PROFESSIONAL
INSURANCE AGENTS LTD

Office Address
Lion Works
Sidley Road, Eastbourne
East Sussex, BN22 7HB
Tel: +44 (0) 1323 648 000

Claims Procedure

Please Note: All 'Insureds' (i.e. clients of PIA who have purchased a policy via ourselves) are advised to notify us immediately of any claims or circumstances that could lead to a claim, without delay. If in doubt, all Insureds are strongly recommended to notify the matter to us for onward transmission to the Insurer. If this is not done, the claim could be declined.

For further information of what could constitute a claim/circumstance please refer to the separate sheet on the following page.

1. Claims Process

Upon receipt of the claim/circumstance notification, a 'claim file' is set up in the Insured's name and the details are saved on file. The file is kept in a paperless format on our database and records all of the relevant written and verbal communication between ourselves, the Insured, Insurers and any appointed Claims Handlers and/or Solicitors.

When you notify us of a circumstance which may lead to a claim, we will keep a watching brief on this, and ask you to keep us updated on any developments as soon as they happen. If there are no developments in regards to this circumstance, the file will generally be closed after 12 months from the date of notification.

After we have received the full details of the claim correspondence, we will forward this on to the Insurer (usually on the same working day), requesting an acknowledgment of the claim, together with any comments that they wish to make, or additional information that they require from the Insured.

An acknowledgment of the claim correspondence (sent to us by the Insured) is emailed to the Insured explaining that we have received the initial details and have passed these over to the insurance company (who provide their policy coverage), and that we will be in contact with them once the Insurer's response is received.

A forward diary system is put in place to follow up the claim, usually within 3-5 working days, depending upon the type of claim that we have received and the applicable time-frames involved.

Generally speaking, Professional Indemnity, Directors' & Officers' Liability and other Commercial Lines Insurance claims can often be quite complex and therefore the Insurers and/or their legal representatives usually need this amount of time (3-5 working days) to investigate the matter and prepare the response to the allegations being made against the Insured by the Claimant.

Upon receipt of the Insurer's response, we will endeavour to contact the Insured on the same working day, or usually within 24 hours of the Insurer's email to discuss this with the Insured. The lines of communication may take the form of email or telephone correspondence, or indeed both, and all written and verbal details are recorded on the Insured's paperless claim file.

If we do not hear back from the Insurers within the 3-5 working days (or the applicable deadline, which may be less than the 3-5 working days), we will issue email chasers to the Insurer requesting a prompt response to the initial claim notification. The Insured will be kept updated and telephone chasers to the Insurer will also be actioned if they still do not respond to our correspondence.

Going forward, we will actively chase both the Insurer and Insured for updates on a regular basis to ensure that the required information is obtained from each party. From time to time a conference call between the Insurer, Insured and ourselves may be needed/requested to discuss the claim notification in more detail.

The applicable details from the claim notification are recorded on the Insured's claim file until closure of the matter and as previously explained, because the nature of Professional Indemnity, Directors' & Officers' Liability and other Commercial Lines Insurance claims can often be far more complex than a Car or House Insurance claim, it is not uncommon for the average claim to be ongoing for 6-9 months. That said, due to the ongoing nature of some of these claims it may even take years to resolve.

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Once the Insurer believes that the matter has reached its conclusion, they will advise us that the file can be closed and we will update the Insured accordingly. In some instances, a claim file may need to be re-opened (usually on precautionary notifications if the allegations re-surface against the Insured) and this should highlight why we recommend that the Insured should keep us updated with all applicable developments.

*Please note that all claim files are kept for a minimum of 7 years after the date of closure.

2. What Constitutes a 'Claim'?

Any of the following would be notifiable:

- Claim served upon the Insured
- Notice of intention to serve a claim upon the Insured.
- Notice, whether orally or in writing, of an intention to commence legal proceedings.
- A demand for money or services by way of compensation or reparation for (an allegation of) negligence, breach of duty or breach of contract.

In addition to notifying the insurers of actual claims there is a requirement to notify them of circumstances that could/may/might give rise to a claim. The reason for this is that insurers need to be able to take control of the Insured's legal position, prevent it becoming prejudiced (by incorrect actions or correspondence) and so weaken the Insured's defence to the allegation

3. What is a 'Circumstance'?

1. There is no definition of "a circumstance". If in doubt notify insurers. Doing so will not automatically affect the future insurance premium, but not to do so will probably affect the validity of the insurance policy.

4. Examples of 'Claims' and 'Circumstances'

1. A letter from a client holding the organisation responsible for alleged neglect, misconduct or deficiency in the services provided, or a formal "letter of claim" received from solicitors or other professionals acting for your client. This is a "claim".

2. Any claim form summons or notice of an intention to serve a claim form or summons or similar stating professional neglect, regardless of its accuracy, substance or merit. This is a "claim".

3. Any internal memorandum or note which relates to conversations where oral allegations of neglect or misconduct have been made. The date of the conversation when the allegation is first made would probably be regarded by insurers as the date the Insured first became aware of the claim. This could be a claim in itself but it is definitely a circumstance.

4. A written or oral demand for money or services by way of compensation or reparation for an alleged professional neglect or service deficiency. This is a "claim".

5. A written or oral demand or request for the organisation to waive or reduce its service fee invoices because of alleged deficiencies in the provision of its services. This is a "claim".

6. A fee recovery dispute, where the basis of your client's intention to withhold all or part of the fee is alleged or anticipated dissatisfaction with the service or professional advice provided. This is a "circumstance".

7. Any occurrence or identification of a problem or dispute which the Insured considers (or a reasonably competent person would consider) exposes the organisation to a threat of litigation. This is a "circumstance".

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5. Discovery of 'Circumstances'

If you discover an error or mistake that is not yet known to your client:

1. This is a sensitive situation and must be treated with extreme care. The firm's first duty is to their client with whom there may be a loyal and long term relationship. At the same time the firm must do nothing that insurers could regard as a breach of policy conditions.

2. Discovery of an error or mistake that is not yet known to your client could very well be regarded by insurers as circumstance. The usual expectation of the insurer would be that any such discovery of errors should not be reported to the client without the prior knowledge and agreement of the insurers.

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