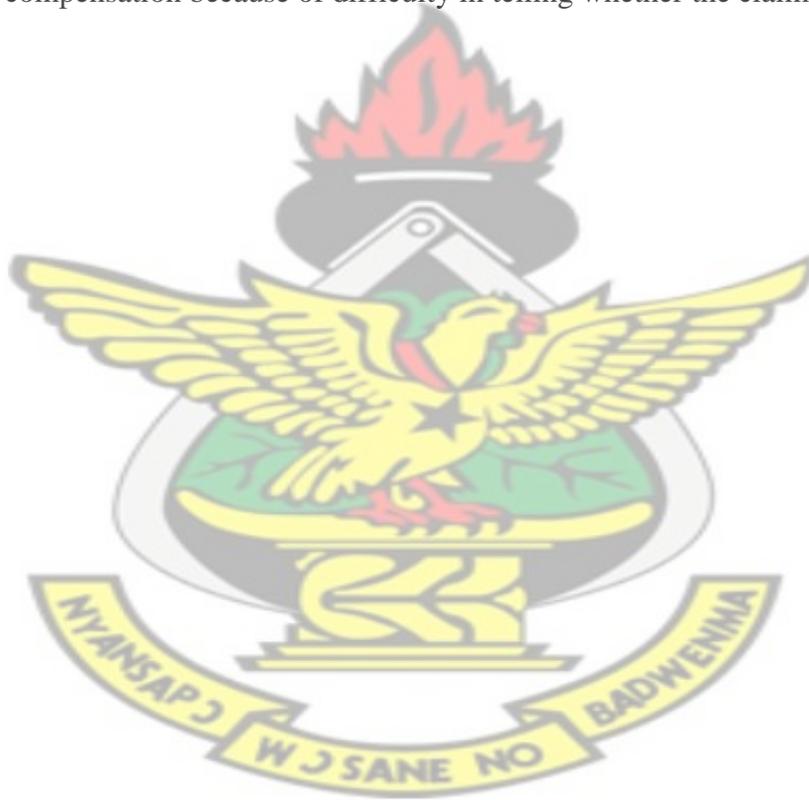
# CHAPTER THREE

# RESEARCH METHODOLOGY

## 3.1    INTRODUCTION

This chapter focuses on the description of the techniques adopted in this research work. It entail the description of the research design, the identification of the data gathering techniques and data processing methods to be adopted, among others, in extracting meaning from the data to be gathered in the course of the research work. The limitations of the approaches adopted also form an essential part of this chapter.

## 3.2.1   HOW TO COLLECT DATA

According to Easter by-Smith, et al (2004), the two main methods of collecting data for a detailed research analysis are the qualitative and the quantitative methods. Qualitative techniques, which basically handle the non-measured features or characters associated with the research topic, are strategies which the researcher adopts when they have close ties with members of the organisation concerned so that they can gain all sorts of insight into people and situations they require. Some qualitative techniques are interviews, observations and diary methods.

The distinction between quantitative and qualitative methods, however, is not so clear. Techniques such as interviews, questionnaire, test/measures, surveys and observations also fall under quantitative method. Quantitative methods are generally conducted by extracting facts and figures from existing surveys and data from tests and measures, activity sampling,

financial statements, etc. One does not necessarily have to seek permission from organisations before sourcing such information (Malhotra, et al, 2002).

However, CII Claims Faulty Report (2007) states that most research conducted on insurance claims settlement is best conducted using qualitative interviews with people working within the sector today.

Therefore, insurance researches have not always been eligible for presentation in correlation statistics formats because the data relates to perceptions rather than objective actual quantity (Soon, 2004).

## 3.3    RESEARCH DESIGN

To get a true reflection of the progression of claims operations in recent years, current issues and potential future directions, this research utilized qualitative research method.

The qualitative research aims at reaching a better understanding of the phenomenon that is being studied and this is conducted by gaining a large amount of information from few research units. Furthermore qualitative studies tend to be more flexible, while the quantitative ones are more structured (Holmes and Solvang, 1997).

Enterprise Insurance Company (EIC) was chosen as the research unit because EIC is a market leader and prides itself as the insurance company that settles claims fastest in the

industry, hence a study into how slow claims payment on such an organisation will provide an insight into the effect of slow claims settlement in the industry wide.

## 3.4 POPULATION

The population for study was considered as the entire client base of Takoradi branch of Enterprise insurance company limited, that is, those customers that have incurred claims and those that have never incurred claims. The population included those customers that have not yet incurred claims because the research sort to answer questions relating to expectations of clients with respect to claims settlement.

Owing to the large geographical locations and numbers of the client base of the company as well as restraint in terms of cost to the study, the study was restricted to only the above branch.

Another factor that informed the selection of the branch was also the fact that Takoradi is a large cosmopolitan area with people emanating from various cultural, educational and sociological backgrounds and also members of such population will reflect the characteristics of the entire customer base of the company.

The population of the study therefore included 120 staff members and 1,500 customers of the branch. The two clusters resulted in a total population size of 1620

## 3.5 SAMPLING PROCEDURE

In conducting a research, a researcher would like to obtain information from the group of people about whom they intend to generalize their findings.

Selection of the sampling method to use in a study depends on a number of related theoretical and practical issues. These include considering the nature of the study, the objectives of the study and the time and budget available. Traditional sampling method can be divided into two categories: probability and non-probability sampling (Samuel et.al., 2003)

Probability sampling is most commonly associated with survey-based research where researcher needs to make inferences from the sample about a population to answer the research question or to meet research objectives (Saunders et.al., 2003). In probability sampling, sampling elements are selected randomly and the probability of being selected is determined ahead of time by the researcher. If done properly, probability sampling ensures that the sample is representative (Hair et.al., 2003)

Non-probability sample provides a range of alternative techniques based on researcher subjective judgment (Saunders et. al., 2003). In non-probability sampling, the selection of elements for the sample is not necessarily made with the aim of being statistically representative of the population. Rather the researcher uses the subjective method such as personal experience, convenience, and expert judgment and so on to select the element in the sample. As a result the probability of any element of the population being chosen is not known (Samuel et al., 2003).

Most non-probability sampling methods are:

I.    Convenience Sampling

Convenience sampling involves selecting sample members who can provide required information and who are most available to participate in the study. Convenience sample enable the researcher to complete a large number of interviews cost effectively and quickly but they suffer from selection bias because of differences of target population (Hair et al., 2003).

II.   Judgment Sampling

Researcher's judgment is used to select sample element and it involves for a specific purpose. Group of people who have knowledge about particular problem they can be selected as sample element. Sometimes it referred as a purposive sample because it involves a specific purpose. Judgment sampling is more convenience and low cost involvement. (Hair et al., 2003).

III.  Quota Sampling

Objective of quota sampling is to have proportional representation of the strata of the target. Population for the total sample certain characteristics describe the dimension of the population (Cooper and Schindler, 2003). In quota sampling the researcher defines the strata of the target population, determines the total size and set a quota for the sample element from each stratum. The finding from the sampling cannot be generalized because choice of elements is not done using a probability sampling methods (Samuel et al., 2003).

The object of this research was to determine the effect of slow claims settlement on the sales and marketing of Insurance products. For the purpose of this study, convenience sampling method was used to select respondents from the staff of EIC who had enough knowledge about claims settlement process in the organization and customers who transacted business with EIC within the period of study.

Secondly a quota sampling method was employed to and deliberately concentrate much of questionnaires to individuals or insured's who have actually gone through the company's machinery of lodging a claim.

### 3.5.1 SAMPLE SIZE

The sample size chosen was 50% of the staff, and 20% of customer base, thus 60 and 300 for staff and customers respectively. The total sample size therefore was 360 out of the population of 1,620.

### 3.6 DATA COLLECTION SCHEDULE

There are two major approaches for gathering information about a situation, person, problem or phenomenon. Sometimes, the required information is already available and need only be extracted. However there are times when the information must be collected. Based upon these broad approaches to information gathering data are categorised as, primary and secondary.

Secondary data are collected from secondary sources such as government publications, personal records, census (Kumar, 1996) and primary data are collected through; observations, interviews and/or questionnaire. (Hair et.al.,2003)

In this study, structured questionnaire which included both open and close ended questions were distributed to respondents. The open ended questions provided the respondents with an opportunity to include information that the researcher was unable to include in the constraint of time.  The questionnaire was the tool used to collect data from the respondents, which was used to answer the research questions and for analysing the relevant research questions.

To achieve the above tasks, the researcher sought for data on the length of time it takes to settle an insurance claim in the subject company, data on the facilities put in place by the insurance companies to achieve effective claims services rendered by the insurance companies vis-à-vis the likely consequence of this on the company's marketing activities.

Two sets of questionnaire were administered in this study. One set solicited responses from the company's clients whilst the other set gathered responses from staff of the insurance company. The response structure for questions in the company's client's questionnaire was two-way question type (yes or no) whilst that of the insurance company combined both the open ended and the two-way questions type.

The questionnaire was hand delivered to intended respondents, who completed and returned them later.

In order to improve and test the questionnaire, the researcher conducted some pilot test. Two sets of the questionnaire were administered to senior executives of the insurance company who were familiar with all the issues involving claims handling and settlement in the industry as a whole. This was done to determine whether the questions made sense and was easy to understand.

After refining some of the questions which were deemed to be too technical for the intended respondents, a much improved questionnaire was developed and administered.

## 3.7    PROCEDURES FOR PROCESSING AND ANALYZING COLLECTED DATA

The responses generated from the survey were edited to detect and deal with any inconsistencies in the data. Computer software was used to achieve further processing of the data by cross tabulating them. Qualitative and quantitative descriptive analysis methods were used to summarize the information generated so that appropriate analytical methods could be used to deliver relationships among the variables or responses.

## 3.8    LIMITATIONS OF THE METHODOLOGY

Although, substantial amount of effort was put into the designing of the research work and in administration of the questionnaire, certain problems were encountered which are worth mentioning. Some of the limitations encountered include:

The literacy level of the Ghanaian populace was discovered to be low. The level of awareness of insurance was also very low. These created problems of poor communication and an abysmally poor response from some intended respondents while others just did not bother to respond to the questionnaire at all despite repeated calls.

Another major constraint that was faced was the time available for the study, which was limiting.

**CHAPTER FOUR**

**DATA ANALYSIS AND DISCUSSION OF RESULTS**

**4.1    INTRODUCTION**

In this chapter, the responses from claimants were categorized according to sex, age, educational background and marital status. This was followed by the presentation and analysis of data according to the research questions. The data are presented using cross tabulations.

**4.2    CLASSIFICATION  AND  CHARACTERISTICS  OF RESPONDENT**

**Frequency Tables – Insured**

**Table 4.1:  valid respondent based on gender**

| Sex | Sample Size | Total Respondents | Frequency (Valid) | Frequency (Invalid) | Percent % (Valid) | Percent % (Invalid) |
|---|---|---|---|---|---|---|
| **Male** | 171 | 138 | 121 | 17 | 87.7 | **12.3** |
| **Female** | 112 | 95 | 72 | 23 | 75.8 | **24.2** |
| **Corporate Entity** | 17 | 17 | 17 | 0 | 100.0 | **0** |
| **Total** | 300 | 250 | 210 | 40 | 84.0 | 16 |

*Source: Field Data, 2011*

*Table 4.1* indicates that out of the 300 questionnaires administered to the Insured, a total of 250 were completed and returned. Out of the total completed questionnaire, 87.7% valid respondents were male while 75.8% valid respondents were female. The table also indicates 17 respondents from corporate organisations. On the other hand 40 invalid respondents were recorded; representing 16% of total respondents submitted where as 210 valid respondents represented 84% of total questionnaires submitted.

**Table 4.2: Age ranges of non-corporate valid respondents**

| Age | Frequency (Valid) | Frequency (Invalid) | Percent (Valid) | Percent (Invalid) |
|------|------|------|------|------|
| **18-30** | 11 | 4 | 5.7 | 10 |
| **31-40** | 52 | 7 | 27 | 17.5 |
| **41-50** | 67 | 12 | 34.7 | 30 |
| **51-60** | 63 | 17 | 32.6 | 42.5 |
| **Total** | **193** | **40** | **100** | 100 |

**Source:** Field data, 2011

*Table 4.2* shows that out of the non-corporate valid respondents, 5.7% of valid respondents were within the 18-30 years age bracket, 27% of valid respondents were within the 31-40 years age bracket, 34.7% of valid respondents were within 41-50 and 32.6% of valid respondents were within the 51-60 years age bracket. This indicates that 10%, 17.5%, 30% and 42.5% of invalid respondents fell within the 18-30, 31-40, 41-50 and 51-60 years age brackets respectively.

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**Table 4.3: Marital status of valid respondent**

| Marital Status | Frequency (Valid) | Frequency (Invalid) | Percent (Valid) | Percent (Invalid) |
|---|---|---|---|---|
| Married | 119 | 26 | 61.7 | 65 |
| Single | 74 | 14 | 38.3 | 35 |
| Total | 193 | 40 | 100 | 100 |

**Source:** Field data,2011

*Table 4.3* shows that 61.7%, representing 119 valid respondents were married, whereas 38.3% representing 74 valid respondents were single. However, the invalid married respondents constituted 65%, whilst 35% invalid respondents were single.

**Table 4.4: Educational background of valid respondent**

| Educational Background | Frequency (Valid) | Frequency (Invalid) | Percent (Valid) | Percent (Invalid) |
|---|---|---|---|---|
| Primary | 5 | 2 | 2.6 | 5.0 |
| Secondary | 41 | 17 | 21.2 | 42.5 |
| Tertiary | 147 | 21 | 76.2 | 53 |
| Total | 193 | 40 | 100 | 100 |

**Source:** Field Data, 2011

The educational background of the respondents, which is represented by Table 4.4, shows that 5(2.6%) of the valid respondents were primary school leavers, whereas 41(21.2) % valid respondents were secondary school leavers, 147(76.2%) valid respondents had completed tertiary education. This is represented in the bar chart below

**Figure    4.1:    Relationship    between    level    of    education    and    frequency**
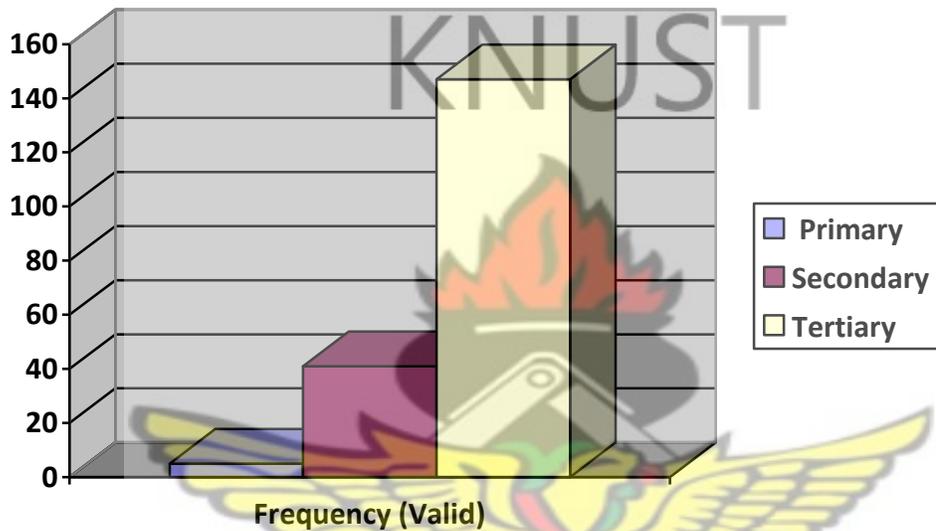


**Source: Field Data, 2011**

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**Table 4.5 Cross tabulation of valid respondent**

| Cases | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Sex | | Age | | | | Marital Status | | Educational Background | | |
| **Total Number of Valid Respondents** | M | F | 18-30 | 31-40 | 41-50 | 51-60 | M | S | P | S | T |
| | 121 | 72 | 11 | 52 | 67 | 63 | 119 | 74 | 5 | 41 | 147 |
| **Total** | 193 | | 193 | | | | 193 | | 193 | | |

**Source:** Field Data, 2011

*Sex*

*Table 4.5* above shows that 121 out of 193 valid respondents were male while 72 of the remaining were female. The reason behind a greater number of respondents being males could be attributed to the diverse attitude towards risk. Males are believed to be risk takers and so would usually take insurance to protect against their high expectation of a misfortune while most females are risk averse hence the lesser number in the valid respondents.

On the other hand, even though there is a social change to more women working today as compared to some few years back in Ghana, on the whole, Males are expected by the society to shoulder all responsibilities of most families and therefore the tendency for them to own insurable properties is very high, which invariably result in higher numbers of valid respondents for males than females.

*Age*

Following the results obtained from the table 4.2, it could be adduced that there is an inverse relationship between risk perception and age. It is evident from the responses that over 60% of valid respondents fell within the age band of 41-50. This could be attributed to the fact that larger numbers of Ghanaians are able to acquire tangible insurable properties within that age band, hence, the higher respondent rate. On the other hand respondents within that age band have understanding of their risk exposures; hence their preparedness to take up insurance cover to protect them from any financial disaster.

*Marital Status*

The marital status of an individual has a lot of influence on the risk perception as well. The results in the table above, reveals that the number of married valid respondents was 119, higher than that of single individuals of 74.

The simple reason being that the married people would want to take insurance to cover themselves and their families unlike the singles who have only themselves to think about.

*Educational Background*

The table also shows that out of 193 valid respondents, 5 of them had up to primary level education, 41 had secondary level education and then 147 of them had tertiary education. Form the valid respondents received and from figure 4.1, an inference could be drawn that education has a lot to do with people taking up insurance. It is evident from the bar graph in fig.4.1 that people with higher education take on more insurance policies than those who

have little education. This is because insurance is perceived to be more technical and has a lot of legal aspects governing insurance products; therefore people who are more educated can decipher the fine prints and make adequate judgement on the products.

## 4.3 PRESENTATIONS AND ANALYSIS OF DATA ACCORDING TO RESEARCH QUESTIONS

### 4.3.1 RESEARCH QUESTION ONE

- Does the payment or non-payment of insured's expected claim amount have any effect on the sales and marketing of insurance products?

**Case Processing Summary 1**
**Table 4.6: Cross tabulation of the total results obtained on research question 1**

| | Cases | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Valid | | Invalid | | Missing | | **Total** | |
| | Total No: | % | Total No: | % | Total No: | % | Total No: | **%** |
| **Amount Paid Equal to Sum Claimed? /Satisfied with Amount Paid?** | 210 | 70 | 40 | 13.3 | 50 | 16.7 | 300 | **100** |
| **Amount Paid Equal to Sum Claimed? /Will you take another Policy?** | 210 | 70 | 40 | 13.3 | 50 | 16.7 | 300 | **100** |
| **Amount Paid Equal to Sum Claimed? /Would you recommend insurance to others?** | 210 | 70 | 40 | 13.3 | 50 | 16.7 | 300 | 100 |

**Source:** Field Data, 2011

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*Table 4.6 above Is Broken Down As Below (Table 4.7-4.12)*

**Table 4.7: Cross tabulation of the effect of amount paid and satisfaction gained**

| Valid Cases | | | Satisfied with Amt Paid? (Valid Cases) | | | Total |
|---|---|---|---|---|---|---|
| | | | Yes | No | Never made claim | |
| **Amount Paid Equal to Sum Claimed?** | Yes | 10 | 13 | | 77 | **210** |
| | No | 123 | | 120 | | |
| **Total** | | **133** | **13** | **120** | **77** | **210** |

**Source**: Field Data, 2011

*Table 4.7* shows that 10 of the valid respondents said the claim settlement amount paid to them was equal to the expected estimates submitted to the insurance company whereas 123 valid respondents said the amount paid was not equal to the expected claim submitted to the insurance company. The higher figure recorded for those respondents who expected more amounts than they received may be attributable to excesses/deductibles imposed or adjustment made by claims officers to validate the estimates presented and dismiss any fraudulent presentations.

Out of these numbers, 13 valid respondents stated that they were satisfied with the claim settlement amount paid to them whilst 120 valid respondents stated that they were dissatisfied with the amount paid to them. The larger frequency of respondents who did not receive the amount they expected and were not satisfied, may be an indication that the amount received has effect on the satisfaction customers derive from the claims settlement. From the table 77 respondents had never made a claim or had their claims declined.

Table 4.8: cross tabulation of the effect of amount paid and repurchase of insurance products

| Valid Cases | | | Will You Take Another Policy? | | | Total |
|---|---|---|---|---|---|---|
| | | | Yes | No | Never made claims/Declined | |
| **Amount Paid Equal to Sum Claimed?** | Yes | 10 | 32 | | 77 | **210** |
| | No | 123 | | 101 | | |
| **Total** | | **133** | **32** | **101** | **77** | **210** |

**Source:** Field Data, 2011

Table 4.8 above shows that although 123 out of 133 valid respondents stated that the amount paid was not equal to the sum claimed, only 101 of them indicated that they will not take another policy. Note that 77 of the valid respondents either did not submit any claim nor had their claims declined.

From this data, it is evident that, about 76% of claimants who were not satisfied with the amount paid to them would not want to take another policy with the same insurance company. Nonetheless, there could be other claimants who would want to still insure with the same company because of customer loyalty or have close ties with the company or staff of the company.

**Table 4.9: Cross tabulation of the effect of amount paid and recommendation of insurance to others**

| Valid Cases | | | Would You Recommend Insurance to Others? | | | Total |
|---|---|---|---|---|---|---|
| | | | Yes | No | Never made claim/claim declined | |
| **Amount Paid Equal to Sum Claimed?** | Yes | 10 | 32 | | 77 | **210** |
| | No | 123 | | 101 | | |
| **Total** | | *133* | 32 | 101 | 77 | **210** |

**Source:** Field Data, 2011

Table 4.9 above shows that although 123 out of 133 valid respondents stated that the amount paid was not equal to the sum claimed, only 32 of them indicated that they would recommend insurance to others.

**Responses related to Table 4.9** *above* shows there is enough evidence to suggest that the amount paid has effect on the readiness of the insured to recommend insurance to others. Accordingly, the amount paid has an effect on the insured's readiness to recommend insurance to others. As evidenced by the results in the table, any claimant who responded positive or negative to questions in table 4.8 responded the same to this question and the reasons for that were the same.

Based on the analyses of the **Responses related to Table 4.7 – 4.9** it can be concluded that non-payment of the insured's expected claim amount has effect on the sales and marketing of insurance products, thus on re-purchase of the same product or recommendation by word of mouth to prospective insured's.

**4.3.2 RESEARCH QUESTION TWO**

▪ Does prompt claims settlement have any effect on the sales and marketing of insurance products?

Table 4.10: Cross tabulation of the total results obtained on research question 2

| | Cases | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Valid | | Invalid | | Missing | | **Total** | |
| | Total No: | % | Total No: | % | Total No: | % | Total No: | **%** |
| **Amount Paid Equal to sum claimed? /Satisfied with time of payment?** | 210 | 70.0 | 40 | 13.3 | 50 | 16.7 | 300 | **100** |
| **How long before settlement? /Will you take another policy?** | 210 | 70.0 | 40 | 13.3 | 50 | 16.7 | 300 | **100** |
| **How long before settlement? /Would you recommend insurance to others?** | 210 | 70.0 | 40 | 13.3 | 50 | 16.7 | 300 | 100 |

**Source:** Field Data, 2011

*The case processing summary table (Table 4.10) above is broken down as below   (Table 4.11-4.13)*

**Table 4.11: Cross tabulation of the effect of time claim is settled and satisfaction derived**

| Valid Cases | | Satisfied With Duration of Payment? | | | Total |
|---|---|---|---|---|---|
| | | Yes | No | Never made claim/claim declined | |
| **How Long Before Settlement?** | Within 3 months | 79 | 1 | 77 | **80** |
| | 4-6 months | 16 | 2 | | **18** |
| | 7-12 months | 3 | 2 | | **5** |
| | 1 year | **3** | **3** | | **6** |
| | 2 years | **11** | **13** | | **24** |
| | 2years + | | | | |
| | **Total** | **112** | **21** | **77** | **210** |

**Source:** Field Data, 2011

Table 4.11 above shows that a total of 133 respondents had their claims settled. 80 claims were settled within 3months, 18 claims were settled in 4-6months, whilst 5 claims were settled within 7-12months, 6 and 24, were settled within 1 year and 2 years respectively. It is worthy to note that, from the valid respondents, none of the claims took more than two years before settlement was effected.

Out of the 133 valid respondents who made a claim, 112 indicated that they were satisfied with the duration of settlement while 21 indicated they were not satisfied. It can be observed that all except 1 claimant whose claims settlement were completed within three months were all satisfied with the duration of the payment but the same cannot be said for the other periods. It could be observed that the rate of dissatisfaction increased with increasing period of claim settlement.

**Responses related to Table 4.11** *above* shows that there is enough evidence to suggest that the length of time it takes Insurance companies to settle a claim has an effect on the satisfaction derived by the claimants.

**Table 4.12: Cross tabulation of the effect of length of time claims are settled and repurchase of insurance products**

| Valid Cases | | Will you take another policy | | | Total |
|---|---|---|---|---|---|
| | | Yes | No | Never made claim/claim declined/Not sure | |
| **How Long Before Settlement?** | Within 3 months | 79 | | 85 | **80** |
| | 4-6 months | 16 | 2 | | **18** |
| | 7-12 months | 3 | 1 | | **4** |
| | 1 year | **3** | **3** | | **6** |
| | 2 years | **11** | **7** | | **18** |
| | 2years + | | | | |
| | **Total** | **112** | **13** | **85** | **210** |

*Table 4.12* above shows that out of 125 claims that were settled within the various periods, 112 indicated that they will take another Policy whilst 13 indicated otherwise, 8 in addition to the 77 respondents whose claim had either been declined or had never made a claim, were not certain whether they would take a new policy or not, bringing the total to 85.

However, all 79 respondents whose claims were settled within 3 months indicated that they would buy another policy with the insurance company.

Furthermore, the above cannot be said for the respondents whose claims settlement span from 3months to 2years. It could be observed that out of the 125 respondents, only 13 of

them indicated that they will not take insurance, which makes only 10.4% of the total respondents.

However, it could be observed from the table that claimant's unwillingness to take another policy is in line with the periods when settlement lagged from 4months to 2years. Considering the total number of respondents of 33 in the periods spanning from 4months to 2years, and 13 No respondents, in addition to the 8 respondents (included in the 85 in table 4.12 above) who were not sure of taking another insurance policy insurance company. It could be inferred that 64% of claimants whose settlement lagged from 4months to 2years will not take another policy.

**Responses related to Table 4.12** *above* shows that there is enough evidence to suggest that the length of time it takes Insurance companies to settle a claim has an effect on the desire of the claimants to take another policy.

**Table 4.13: Cross tabulation of the effect of amount paid on recommendation of insurance to another person**

| Valid Cases | | Will you recommend insurance to another person | | | Total |
|---|---|---|---|---|---|
| | | Yes | No | Never made claim/claim declined/Not certain | |
| **How Long Before Settlement?** | Within 3 months | 79 | | 85 | **80** |
| | 4-6 months | 16 | 2 | | **18** |
| | 7-12 months | 3 | 1 | | **4** |
| | 1 year | **3** | **3** | | **6** |
| | 2 years | **11** | **7** | | **18** |
| | 2years + | | | | |
| | **Total** | **112** | **13** | **85** | **210** |

Table 4.13 above shows that as in Table 4.12 , out of 125 claims that were settled within the various periods, 112 indicated that they will make recommendations to others whilst 13 indicated otherwise, 8 respondents (included in the 85 in table 4.13) above were not certain whether they would make recommendations to another person or not. However, all the 79 respondents whose claims were settled within 3 months indicated that they would recommend insurance to another person.

It must be emphasised that the above cannot be said for the respondents whose claims settlement spanned from 3months to 2years. It could be observed that out of the valid 125 respondents, only 13 out of them indicated that they will not recommend insurance to another person, which makes it only 10.4% of the total respondents.

However, it could be observed from the table that claimant's unwillingness to recommend insurance to another person began from periods when the time lagged from 4months to 2years.

Considering the total number of respondents of 33 in the periods when settlement lagged from 4months to 2years, and 13 respondents plus 8 uncertain respondents who indicated that they will not recommend insurance cover for another person, it can be concluded that 64% whose settlement lagged from 4months to 2years will not recommend insurance to another.

**Responses related to Table 4.13** *above* shows that there is enough evidence to suggest the length of time it takes Insurance companies to settle a claim has an effect on their policyholders' willingness to recommend Insurance to others.

Based on the analysis of the **Responses related to Table 4.11 – 4.13** above, it could be concluded that there is sufficient evidence to suggest that that prompt claims settlement has an effect on the re-purchase by word of mouth advocacy of insurance products which invariably translates into the sales and marketing of insurance products
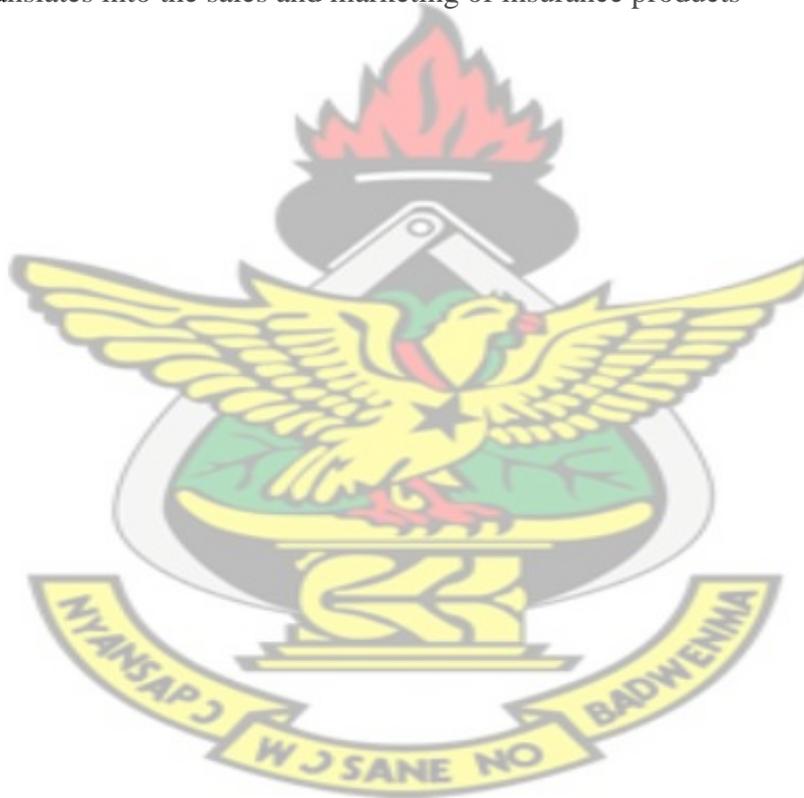
### 4.3.3 RESEARCH QUESTION THREE

❖ Does the settlement or non-settlement of claims have any effect on the sales and marketing of insurance products?

**Table 4.14: Cross tabulation of the total results obtained on research question 3**

| | Cases | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Valid | | Invalid | | Missing | | **Total** | |
| | Total No: | % | Total No: | % | Total No: | % | Total No: | **%** |
| **Claim declined before? /Will You Take Another Policy?** | 210 | 70.0 | 40 | 13.3 | 50 | 16.7 | 300 | **100** |
| **Claim declined before? /Would you recommend insurance to others?** | **210** | **70.0** | **40** | **13.3** | **50** | 16.7 | **300** | **100** |

**Source:** Field Data, 2011

*Table 4.14 above is broken down as below (Table 4.15 and 4.16):*

**Table 4.15: cross tabulation of the effect of declined claim on repurchase of insurance policy**

| Valid Cases | | | Will You Take Another Policy? | | | Total |
|---|---|---|---|---|---|---|
| | | | Yes | No | Nil | |
| **Claim** | Yes | 5 | 1 | 4 | 80 | **5** |
| **Declined** **Before?** | No | 125 | 125 | | | **125** |
| **Total** | | *130* | **126** | 4 | 80 | **210** |

**Source:** Field Data, 2011

*Table 4.15* above shows that out of the 210 valid respondents that made a claim on their policies, 5 had their claims declined whilst 125 claims were accepted. Of this total, 4 out of the 5 whose claims were declined said they would not take another policy, whereas all the 125 whose claims were accepted indicated they would take another policy.

It is evident here that most of the claimants whose claims were declined were not willing to take another policy, probably because of disappointment .The one who said yes to taking another policy after the decline could be the company's loyal customer, who accepted the reason behind the decline.

**Responses related to Table 4.15** *above* shows that there is enough evidence to suggest, that, refusal of Insurance Company to settle a claim has an effect on their policyholders' readiness to take another Insurance Policy.

**Table 4.16: Cross tabulation of the effect of amount paid on recommendation of insurance to another person**

| Valid Cases | | | Will You Recommend Another? | | | Total |
|---|---|---|---|---|---|---|
| | | | Yes | No | Nil | |
| **Claim** | Yes | 5 | 1 | 4 | 80 | **5** |
| **Declined Before?** | No | 125 | 125 | | | **125** |
| **Total** | | *130* | **126** | 4 | 80 | **210** |

**Source:** Field Data, 2011

*Table 4.16* above shows that out of the 130 valid respondents that made a claim on their policies, 5 had their claims declined whilst 125 claims were accepted. Out of this total, 4 out of the 5 whose claims were declined said they would not recommend Insurance to others whereas all 125 whose claims were accepted said they would recommend Insurance to others.

The same can be said for this table that most of the claimant whose claim were declined were not willing to recommend insurance to others probably because of disappointment.

The little who said yes to recommending insurance to others after the decline could be the company's loyal customers of claimants who have accepted the reason behind the decline.

*Responses related to Table 4.16* *above* shows that there is enough evidence to suggest, that refusal of Insurance Company to settle a claim has an effect on respondents' willingness to recommend Insurance to others.

Based on the analysis of the *Responses related to Table 4.15 – 4.16* above the conclusion can be drawn that there is sufficient evidence to suggest that non-payment of the insured's claims has effect on the sales and marketing of insurance products.

It can be concluded from the above that non-payment of an insured's claim has a negative effect on the demand for insurance by other prospects and vice versa.

### 4.3.4 SUMMARY

This is a summary of all the research questions earlier analysed. These research questions dealt with the following variables:

- Non-payment of the insured's expected claim amount and its effect on sales and marketing of insurance products.

- Customer satisfaction and its effect on sales and marketing of insurance products.

- Reduced payment than that claimed and its effect on sales and marketing of insurance products.

- Prompt claims settlement and its effect on sales and marketing of insurance products.

- Repudiation (decline) of claim and its effect on sales and marketing of insurance products.

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***The result of the analysis the researcher*** conducted on research questions one, two and three showed that there is a positive relationship between these variables.

From the analysis it was obvious that there is a positive correlation between the time claims are settled and the sale and marketing of insurance.

In conclusion, it can be inferred that satisfactory claims service/settlement has positive effects on the demand for insurance products whilst unsatisfactory claims settlement would have negative effects on the demand for insurance products.

### 4.4    COMPANY DATA PRESENTATION AND ANALYSIS

Based on the above, although there appears to be variations in the results, the researcher is of the opinion that there is some form of relationship between the premium income of majority of the insurance companies and the claims payment made by the insurance company selected**.** The reason for this variation could be the fact that an increase in the gross premium income does not always mean there will be a corresponding increase in the claims made by the policyholders because prudent underwriting, Acts of God, compulsory insurance, increased awareness on safety measures, and customer loyalty, etc might have accounted for the variation.

## 4.5    *CUSTOMER SERVICE RELATED QUESTIONS FROM THE QUESTIONNAIRES*

**Table 4.17: Cross tabulation of the total valid respondent received on customer service from EIC staff**

| Company | Valid | Invalid | Missing | Do You Have Any Customer Service Unit for Complaints? | | Do You Have Any System for Customer Feedback After Claims Settlements? | | Do You Undertake Any On-going Customer Satisfaction Research? | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Yes | No | Yes | No | Yes | No |
| **Managers** | 12 | -- | -- | 6 | 6 | 8 | 4 | 10 | 2 |
| **Team leaders** | 10 | -- | -- | 6 | 4 | 6 | 4 | 8 | 2 |
| **Officers** | 38 | -- | -- | 24 | 14 | 20 | 28 | 30 | 8 |
| **Total** | 60 | -- | -- | 36 | 24 | 34 | 26 | 48 | 12 |

**Source:** Field Data, 2011

*Table 4.17* shows the responses received from the staff of Enterprise Insurance Company to questions relating to structures put in place to cater for claimant's complaints, feedback and on-going customer satisfaction.

The results indicate as follows: 36(60%) of the valid respondents said there is the existence of a Customer Service Units where claimants could lodge their complaints.  In the same vein, 34(57%) of the same respondents indicated that they have in place systems for customer feedback after claims settlement and 48(80%) stated that there is an on-going customer satisfaction research.

From the results presented in the analysis above, it can be concluded that the Company has structures in place to cater for claimants (customers) complaints and satisfaction.

**Table 4.18: Customer satisfaction of client from staff respondent**

| *Were Claimants' Satisfied With the Time Taken to Settle a Claim* | | |
|---|---|---|
| **Satisfied** | Not Satisfied | **Total** |
| **48** | 12 | **60** |
| *Do Settled Claimants Renew their Insurance Policies?* | | |
| **Yes** | No | **Total** |
| **37** | 23 | **60** |
| *Has there been any Increase in the Number of Policies Written in the Last Three Years?* | | |
| **Yes** | No | **Total** |
| **40** | 20 | 60 |
| *Is the Increase in the Number of Policies Written Attributable to the Quality of Companies Claims Service?* | | |
| **Yes** | No | **Total** |
| **48** | 12 | **60** |
| *Have you ever Decline to Settle a Claim?* | | |
| **Yes** | No | **Total** |
| **13** | **47** | **60** |

**Source:** Field Data, 2011

The above table shows responses of the insurer's staff to questions relating to customer satisfaction. The responses show that 12(20%) claimants were not satisfied with the time it took the Insurer to settle their claims, whereas 48(80%).

The responses received showed that even a larger number of staff members thus, 23(38%) stated that settled claimants did not renew their policies after settlement of claims, whereas 37(62) claimed clients renewed their policies after claims settlement.

Furthermore, 48(80%) of the company's staff stated that there has been an increase in the number of policies written. This, they believed was attributable to the quality of claims service provided but 12(20%) indicated otherwise.

On the question of whether they have ever declined to settle a claim, 13(22%) of the respondents claimed in the affirmative, where as 47(87%).

# CHAPTER FIVE

## CONCLUSIONS AND RECOMMENDATIONS

### *5.1* **INTRODUCTION**

Claims management is considered to be one of the most valuable possessions of any insurer. It is one aspect of insurance practice, the handling, which can make or mar the image of Insurance Company. In fact, one of the principal functions of Insurance is the settlement of claims because it is the fear that a loss might occur that induces individuals and economic institutions to take out Insurance policies.

The problem of running an effective claims administration that would satisfy the customers, thereby earning the confidence of the customers and consequently inducing repurchase.

There was therefore a need to carry out a research with a view to finding out a more efficient and effective method of handling claims that will meet customers' satisfaction and in turn, redeem the sinking image of the insurance companies in the eyes of the insuring public, pave way for better performance and hence contribute to the economic development of Ghana.

The emphasis here was to investigate the relationship between fast claims settlement and the sales and marketing of insurance products.

Due to the constraints of time, the inability to measure the level of demand using the total sales and marketing figures of the selected company and the fact that the total amount of

claims settled as reflected on their financial statements is not a true reflection of the extent of customer satisfaction in the claims service provided by the insurers, the researcher relied more heavily on the responses from the insured who were randomly picked from the company's clientele.

In order to chart a trend of thought for the research effort, there was the need to have a good understanding of the history of claims and insurance.

There was also the need to review the current literature on service marketing and claims administration to enable the researcher see how other researchers who worked on similar problems went about their study. Some of the important current issues reviewed included the unique features of service marketing, challenges of service marketing, on-line claims tracking and rapid communications, automated claims processing that eliminates lengthy delays and reduces cost and claims services outsourcing.

The efficient and effective conduct of the entire research work required a description of the approaches to be used in the study. This was done by carrying out a description of the research design, the identification of the data gathering techniques and data processing methods to be adopted in order to extract meaning from the data gathered in the course of the research work.

Structured questionnaire was randomly administered in the study area to gather the required data from the insuring public and the insurance company. The data gathered were thereafter screened and analysed to answer the research questions based on the processed data.

## 5.2    CONCLUSIONS

Even though the demand for certain insurance policies might have been affected by contractual and legal requirements such as Bond, Motor, Workmen's Compensation Insurances etc, the results of the analysis of data as presented in chapter four showed that prompt and satisfactory claims settlement has positive effects on the sales and marketing of insurance products and vice versa. This confirmed the supposition by the researcher that the dented image of the insurance industry in the West African sub-region and the consequent effects on the economies of Ghana may not be unconnected with the poor claims administration. This inference drawn from the results of the analysis of the study data is supported by opinions strongly held by some authorities;

In a paper presented before the Image Committee of the Chartered Insurance Institute of Nigeria (CIIN), Irukwu (2000) concluded that, "claim settlement must be done promptly and equitably because the best form of advertisement for insurance companies is prompt claims settlement." Several years earlier, Green (2000) in his write up in Annals of the Society of Chartered Property and Casualty Underwriters stated that, "Public perception of the industry (Insurance) is bound to affect the attitudes of the insuring public". According to him, "Any

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industry, whose market is affected by public opinions as insurance, certainly must learn, as much as it can, about the forces affecting public opinions if it is to operate successfully."

"To all intents and purposes, the claim department can be seen as the 'shop window' of the insurance company. It does not matter how cheap an insurance company's premium is, or how efficiently they conduct their underwriting administration if a claim is not properly and fairly dealt with. This is where an insurer will be judged." (Roff, 2004)

From the foregoing therefore, it follows that prompt claims settlement has a significant influence on the purchase and repurchase of insurance products in EIC and Ghana on the whole.

## 5.3    RECOMMENDATIONS

The problem of claim settlement has plagued the Insurance industry in Ghana for a long time giving it a poor image. This poor image is due to the complex and peculiar nature of the insurance business.

However, there is the need to improve on the image of Insurance Company, which will lead to the growth of the company and the insurance industry as a whole.

From this research findings and conclusions, it has been established that claims administration affects the sales and marketing of insurance products.

Consequently, measures directed at running efficient and effective claims administration would go a long way in addressing the image problem of the industry.

It is in line with this that the following recommendations are made:

- Claims must be settled promptly and equitably in order to earn the confidence of customers and to retain their loyalty. Reducing documents required to process a claim and minimize correspondence and claims communication and reporting could do this.

- Where ex-gratia payments are made, EIC should use it as a launch pad for an effective public relations campaign through publication in the mass media.

- The underwriting and claims personnel in EIC should be properly trained in order to appreciate the sensitive nature and the role claims play in the insurance industry.

- EIC should create and improve on their Customer Service Units so that complaints and suggestions could be addressed promptly.

- EIC should undertake claims satisfaction research regularly. This would keep them abreast of the extent of customers' satisfaction, which will enable them to adopt better approach to claims settlement.

**5.3.2 SUGGESTED AREAS FOR FURTHER RESEARCH**

Claims administration is a very wide topic. There is therefore the need for further research in the following areas:

- The effect of compulsory insurance on the demand for insurance in West Africa or vice-versa.

- The difficulties faced by Insurance companies in claims administration.

- The effect of fraudulent claims on claims administration/corporate profits or sales and marketing.

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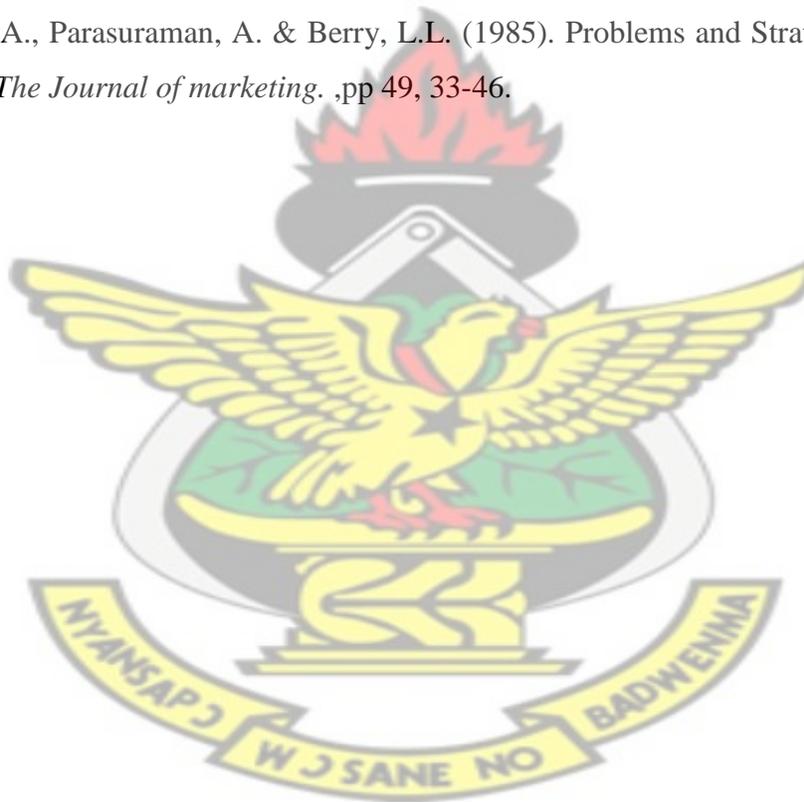
# APPENDIX

## DEFINITION OF TERMS

**Insurance:** is a "risk transfer mechanism that makes it possible to transfer the financial consequences of potential accidental losses from the insured firm, family or individual to an insurer" (W. B. Coker, 2006).

**An Insurance Contract** "is an agreement between two parties, the Insurer and the Insured, whereby in consideration of payment of a sum of money known as the premium by the Insured to the Insurer, the Insurer assumes the risk of an uncertain event which is not within his control and in which event the proposer has an interest, so that if the anticipated event should happen at any time during the period of Insurance, the Insurer is bound to settle the claim" (Olatunbosun, 2001)

**Claims settlement** is the monetary compensation that is paid to the policyholder in the event of a loss that is insured is therefore, the only reason the consumer (insured) buys an insurance product. (Marshall, 2005).

**Insurable Interest** was defined in Castellain v. Preston (1883) as "The legal right to insure arising out of a financial relationship recognized at law between the insured and the subject matter of insurance." (Peter Wildman, et al, 2005)

**Utmost Good Faith ("Uberrima Fides")**:  The duty of utmost good faith require that the insurer and the insured must reveal to each other details which are material to the risk. A

material fact is that which could influence the other's decision to enter the contract, whether such information is requested or not (Wildman, et al, 2005)

**Indemnity** is placing of the insured in, if not exactly as close as possible, the position he was in immediately prior to the occurring of the loss (Graham, 2005).

**There are two other principles, which are referred to as corollaries (as a result of) of indemnity. These are subrogation and contribution.**

**Subrogation:** This word comes from a Latin phrase "sub" "rogare" meaning "to ask under". In the case of Burnard v. Radocanachi (1882), "it was held that an insurer, having indemnified a person, was entitled to receive back from the insured any payment they may receive from any other source" (Brear, et al, 2004)

**Contribution** is the right of an insurer to call upon others similarly, but not necessarily equally, liable to the same insured to share the cost of an indemnity payment (Brear, et al, 2004).

**Proximate cause** is defined in Pawsey v. Scottish Union and National (1908) as the active, efficient cause that sets in motion a train of events which brings about a result without the intervention of any force started and working actively from a new and independent source." (Peter Wildman, et al, CII 2005).

**Loss Adjuster:** A person or professional contracted to investigate and adjust losses through loss causing events, to agree on the loss and the compensation to be paid under an insurance contract.

**Arbitration:** The hearing and determination of a dispute to achieve a settlement between an insured and an insurer as to the amount payable under the policy.

**Beneficiary:** A person entitled to receive fund or other property under an insurance policy.

**Claims:** A demand for an indemnity or benefit under an insurance policy by a person with legal title who can give the insurer a good discharge.

**Ex-gratia Payment:** This is a payment out of grace or favour, and not out of legal obligation by the insurer to the insured under an insurance contract.

**Expressed Terms**: These are the conditions expressed or stated in the policy.

**Implied Terms**: These are conditions to which policies are subjected but do no appear in writing on the policy document.

**Insurance:** The business of transferring risk by means of a contract.

**Insured:** The party who bought insurance and will be entitled to enforce the claim under the policy as a party to the contract. Also known as the assured or policyholder.

**Insurer:** An Insurance Company authorized to supply insurance.

**Intermediary:** A person who acts as a mediator or agent between parties in an insurance contract.

**Liability:** Responsibility created and enforced by law or legal action.

**Quantum:** The amount an insurer is legally liable to pay to the insured in claim.

**Risk:** The uncertainty of loss.

**Premium:** The amount paid or payable for an insurance policy. The consideration paid to purchase a policy and to keep it in force.
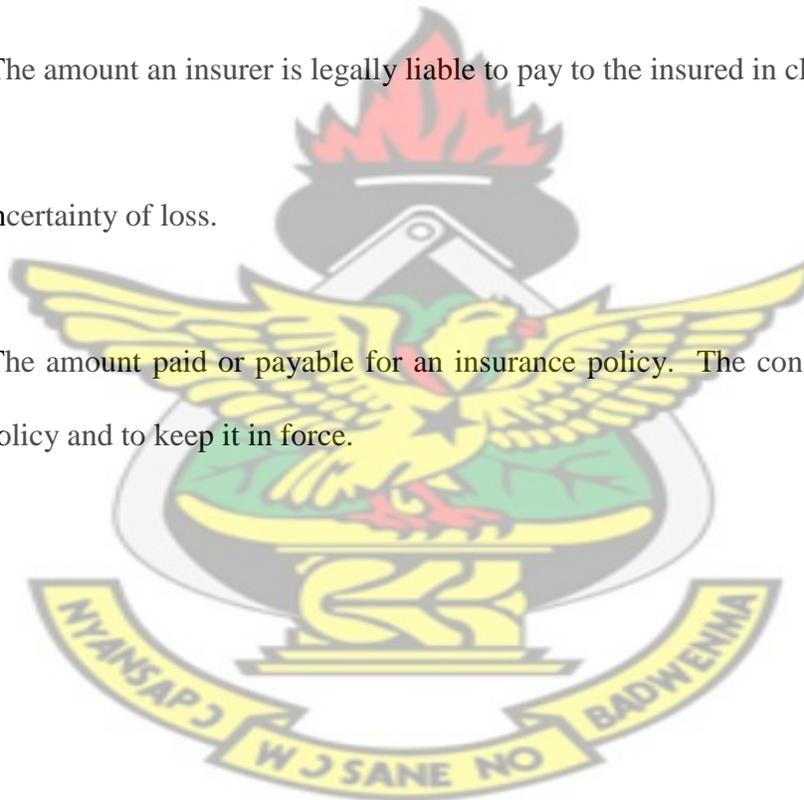
_**QUESTIONNAIRE TO RESPONDENTS**_

Dear respondent,

Harry Ernest Boakye Ofori-Attah is interested in knowing **"The Effects of Slow Claims Settlement on the Sales and Marketing of Insurance Products"** as part of an academic work.

I would therefore be grateful if you could kindly answer the under-listed questions in all honesty.

Your responses would be treated with utmost confidentiality.

Thank You.

---

**SECTION A**

(Please tick ☐ the appropriate answer)

**IGNORE QUESTIONS 1, 2, 3 AND 4 IF A CORPORATE ENTITY**

1. Sex: Male ☐ Female ☐

2. Ages: 18-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ Above 60 ☐

3. Marital Status: Married ☐ Single ☐

4. Educational Background: Primary ☐ Secondary ☐ Tertiary ☐ Professional ☐

**SECTION B**

1. Do you have any insurance policy with Enterprise Insurance Co. Ltd (EIC)-Ghana?

    Yes ☐ No ☐

2. Please tick the type(s) of policy?

    Burglary Insurance ☐        Motor Insurance ☐

    Marine Insurance ☐        Fire Insurance ☐        Aviation Insurance ☐

    Engineering ☐        Personal Accident Insurance ☐

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Employers/Product/Public Liability ☐    Any other (Specify)…………………

3. For how long have you had the policy (ies)?

Less than 2 years ☐    2-5 years ☐    6-9 years ☐    10 years and above ☐

4. How did you get to know about Enterprise Insurance Co. Ltd (EIC) -Ghana?

Friends ☐ Relations ☐ Agent/Broker ☐ Media ☐

Publicity (Fairs, Exhibitions) ☐ Website ☐ Others ☐

5. Do you have any friends/relatives currently insured with E I C-Ghana?

Yes ☐    No ☐

6. Have you ever made any claim on your insurance Policy (ies)?    Yes ☐    No ☐

If yes, in the above question please answer questions 7-14.  If No, as in above question; please    answer questions 24-26

7. Was this claim settled by EIC-Ghana?  Yes ☐    No ☐

8.  How long did it take EIC-Ghana to settle the claim?

Within 1 week ☐    2 weeks ☐    3-4 weeks ☐    5-6 weeks ☐    6-8weeks ☐

3-5 months ☐    6-8months ☐    9-12 months ☐    2 years ☐    Above 2 year ☐

9.  What was your expectation in terms of how long it would take before the claim is settled?

Within 1 week   2 weeks        3-4 weeks        5-6 weeks        6-8weeks

3-5 months     ☐-8months     ☐12 months     ☐ years     ☐Above 2 year        ☐

10. Was the amount paid equal to the claim estimate submitted to EIC-Ghana?

Yes     ☐     No     ☐     Indifferent     ☐

11. To what extent were you satisfied with the claim amount paid? Not Satisfied     ☐

Satisfied  ☐ Very Satisfied  ☐ Indifferent  ☐

12. To what extent were you satisfied with the length of time taken to settle the claim?

amount paid? Not Satisfied ☐     Satisfied ☐ Very Satisfied ☐ Indifferent     ☐

14. How would you describe the claim handling procedure of EIC – Ghana?

…………………………………………………………………………………………

15. Has EIC-Ghana ever declined your claim at any time?     Yes ☐ No     ☐

If yes, in the above question please answer questions 16-21

16. Were you given any reason(s) by EIC-Ghana as to why your claim was

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declined?    Yes ⬜    No ⬜


18. Were you satisfied by the reason(s) given for the decline of your claim?

Yes ⬜    No ⬜

19. Did you have any customer service machinery for you to lodge a complaints or an appeal?

Yes ⬜    No ⬜

20. What were the reason(s) given?

Breach of policy condition ⬜    Loss not covered by Policy ⬜

claim was settled by third party ⬜    If other specify…………………………………

21. Will you continue to maintain your policy with EIC-Ghana in spite of your

Claim being declined? Yes ⬜    No ⬜

23. If yes/no, why?.................................................................................................................

24. Has any relative or friend made a claim with Enterprise Insurance Company Ltd?

Yes ⬜    No ⬜

25. Did you expect the claim to be paid the claim to be paid? Yes ⬜    No ⬜

26.  How long did it take EIC-Ghana to settle the claim?

Within 1 week ☐ 2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ 6-8weeks ☐

3-5 months ☐ 6-8months ☐ 9-12 months ☐ 2 years ☐ Above 2 year ☐

27. How long did you expect settlement to take?

Within 1 week ☐ 2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ 6-8weeks ☐

3-5 months ☐ 6-8months ☐ 9-12 months ☐ 2 years ☐ Above 2 year ☐

28. Do you intend to take a policy or buy another Insurance policy (ies) from EIC Yes ☐

No ☐

29. Would you recommend to others to insure with EIC-Ghana given your

experience?

Yes ☐ No ☐

30. Have you been paying Insurance premium without making a claim on your

policy (ies)? Yes ☐ No ☐

31. Will you continue to maintain your policy even when you have not been making

claim? Yes ☐ No ☐

32. If yes/no, why?.......................................................................................................

33. What suggestions/recommendations would you give to Enterprise Insurance Co. Ltd.-Ghana regarding claims settlement in order for them to offer you better service?

………………………………………………………………………………………

………………………………………………………………………………………

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## QUESTIONNAIRE TO STAFF OF THE COMPANY

Dear Sir/Madam,

As part of the requirement for the award of an Award of Executive Master of Business Administration degree from Kwame Nkrumah University of Science and Technology, Mr. Harry Ernest Boakye Ofori-Attah is conducting a research on **"The Effects of Slow Claims Settlement on the Sales and Marketing of Insurance Products"** as part of an academic project work.

I would therefore be grateful if you could kindly answer the under-listed questions in all honesty. Your responses would be treated with utmost confidentiality.

Thank You.

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### SECTION A

1.      Name of Respondent (Optional):………………….……………………

2. Sex:          Male  ☐      Female  ☐

3.      Position of the person providing answers to the question:……….………………

4.      Number of years worked with the company:……………….………………

### SECTION B

1.      When was your Company established? ..........................................................

2.      What class (es) of insurance business does your Company underwrite:

………………………………………………………………………………

……………………………………………………………………………….

3.      How long does it take on the average to settle the following types of claims after notification and documentation?

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**DURATION**

| POLICY | Within 3 months | 3-6 months | 6-9 months | 9-12 months | Above 12 months |
|---|---|---|---|---|---|
| Life | | | | | |
| Motor | | | | | |
| Personal Accident | | | | | |
| Fire | | | | | |
| Marine | | | | | |
| Fire | | | | | |
| Burglary | | | | | |
| Employers/Product/Public Liability | | | | | |
| Aviation | | | | | |
| Engineering | | | | | |

4. What are the responses of claimants to No. 3 above?

Satisfied ☐    Not satisfied ☐    Indifferent ☐

5. Do claimants who have been settled come back to renew their policy (ies)?

Yes ☐    No ☐

6. Has there been any increase in the number of policies written in the last 3 years?

Yes ☐        No ☐

7. Would you say the increase or decrease in the number of policies is as a result of    quality of your claim services?  Yes ☐       No ☐

8. Have you ever declined to settle a claim? Yes ☐   No ☐

9. If yes, on what ground(s) was the claim declined?

……………………………………………………………………………………

……………………………………………………………………………………

10. Do claimants whose claim have been declined come back to renew their policy (ies)?

Yes ☐          No ☐

11. If yes, what steps are taken to get them to renew their policy?...............................

…………………………………………………………………………………….

……………………………………………………………………………………

12. Has there been occasions when you had to pay amounts less than that claimed by your customers? Yes ☐   No ☐

13.  If yes, briefly state your reasons for paying amounts less than that claimed by your claimants……………………………………………………………………………

14. Do you have any claimants Service Unit where claimants can lodge their complaints?

Yes ☐   No ☐

15.     How     do     you     handle     complaints     of     dissatisfied     claimants?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

16. Do you have any system of customer feedback after claims settlements?

Yes     ☐     No     ☐


17. Do you undertake on-going claims satisfaction research?

Yes     ☐     No     ☐

KNUST