ST. MARY'S UNIVERSITY
SCHOOL OF GRADUATE STUDIES

FACTORS AFFECTING MOTOR INSURANCE CLAIM PROCESSING TIME: THE CASE OF AWASH INSURANCE COMPANY S.C.

BY: SOSINA LEMMA

JUNE, 2019
ADDIS ABABA, ETHIOPIA

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A THESIS SUBMITTED TO ST. MARY'S UNIVERSITY, SCHOOL OF GRADUATE STUDIES IN PARTIAL FULFILLMENT OF MASTERS OF BUSINESS ADMINISTRATION IN BUSINESS MANAGEMENT

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Declaration

I, the undersigned, declare that this study entitled – "***Factors Affecting Motor Insurance Claims Processing Time in case of Awash Insurance Company S.C***" is my original work prepared under the guidance of Dr. Maru Eshete. To the best of my knowledge, all sources of materials used for the thesis have been duly acknowledged. I further confirm that the thesis has not been submitted either in part or in full to any other higher learning institution for the purpose of earning any degree.

Name: _____

Signature:_____

Date of Submission:_____

ADVISOR APPROVAL

This paper has been submitted for examination with my approval as university advisor.

Name: **Dr. Maru Eshete**

Signature:_____

Date: _____

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APPROVED BY BOARD OF EXAMINERS

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LIST OF ACRONYMS

AIC…… AWASH INSURANCE COMPANY (S.C.)

CII …… CHARTERED INSURANCE INSTITUTE

GWP……GROSS WRITTEN PREMIUM

NBE…….. NATIONAL BANK OF ETHIOPIA

SPSS……STATISTICAL PRODUCT AND SERVICE SOLUTIONS

VIATPR……. VEHICLE INSURANCE AGAINST THIRD PARTY RISK

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ABSTRACT

The aim of this research was examining the factors that affect motor insurance claim processing time in Awash Insurance Company S.C. The study has analyzed the effect of selected independent variables, which are assumed to have major impact on motor insurance claims processing time. The variables: competency of claims staff, customers' awareness of motor policy and competency of service providers were selected. The researcher used both primary and secondary sources of data. As a primary source, the relevant data was gathered from customers of AIC, who had motor own damage claims previously through structured questionnaire that has four demographical and twenty three close-ended questions. Questionnaires were dispatched to 134 conveniently selected customers from top 10 motor claim paid branches in the year 2017/18, and 117 or 87.3% returned. For data analysis and interpretation, quantitative and qualitative research approaches are used and to show the cause and effect relationship between variables, explanatory research design was used. The collected data was analyzed with the help of SPSS version 20. Regression analysis was used to investigate the impact of independent variables on dependent variable. Major findings from the regression result of the research showed that competency of service providers are found to be the most significant factor in affecting motor insurance claims processing time in AIC. Next to competency of service providers, competency of claims staff has an impact on motor claims processing time. Customers' awareness of motor policy was found to have no significant impact on process. Based on these findings, a recommendation which can facilitate motor insurance claims processing time to increase customer satisfaction has been forwarded. Therefore, the need for careful selection of garages based on the skilled manpower they have; punctuality to deliver; and quality of work are suggested. Furthermore, intensive training for claims staff in relation to customer handling; and underwriters need to disclose the contents of the policy up on underwriting are recommended.

Key words:-*Motor Claims process, Competency, Awareness, Awash Insurance Company S.C., Addis Ababa,*

CHAPTER ONE
INTRODUCTION

This chapter presents a general background of the study, statement of the problem, objectives of the study, research questions as well as hypothesis. The chapter further describes the scope and limitation of the study, significance of the study and organization of the study.

1.1. Background of the Study

Insurance is a social device providing financial compensation for the effects of misfortune, the payments being made from the accumulated contributions of all parties participating in the scheme (Hansell, 1974). It may be seen as a kind of fund, into which all who are insured will pay an assessed contributions called premium. In return, those insured will have the right to call on the fund for any appropriate payment should the insured events occur. Insurance exists to protect the adverse effect of risk in our daily activities. An individual or organization agrees to pay a fixed premium and in return, the insurance company agrees to meet any losses which fall within the terms of the policy (Vaughan & Vaughan, 1995).

Motor insurance is the major property insurance under non-life insurance category. According to different reports from insurance industry, on the general insurance market in Ethiopia, for most insurance companies, motor insurance premium contribution to the gross written premium is considerably high and it has a lion's share on the general insurance portfolio mix.

Motor insurance contract between the insurer company and the insured, like others, depends on the insurance company's ability to pay claims. 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. An insurance company which intends to maintain a competitive edge must perform better than competition in its management of the claims function (Earnest, 2012).

A claim is a demand made by the insured to the insurer for the payment of benefits under a policy (Asokere & Nwankwo, 2010). Claims are the defining moment in the customer relationship for insurance firms, with a firm's success often defined by one factor: the customer's experience around claims (Singh, 2007). Furthermore, 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).

Thus, to fulfill the demand of customers to be competitive in the market, insurance companies have to compensate adequately within a relatively shorter time. Otherwise, it erodes good names of the companies through time. The insurance industry is perceived as quick to collect premium, slow to pay claims, using small prints to confuse customers, providing poor services and engaging in sharp practices (Lijadu, 2002).

Awash Insurance Company S.C. has similar experience with other companies in the insurance industry regarding motor portfolio; the major part of the Company's written premium was from motor class of business. For the last five years, motor written premium constituted from 62% to72% of the gross written premium. Motor loss ratio of the company for the last five years was also on average 66 % (Annual reports of AIC, 2013-2018).

As motor holds the major written premium of the insurance business, it is vital to emphasis on facilitating motor claims to retain customers by addressing factors that can affect motor insurance claims processing time so as to ascertain the company's sustainable growth and profit.

Thus, this study mainly focuses on examining the factors that can affect most in motor insurance claim processing time and to recommend constructive measures based on the findings.

1.2. Statement of the Problem

Various researches conducted on motor insurance related issues. Some of them are Tsegereda Zeru(2016) the effect of opportunity and challenges on motor insurance, and Ayele Desalegn(2016) assessment of motor insurance business financial performance of the same insurance company. They discussed the major income of most insurance companies is from motor insurance and wider resources has been taken by high motor claims. In addition to them, Moltot A.(2016) conducted a research on assessment of challenges and prospects of motor claims management in Africa Insurance Company. He discussed the challenges in motor insurance claim and the gap between customers' expectation and management perception of service quality in motor claim management due to internal and external factors of the studied Company. Fasika Tatek(2018)on his study and finding entitled assessment of factors affecting satisfaction of motor insurance customers: in selected insurance companies,

in Addis Ababa, there is delay in compensation due to longer motor claims process that lead to low customer satisfaction. None of them has addressed the factors that affect motor insurance claims processing time.

As one of the employee working in the insurance industry, the researcher observed that most of the time customers' dissatisfaction in relation to motor claim arises from two main reasons: motor claims compensation adequacy or delay in settlement. In addition to that, there is a decrease in customer retention rate caused by complain related to claims processing time in motor insurance that makes claims management poor which needs improvement to maximize customer satisfaction.

Annual reports of Awash Insurance Company S.C. for last two years show that retention of customers is 73% and 70% which has decreasing trend. Even if AIC's minimum retention rate is 80%, the reported retention is below expectation. As per the branches annual performance reports, from few challenges of retention, the grievance on motor insurance claims is the bigger one. Due to this AIC cannot meet its annual target of year 2016/17 by 1.5% shortfall and for the year 2017/18 by 2% short fall. Thus, the researcher believes that the longer claims processing time is one of the reasons for bad performance in motor claims. On the other hand, in order to maximize customers' satisfaction to be competitive, profitable and grown market share in the insurance industry, settlement of claims should be fast. Thus, factors that affect motor insurance claim processing time will be discussed under this study.

1.3. Research Objective

1.3.1. General Objective

The general objective of this study is to identify the factors affecting motor insurance claim processing time in Awash Insurance Company S.C.

1.3.2. Specific Objectives

The specific objectives of the study are to:-

- ✓ Identify the effect of competency of claims staff on motor insurance claim processing time.
- ✓ Determine the effect of customers' awareness of policy on motor insurance claims processing time.

- ✓ Identify the effect of competency of service providers on motor insurance claim processing time.

1.4. Research Questions

From the objective of the research, the following questions are raised in order to determine the effect of independent variables on the dependent variable.

1. What is the effect of competency of claims staff on motor claims processing time?
2. What is the relationship between customers' awareness of motor policy and motor claims processing time?
3. What is the effect of competency of service providers on motor claims processing time?

1.5. Research Hypothesis

In order to achieve the objective of the study stated above, the following hypothesis is framed.

H1: There is a positive and strong relationship between competency of claims staff and motor insurance claim processing time.

H2: There is a positive and strong relationship between customers' awareness of motor policy and claims processing time.

H3: There is a positive and strong relationship between competency of service providers and motor insurance claim processing time.

1.6. Scope and Limitation of the Study

This study is focused only on investigation of the factors affecting motor insurance claim processing time in Awash Insurance Company S.C. Among other factors, it examined the effect of competency of claims staff, customers' awareness of policy and competency of service providers. As the unit of data analysis, the researcher used structured questionnaire among the different data collection methods. It might limit customers' responses. Besides, due to time and resources constraints, the population of the study is limited to customers of Awash Insurance Company S.C. some Addis Ababa branches. Thus, generalizing to all including up-country branch customers may be difficult, as claim is centralized.

1.7. Significance of the Study

This study is expected to provide empirical evidence on the factors affecting motor insurance claim processing time. By identifying the factors that affect motor insurance claim processing time, the management of Awash Insurance Company will take necessary actions to improve the performance of the company in this area and choose the right decisions. Since the competitiveness and strength of the Company is based on its claims management efficiency, it can also help the company to identify the gap between its customer's expectation and the existing performance in motor claims to fill the unsatisfied demand by indicating the root cause for poor motor claims performance. In addition to this, fleet customers, be part of a solution by understanding the problem of the company in relation to service providers like garages, towing services, spare part providers. Investors of the area will provide efficient services with the interests of their customers as well as insurance companies.

1.8. Organization of the Study

This study is organized in five chapters. Chapter one introduced the background of the study, problem statement, research objectives, research questions, scope and limitation of the study and significance of the study. The second chapter presented the theoretical and empirical review of literatures related to the topic and the conceptual framework which tried to indicate how the variables in the study connect with each other. Chapter three is comprised of research methodology and that describes the approach and design of the research; the variables data sources and data collection methods; population & sampling and method of data analysis of the study. The fourth chapter deals with data analysis, presentation and interpretation. Finally, in the fifth chapter summary of the findings, conclusion and recommendation will be presented.

CHAPTER TWO

LITERATURE REVIEW

This chapter consists of two parts: The first part is theoretical review which deals about insurance and insurance types, the importance of insurance, principles of insurance, effectiveness and efficiency in claim service. The second part is empirical studies which deal about motor vehicles and motor insurance, motor insurance procedure and factors that affect motor insurance claims process.

2.1. Theoretical Review

2.1.1. Insurance and Insurance types

Insurance is an important risk management tool by risk transfer arrangement. In a typical insurance arrangement, the insurer promises, in return for a premium, to fulfil its contractual obligations upon the occurrence of some event, often a qualified loss (Skipper and Kwon 2007).

Insurance coverage is categorized as life insurance and non-life insurance. Life insurance gives a protection for insured's family, creditors, or other beneficiaries against financial loss when death happens to the insured. Non-life insurance provides cover against financial loss of property, liability, engineering, pecuniary, casual and others. Among property insurance there are different types of covers: Fire & lightning, Burglary and Housebreaking, Marine Cargo, Inland Transit Risk, House holder's Comprehensive, Plate glass and Motor insurance.

Motor insurance covers the policyholders against financial loss in the event of an incident on a vehicle they own due to overturning, fire, or in a traffic collision; or liability cover age for the legal responsibility to others for bodily injury or death or property damage and medical coverage for the cost of treating injuries, rehabilitation and sometimes lost wages and funeral expenses.

2.1.2. Importance of Insurance

The business activities in the world without insurance are unsustainable since risky business may not have the capacity to retain all kinds of risks in ever changing and uncertain global economy (Ahmed et al., 2010). In this regard, insurance companies play an important role as facilitators in the economic growth by indemnifying losses and making stable individuals and

institutions to focus on innovative investment. Thus, in Ethiopia, as developing country, the role of insurance is vital.

Insurance contributes a lot to accelerate the general economic growth of the country in different ways. It provides financial support by distributing risk; reduces uncertainties in business and human life; encourages investment by generating funds in collecting premium; provides an investment channel by developing a habit of saving money (endowment policy); enhances provision of credit facilities; provides medical support for the society and many others.

Insurance as an economic device is justified because it creates certainty about the financial burden of losses and because it spreads the losses that do occur. In providing a mechanism through which losses can be shared and uncertainty reduced, insurance brings peace of mind to society's members and makes costs more certain (Vaugan & Vaugan, 2007).

Insurance also provides for a more optimal utilization of capital. Without the possibility of insurance, individuals and businesses would have to maintain relatively large reserve funds to meet the risks that they must assume. These funds would be in the form of idle cash or would be invested in safe, liquid, and low-interest-bearing securities. This would be an inefficient use of capital. When the risk is transferred to the professional risk bearer, the deviations from expected results are minimized. As a consequence, insurers are obligated to keep much smaller reserves than would be the case if insurance did not exist. The released funds are then available for investment in more productive pursuits, resulting in a much greater productivity of capital. (Vaugan & Vaugan, 2007).

2.1.3. Basic Principles of Insurance

The pillars in insurance underwriting and claims are principles of insurance. Every subject or discipline has certain generally accepted and systematically laid down standards or principles to achieve the underlying objective (Bodla et.al., 2004).

The following are basic principles of insurance (Hansell, 1975):- Insurable interest, utmost good faith, Indemnity, Subrogation, Contribution, and Proximate cause. Each basic Insurance principle is explained further hereunder:-

1. Insurable Interest

Insurable interest in property may arise through ownership, possession or contract and in certain cases it may be created or modified by statute. (Hall, 1985). A property owner has insurable interest in his property because damage or loss sustained by the property would result in financial loss to the owner. On the other hand, if a person has no financial interest on the subject of insurance (property, vehicle, and etc.), such a person is said to have no insurable interest.

Thus, any one person that has no insurable interest on a particular property would not be allowed to insure such property.

2. Utmost Good Faith

The insurer undertaking the risk and the person applying for insurance have a duty to deal honestly and openly with each other in the negotiations which lead up to the formation of the insurance contract. This duty may also continue while the contract is in force. If one party is in breach of this duty, the other party usually has the right to avoid the insurance contract entirely. In other words, a breach of utmost good faith renders the insurance contract voidable. The principle of utmost good faith protects the interest of both the insured and the insurer and imposes two duties on both parties to the insurance contract; not to misrepresent any matter relating to the insurance, and to disclose all material facts relating to the contract.

3. Indemnity

The concept of indemnity implies that the object of insurance is to provide the exact financial compensation for the insured. It also implies that the insured should not be over-compensated and should not "make a profit" from his loss. In other words, the principle of indemnity requires that the insured should be fully compensated, but not over-compensated, for the loss.

The intention of the parties to the contract is that the insured, on the happening of an event insured against, will be placed by the insurer in the same pecuniary position that he occupied immediately before the event, subject to any limitations which may have been agreed and written into the contract(Hall, 1985).

4. Subrogation

Subrogation is the legal principle, whereby one person takes over the rights or remedies of another against a third party. Subrogation is defined as the "right of one person (the insurer)

to take over the rights of another (the insured)". It is often described as "stepping into the shoes of another" and is applicable only to contracts of indemnity. The basic premise is that where one person, i.e. typically an insurer in this case, makes a payment on an obligation which, in law, is the primary responsibility of another party, then the insurer making the payment is subrogated to the claims of the insured to whom the insurer has made the payment with respect to any claims or remedies which are exercisable against the primarily responsible party.

Subrogation exists to make sure that an insured does not get more than an indemnity, by claiming for the same loss or damage from both the insurance policy and another source or sources. This is to say that subrogation will arise only, where the insured has suffered a loss and has another means of recovering for it, i.e. a claim on his insurance policy and a legal right or claim against some other persons for the same loss. If the insured chooses the first option (a claim on his policy), then the alternative right, i.e. the claim against another, will pass on to the insurer. The effect is to prevent the insured from recovering twice for the same loss, so as to preserve the principle of indemnity.

5. Contribution

The principle of contribution, which, like the principle of subrogation, has been described as a corollary of indemnity, is concerned solely with the apportionment of liability as between insurers in the event of double insurance, and the rules adopted for its application are primarily rules of practice designed by insurers for their own guidance. (Hall, 1985). When risk materializes in a situation where double insurance exists, the insured shall claim to one of the insurance companies and the insurance company that received notification of claim shall indemnify the insured and request for reimbursement proportional cost of the claim from the other insurance company. If the insured is allowed to claim from both insurance companies, it would be in violation of the principle of indemnity. In case the claim is reported to both insurance companies, there is a possibility of paying their proportional cost of the claim direct to the insured.

6. Proximate cause

The classic definition of proximate cause was given in Pawsey v. Scottish Union & national (1907) "Proximate cause means 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" (Hansell, 1974).

According to the principle of proximate cause, if an insured person lodged a claim, he is required to justify that the loss is caused by a peril insured under the policy. In other words, he must ensure that the loss is not caused by uninsured peril. For example, under motor insurance, damage caused by war and war like operation is an excluded risk. Loss or damage to the vehicle by fire, however, is covered peril. If the insured vehicle is burnt down to ash due to exchange of fire between two parties at war, the insured will not be indemnified in respect of losses incurred in this regard. Because the proximate cause for the loss is war which is a peril not covered under the policy.

2.1.4. Effectiveness and efficiency in claims handling

Nowadays, customers give high priority to claims handling culture of the insurer and how fast the insurer pays when they face accident. The increased customers' knowledge about the service helps the industry for improvement to provide efficient service to compete each other.

The speed, accuracy and effectiveness of claims processing is also paramount for controlling costs, managing risks and meeting portfolio underwriting expectations (IBM, 2011).

One of the major ways a service firm can differentiate itself, is by delivering constantly high quality than its competitors do. As a result, every service business needs to proactively define and assess the level of customer satisfaction (Kotlar 2004).

The task of handling claims process has been challenging. However, modernizing the claims process for efficiency, effectiveness and flexibility has been being daunting task, due to the fact that it is a mission-critical function that touches all parts of the organization, affecting competitive positioning, customer service, fraud management, risk exposure, cost control, and IT infrastructure (TIBCO, 2011).

Fast claims handling is not only for the benefit of customers to fulfill the contract, but also for the insurer company to get cost benefit in the ever increasing prices of labor and spare parts in the market. Claims must be settled promptly and equitably in order to earn the confidence of customers and to retain their loyalty.

Excellence in claims handling is being a competitive edge for an insurance company and it is a service that clients greatly value. Regarding claims process some step-by-step claims handling activities include: acknowledging and assigning the claim, identifying the policy, contacting the insured or the insured's representative, investigating and documenting the claim, determining the cause of loss and the loss amount, and concluding the claim (Brooks et al., 2005).

However, the payment of legitimate claims represents the delivery of the promise at the heart of the insurance contract; which, indeed, for many insurance companies, excellent claims handling service is considered to be a differentiator that distinguished them from the competition (AIRMIC, 2009).

A good claim management holds: proactive in recognizing and paying legitimate claims; assessing accurately the reserve associated with each claim; reporting regularly; minimizing unnecessary costs; avoiding protracted legal disputation; dealing with claimants courteously; and whatever possible, handling claims expeditiously (Yusuf and Dansu,2014). Then, to reduce the cost of claims and deliver on a value-added brand promise to customers, insurers must focus on enhancing efficiency and effectiveness in their claims function (Singh, 2012).

2.2. Empirical Review

2.2.1. Motor Vehicles and Motor Insurance

As per Article 2(6) of VIATPR Proclamation No 799/2013, "Motor Vehicle" is defined as any vehicle moving on a road by mechanical or electrical power; and according to Article 2(5) "Vehicle" is defined as any wheeled motor vehicle, semi-trailer or trailer for use on the road with the exception of wheelchair and bicycle.

Any vehicle moving on a road by mechanical or electrical power can be considered for motor insurance. The significance of motor insurance is to indemnify the covered losses of the insured vehicle due to accidental own damage and the liability against third party person and property due to theft, overturning, collision and fire depending upon the type of cover. The subject matter in motor insurance is motor vehicle. A motor vehicle is defined by road traffic act of UK as a mechanically propelled vehicle intended or adapted for use on roads. Road means any highway and any other road to which the public has access and includes bridges over which a road passes (CII, 2011). Motor insurance cover has different types, Own damage, third party and third party plus fire & theft insurance. A customer can buy one or both types.

Motor insurance cover can be seen as three different cover policies that is own damage cover for the damage or theft of own vehicle; third party cover which became mandatory under Compulsory Motor Third Party Insurance Proclamation No.559/2008 for liabilities to third party risks and third party plus fire and theft cover that will indemnify for losses of third party including due to fire and theft. To have a full coverage for a vehicle the insured should

have both own damage and third party cover. Currently, in Ethiopia, own damage insurance is optional and third party insurance is mandatory.

Motor own damage insurance is divided into two as motor private and motor commercial depending on the nature and use of the vehicle. A vehicle is classified as private vehicle if it is used solely for social, domestic, pleasure and professional purposes or business calls of the insured. The term 'private use' does not include use in connection with the motor trade, racing, commercial travelling and hire and reward. On the other hand, commercial vehicles are goods carrying vehicles as well as passenger carrying vehicles. It is used to describe different types of vehicles that are intended or designed to carry goods and passengers. It ranges from trucks, busses to small goods caring delivery vans and small mini buses.

2.2.2. Motor insurance claims process

The time duration to do multiple administrative and customer service layers that includes; review, investigation, adjustment, payment or denial of motor insurance claim by the insurer to fulfill its obligation on the contract or policy to the insured.

Motor claim is a notification to an insurance company that payment of an amount is due under the terms of a policy (Vaughan & Vaughan, 2008). An insurance claim, therefore, is a demand by a person or an organization seeking to recover from an insurer for a loss that an insurance policy might cover (Brooks et al., 2005). Insurance claims varies from simple that can be settled within days of notification to complex claims that remain open for many years.

However, a claim on the policy is thus demand on the insurer to fulfill its part of the promise, committed to while writing the contract with the insured (Krishnan, 2010).

Insurance claim is a request to an insurance company by the insured for compensation of financial loss or policy event for the covered risk. Claims management is the carrying out of the entire claims process with a particular emphasis upon the monitoring and lowering of claims costs, (Wedge & Handley 2003). Thus, the fulfillment of the insurance contract depends on a company's ability to pay claims.

2.2.3. Motor Claims Procedures

The way an insurance company manages the claims process is fundamental to its profit and long-term sustainability (Rose, 2013). Core aspects of predictive insurance claims processing were noted to include: fraud management, recovery optimization, settlement optimization, claims benchmarking, activity optimization, and litigation management.(Earnest, 2012)

The procedure of handling claims depends on a number of cases like type of cover, amount of claim, etc. (Iruku, 1977).

1. Notification of Accident

Notification is a written notice of the insured to the insurer that explains the loss, what accident happened, how, when and the overall situations at the time of incident on the insured item. Written notification should reach the insurer as soon as possible unless otherwise there are material reasons to be late to inform. 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.

2. Verification:

Verification is checking the reported loss is covered at the time of loss by the insurer that received notification; and then 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.

Before accepting liability the insurer determines the validity of the reported claim by checking whether: (CII, 2007:70).

- Cover was in force at the time of the loss
- The person making the claim has the right to claim under the policy
- Peril is covered by the policy
- The sum insured is adequate
- The insured has complied with the policy conditions
- No exclusions apply

There is any other reason the insurer might wish to reject the claim (e.g. suspected fraud).

Claims that do not fulfill the minimum requirement will be rejected. The claim resolution process will start only after the validity of the claim is verified.

3. Site Survey

In most insurance companies, internal surveyors inspect the loss that damaged at the time of incident. After inspection, surveyors give professional proof of loss and extent of loss to claims officers. Surveyors advise claims officers and managers what part to be changed or replaced and the part to be repaired or payment to the insured at the time of theft and total

loss and they advise the best way of compensating the insured. If the case is beyond their professional capability or the insured not agreed it will go to external/independent surveyors

At the time of loss inspection, the insured expect to agree with the extent of the loss and accept the surveyor's professional opinion to continue to the next step. This helps the insurer to investigate if there is any fraudulent act.

4. Negotiation:

After acceptance, 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.

5. 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

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).

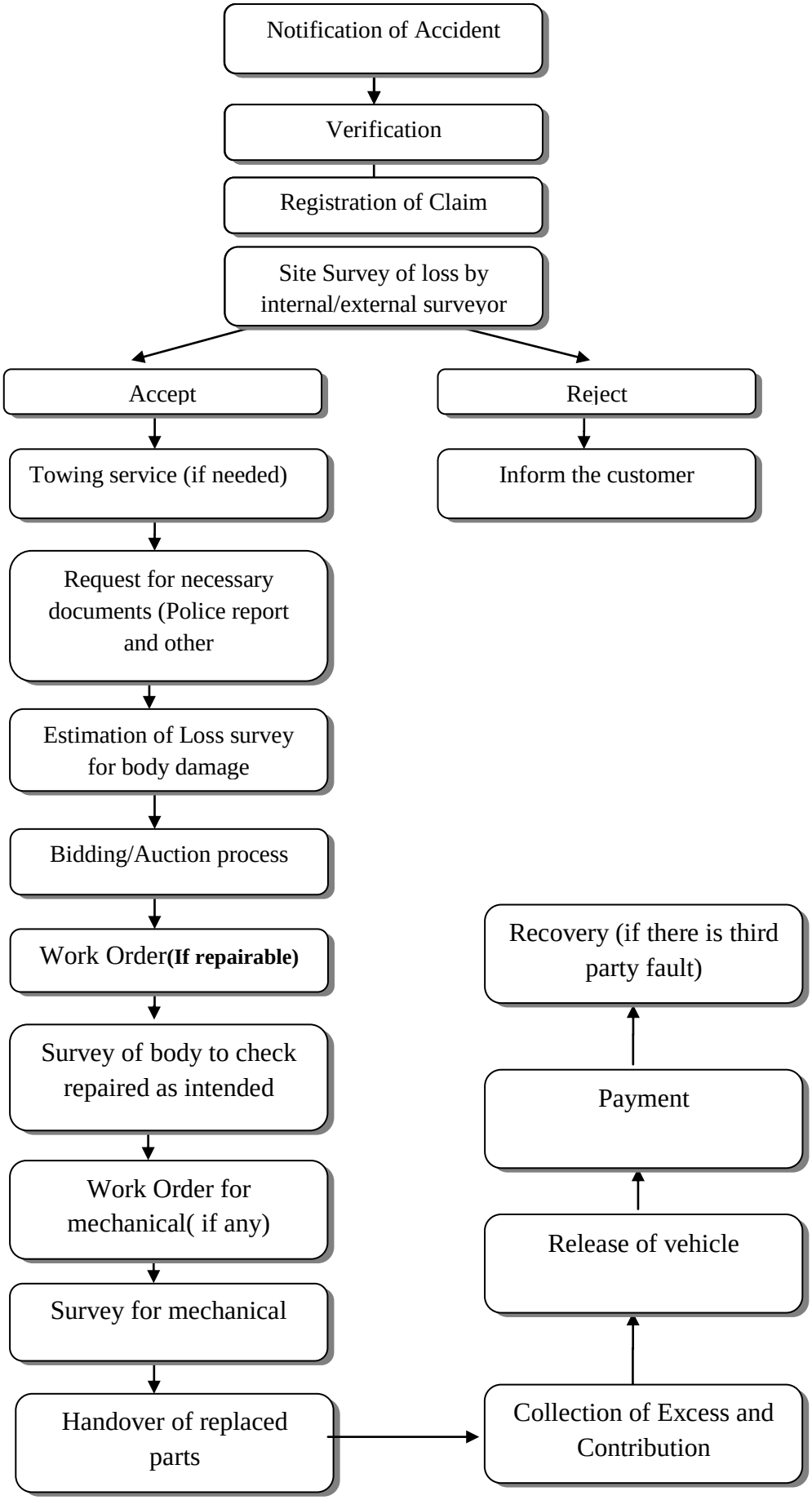


Figure 2.1. Motor Claims Process Chart

2.2.4. Factors that affect motor insurance claim processing time

Motor insurance claim processing time is the time from notification of accident to the insurance company by the insured to the final settlement to compensate the peril insured. Motor insurance claim and procedure differs from one claim case to the other because of the difference in severity of accident, type of insurance cover; type of vehicle and other. The major factors that assumed to affect the duration of the motor claim process are; competency of claims staff, customers' awareness of policy and competency of service providers outside the company. Even if there are so many factors that affect motor insurance claims process, the researcher seen only three factors in this study.

1. Competency of Claims Staff

Competence is the skill and knowledge of the claims staff to handle efficiently. Competency is not only for the front desk staff but also for supporting staff. It is an important dimension from the customer's point of view in service industries (Gronroos, 1983).

The need for qualified and competent insurance claims staff or specialists to enhance the claims service is important. Since the ultimate objective of insurance companies is to make profit for their stakeholders, they have to be efficient in claims management through reduced claims processing time as they are efficient in underwriting.

In a service industry like insurance, contact employees are the face of the organization, and can directly influence customer satisfaction (Zeithaml & Bitner, 2003). Employees in claims service desk are in close contact with the customer and/or intermediary from the time a claim is reported, throughout its processing, until it is eventually settled or rejected. The difference between one service supplier and another often lies in the attitude and skills of their employees (Lovelock &Wirtz, 2007).

The experience and qualifications of the employees is important, as claims processing involves a lot of decision making, which should not be left to inexperienced or incompetent staff (Wedge & Handley, 2003).

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).

The individual competencies and key organizational ones are closely related each other: the organizational competencies form through integration and coordination of individual competencies. The key competencies of organization are "what an organization can do best", key competencies related to job position are the most important to accomplish organizational goals, employee key competencies are identical with his strength, used in his work (Delamare Le Deist, Winterton, 2005).

Organizational competencies as well as individual ones, there are relations between knowledge, abilities and individual virtues. Therefore, this is very important for organization to manage individual competencies effectively, both present and potential. If the competencies are the employee virtue, they generate profits for whole organization that hired him (Janowski, 2012).

Despite of competencies, necessary for organizational operation, that is also important to possess "distinctive competencies", enable to reach a competitive advantage. These competencies are the "competency organizational weapon" (Itami, 1987).

Some insurance firms are doing better and even heavily expanding while others are either stuck or are not well performing. The success in some is a sign that some internal processes are being managed properly in these companies than it is in others. The internal processes are their core competencies. These help companies distinguish their service or product from those of their rivals. It also helps to reduce product development and marketing costs which in the end contributes to achieve a competitive advantage (Ombati, 2012).

2. Customers' awareness of policy

Underwriting refers to the process of evaluating a proposal that comes for insurance, and making a decision of whether to accept the proposal or not. If the proposal is to be accepted, at what price and on what terms, conditions and scope of cover (Brown, 1997).

Underwriters should have a good knowledge about the insurance policy they are providing and sometimes the insureds might not see details of the policy at inception. They have a responsibility to disclose all the facts about covers, conditions and exclusions of the policy to avoid unnecessary complain at the time of claims. Otherwise, the insured feels unfairly treated, if the claims staff realizes a specific peril is not covered. To a large extent, the quality of underwriting has a bearing on claims eventually made.

The customer expects adequate insurance coverage, timely delivery of defect free policy documents with relevant endorsements; and quick settlement to his satisfaction (Qaiser, 2015).

Claim handling of the insurance company is highly affected by the policy the insured have which is the result of quality of underwriting. Underwriting and claims are related functions one depends on the other and vice versa. Insurance companies underwrite risks to pay claims when risks materialize; and payment of claims is based on the policy documents which the customers take at the time of underwriting.

Policy documents create a major challenge to a claims handler unless completed and to the standard. The insured will be offended, if they know there is a breach of a policy condition to reject a claim. Other challenges include wrongly worded policy documents, incomplete or no proposal forms, agents/brokers completing proposal forms on behalf of the insured among others. The claims manager ends up paying claims which would otherwise not have been paid if proper underwriting was done.

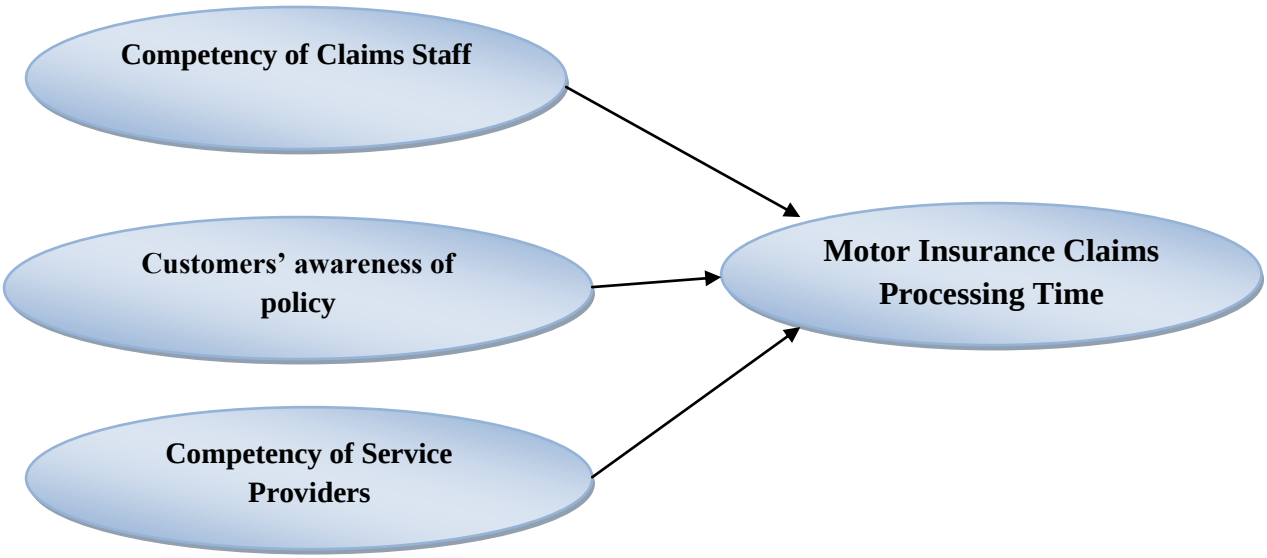
3. Competency of Service Providers

Service providers are individuals or institutions that give different services in relation to motor insurance claims. They are mostly external to the company and their main duties are measuring the level of loss or damage, repairing, towing, consulting and providing information about the loss and damage. These individuals and institutions follow their own procedures and time table to accomplish what the insurance needs in relation to handling the claims.

An insurer relies on assessors, investigators and loss adjusters, to ascertain whether to pay a claim, and if so the amount of compensation. Garages are also appointed to carryout repairs for the purpose of indemnifying an insured whose vehicle has sustained accidental damage. Some insurance companies employ full time employees to perform these functions; others outsource the functions to independent service providers. Insurers expect their service providers to adhere to the set customer service benchmarks, while at the same time exercising a high level of integrity. In addition, they are expected to assist the insurer reduce claim costs. Usually, this may not happen, either due to lack of the necessary skills to perform the task assigned or due to lack of integrity. The external service provider may also not attach as much importance to customer retention as the insurer. As a result, service to the customer may be compromised (Wedge &Handley, 2003).

2.2.5. Conceptual Framework of the Research

The study focused on three independent variables that assumed as factors affecting motor insurance claims processing time: Competency of claims staff, customers' awareness of policy and competency of service providers.



Source: Conceptual framework of the study adopted from Hornby, 2005.

CHAPTER THREE
RESEARCH METHODOLOGY

This chapter outlines the overall methodology that was used in the study. It begins by describing the research approach and design, then variables, data sources and data collection methods. It also describes target population and sampling, method of data analysis; validity, reliability and ethical considerations that was adopted in the course of the research.

3.1 Research Approach and Design

In this study, researcher prefers to use both quantitative and qualitative research approach so as to analyze the collected data through questionnaires and come up with results and provide interpretations. Quantitative design is helpful to assess the magnitude of something while qualitative design is suitable to describe, interpret, verify and evaluate a given phenomenon (Newman and Benz, 1998: 12).

An explanatory research design was used because the aim of this study is to examine the cause and effect relationships between dependent and independent variables in order to distinguish patterns. Explanatory research design examines the cause and effect relationships between dependent and independent variables (Saunders et al. 2009). Thus, explanatory design is the most appropriate for this study.

3.2 Variables, Data Sources and Data Collection Methods

The researcher tried to investigate the factors that affect motor insurance claim processing time in Awash Insurance Company S.C by examining the relationship between dependent variable, 'motor insurance claims processing time' and independent variables such as competency of claims personnel, customers' awareness of the policy and competency of service providers.

The researcher used both primary and secondary data sources to obtain quantitative and qualitative data. The primary data was collected from the customers of the company in ten branches in Addis Ababa by using structured questionnaire as a method of data collection.

Since the secondary data is also important as the primary data; the researcher has collected essential data from secondary sources. Secondary data used in this study such as relevant

journal articles related to motor insurance claim, books written on insurance, similar researches conducted previously, Company's annual performance reports, claims and underwriting reports, claim manual and procedure, and other documents related with claim.

The data collection method used in this research was structured and well organized questionnaire. The research instrument that was used to collect primary data was a five-point Likert Scale questionnaire which aimed to assess the essential data from respondents.

The questionnaire, developed in English and translated to Amharic has two parts. The first part contained four demographic variables which indicate profile of participants of the survey(gender, age, type of motor policy they have in AIC and their experience or client-ship in AIC). The second part was comprised of 24 close-ended question statements, so as to measure the variables of the study using a five-point Likert Scale being '1=Strongly Disagree', '2=Disagree', '3=Neutral', '4=Agree' and '5=Strongly Agree'. Thus, the respondents were requested to select their own choice among the given five dimensions in order to specify their level of agreement or disagreement on each question item.

3.3 Population and sampling

Awash Insurance Company manages motor own damage and compulsory third party claims separately under one claims Directorate. From the two types of motor insurance claims, the researcher selected motor own damage claims due to the fact that AIC handles third party claims in a different way in which only payments make after estimation of the loss by professionals or surveyors and according to the receipts the insured provide. Since the process of third party claims is estimating the loss and paying the estimated loss, it does not qualify for the process. Therefore, the targeted population in this study are customers who are treated under the own damage type of motor claim only which existed in the company in the specified period.

Population is a set of all elements that belong to a certain defined group to whom the researcher intends to generalize the results of the study. AIC has 48 branches over the country, the target population of the study is selected from 10 branches located in Addis Ababa according to the volume of motor claims they managed in the fiscal year 2017/18.

For the year 2017/2018, from the total reported claims, 1,096 own damage claims were settled. To study the total claims settled cases in the Company is very difficult, so the number of sample size from the target population should be determined.

Therefore, to determine the sample size, the researcher used the following formula(Kothari, 2004).

$$n = \frac{\frac{Z^2 P(1-P)}{e^2}}{1 + (Z^2 P(1-P)/e^2 N}$$

Where; n = sample size;

N= Population size;

Z = z-score (1.96);

e= margin of error (5%);

P = Probability of getting failure

As a result, the researcher has identified a sample of 122.8 or 123. By adding 10% as a contingency the total of 134 questionnaires were distributed to the randomly selected company customers in ten branches. They are selected conveniently when they come to branch offices.

Table 3.1.Sample Distribution by Branches

Ser. No	Branch Name	Total Settled Claims (Own damage)	%	Pro-portion	Not Returned/ defective	Sample
1	Bole Branch	637	58	78	11	67
2	Nefas Silk	145	13	18	3	15
3	Teklehaimanot	74	7	9	1	8
4	Kazanchis	70	6	8	--	8
5	Gofa	62	6	8	1	7
6	Kolfe	36	3	4	--	4
7	Dilgebeya	35	3	4	1	3
8	Wellosefer	14	1	1	--	1
9	Merkato	13	1	1	--	1
10	Kality	10	1	1	--	1
Total		**1,096**	**100%**	**134**	**17**	**117**

Source: own survey 2019

3.4 Method of Data Analysis

Concerning data processing, the researcher applied data editing, encoding, data entry and data cleaning activity in order to check the consistency of the data. In data analysis, the researcher used Statistical Package for Social Science (SPSS) version 20 software. Hence both

quantitative and qualitative methods used; the quantitative data analysis includes descriptive statistics which includes frequency distribution, mean, standard deviation and regression.

3.5 Validity and Reliability

3.5.1. Validity

Validity is the extent, to which data accurately reflects what they are meant to reflect, i.e., the instrument measures what is supposed to measure. In other words, the right questions being asked should help to obtain meaningful and usable responses on concepts under the study. Thus, the purpose of checking validity in the study was to seek relevant evidence that confirms the answers found with the measurement device which is the nature of the problem.

Accordingly, the questionnaire has been developed in English and translated to Amharic for convenience of respondents and in order to increase its validity. Besides, pilot test was conducted before all the questionnaires were distributed, in order to check whether the respondents understand the questions and respond applicably.

3.5.2. Reliability

Reliability refers to consistency, where internal consistency involves correlating the responses to each question in the questionnaire with those other questions in the questionnaire (Khotari, 2004).

One of the most commonly used indicators of internal consistency is Cronbach's alpha coefficient. The Cronbach's alpha coefficient of scales should be at least 0.70 (70%) and the higher the better(Pallant,2005). Therefore, as shown in table 3.2 below, the results for reliability test of Cronbach's alpha coefficients totally was 0.946(94.6%). Therefore, it can be considered as reliable and valid construct.

Table 3.2: Reliability Analysis: Cronbach's Alpha Value

Ser. No	Description	Items	Cronbach's Alpha
1	Competency of Claim staff	10	0.946
2	Customers' Awareness of Motor policy	6	0.653
3	Competency of Service Providers	7	0.934
	Total number of items	**23**	**0.946**

3.6. Ethical Consideration

An important consideration a researcher must not overlook is the issue of ethics in research. The researcher, in accordance with this, took steps to make sure that no respondent in this research work was harmed in any way. The purpose of the study was clearly disclosed for the respondents on the questionnaire. Moreover, the voluntary participation of respondents was done and to follow anonymity and confidentiality ethics of the research, the researcher clearly informed respondents in written form that not to write their names on the questionnaire.

CHAPTER FOUR
RESULTS AND DISCUSSION

This chapter presents the findings and results based on the data collected from respondents. It intends to address the research questions using the data collected from the sample source. The chapter is organized into three sections. The first part presents the response rate and characteristics of the respondents. In the second part, results of descriptive statistics on motor claim process were assessed. Then, it summarizes the results of data analysis using inferential statistics. Finally, the results are discussed in the last section of this chapter.

A questionnaire with four demographical and twenty-three main questions was developed to answer the research questions. The first four demographic questions focus on gender, age, type of policy and customers experience in AIC.

4.1. Response Rate and Characteristics of Respondents

From the total 134 questionnaires that were dispatched, 117 were returned, which make the response rate 87.3%. The following table summarizes the demographic data of respondents:

Table 4.1. Gender and age of the Respondents

Variable	Category	Number	Percentage
Gender	Male	88	75.2
	Female	29	24.7
Age	Below 25	5	4.2
	26-35	40	34.1
	36-45	43	36.8
	Above 46	29	24.8

Source: Own survey data(2019)

The above table describes the participants' gender and age category. Accordingly the highest group(75.2%) are male and 24.7% female. This implies that more male had reported claim in the ended year.

Regarding age category, the highest group is from 36-45(36.8%), the second higher is from 26-35(34.1%), in total, 71% of the population is in between age 26 and 45. This implies that more young population is involved in motor accident.

Table 4.2. Type of Policy and Experience in AIC of the respondents

Variable	Category	Number	Percent
Type of Policy	Private	71	60.7
	Commercial	46	39.3
Experience in AIC	Below 1 year	10	9
	1-4 years	66	56
	5-10 years	39	33
	Above 10 years	2	2

As the above table describes from the total participants 71 or 60.7% are private vehicles. This implies that from the total insured vehicles there are more private motor cars which were involved in an accident and reported claim.

Regarding experience with AIC the highest number of respondents (65%) involved in an accident, is the group below four years. This implies that more new customers reported accidents.

4.2. Results of Descriptive Statistics on Claim Processing

The second part of the questionnaire comprises twenty-three questions used to assess the scenario and the influence of independent variable on the dependent variable. The last question was developed to measure the general reaction of the respondents regarding the process of motor claims in AIC. The results obtained through different statistical techniques are presented as follows.

4.2.1 Claims processing time in AIC

The specific objective of this research is to evaluate the experience of customers of AIC towards claims process if there is any delay in settlement and to identify which variable most affects the process. Therefore, to assess what the trend looks like, the respondents were asked whether the claims settlement process is long in the company or not by using Likert Scale questionnaire which has five dimensions for each question; i.e., (1) Strongly Disagree

(2) Disagree (3) Neutral (4) Agree and (5)Strongly Agree. The following table presents the result.

Table 4.3. Responses regarding motor claims processing time in AIC

Level of Agreement	Frequency	Percent	Aggregate %
Strongly Disagree	12	10.3	51.3
Disagree	48	41	
Neutral	4	3.4	3.4
Agree	32	27.4	45.3
Strongly Agree	21	17.9	
Total	**117**	**100**	**100**

As it can be seen on the above table, the responses to the statement "Motor Insurance Claims processing time in AIC is reasonably short." is, 51.3% of the respondents disagreed while 45.3% of the respondents agreed, and the remaining neutral. Thus, the result signifies there is inclination as it is long which can affect the retention negatively and can also affect the company's growth.

4.2.2. Perception of customers towards the competency of claims staff

Table 4.4 below, presents ten statements under the independent variable, competency of claims staff which are rated in Likert scale. The responses to each statement are presented in numbers, percentage, mean and standard deviation.

The mean score measurement can be used while interpreting the data. If the mean score is greater than 3.79, it will be considered as high; if it is between 3.40 and 3.79, it will be considered as moderate; and if the mean score is below 3.40, it will be considered as low(Akmaliah, 2009).

The statements were arranged in a manner that respondent customers can present their experience in relation to competency of claims staff. Accordingly, the observation of respondents regarding the activities in each process in related to claims staff are presented as follows:

Table 4.4.Responses in relation to competency of claims staff

Ser. No	I. Competency of Clams Staff		Frequency					Mean	S.D
			SD (1)	D (2)	N (3)	A (4)	SA (5)		
1	The claims staffs are prompt to verify the policy and acknowledge the acceptance of claim notification.	**No.**	6	33	2	53	23	3.46	1.23
		%	5	28	2	45	20		
2	The claims staffs create awareness on required documents to process the claim at the time of accident notification.	**No.**	7	35	--	62	13	3.33	1.18
		%	6	30	--	53	11		
3	There is reasonably quick towing or inspection service.	**No.**	8	53	2	45	9	2.94	1.06
		%	7	45	2	38	8		
4	The bid process is prompt.	**No.**	30	47	5	28	7	2.44	1.26
		%	26	40	4	24	6		
5	Prompt assignment of surveyors to the damaged vehicle.	**No.**	11	41	8	46	11	3.04	1.22
		%	9	35	7	39	9		
6	There is consistent follow up of the case while at garage.	**No.**	23	55	7	27	5	2.45	1.17
		%	20	47	6	23	4		
7	Surveyors are punctual.	**No.**	7	52	6	47	5	2.92	1.12
		%	6	44	5	40	4		
8	Surveyors are careful to see the damage to avoid re-survey.	**No.**	15	41	2	44	15	2.92	1.32
		%	13	35	1	38	13		
9	Settlement process is reasonably fast.	**No.**	9	40	12	41	15	3.09	1.23
		%	8	34	10	35	13		
10	Overall, performance of claims staffs is reasonably fast.	**No.**	8	53	1	35	20	3.11	1.31
		%	7	45	1	30	17		
Aggregate mean								**2.97**	

Source: Own Survey, 2019

When customer respondents were asked about the promptness of claims staff on verification and acknowledgement of acceptance of claim; 65% agreed, while 33% disagreed. This indicates that the number of respondents who agreed on the promptness service on verification and acceptance of claim is greater than those who disagreed. The mean score for this statement is 3.46 which are in the group of moderate acceptance. When we see the answer of respondents in relation to claims staff activity in notifying the claimant all the necessary documents required at the beginning; 64% of the respondents agreed and 36%

disagreed. The mean indicates that the performance of claims staff in relation to this question is low(M=3.33). When the respondents asked whether there is reasonable and quick towing or inspection service by the claims staff; 46% of them replied as they agreed, while 52% of them disagree. This indicates that greater number of respondents disagreed with prompt towing and inspection service in AIC. The mean(2.94) also indicates that the agreement level is low. Regarding promptness of bid process to give work order, most of the respondents(66%) disagreed with the service of claims staff and 30% agreed while 4% of them are neutral. The mean is 2.44 which imply that low agreement from the group. When the customer respondents asked about prompt service to assign surveyors to see the damaged vehicle, 48% of respondents agreed and the remaining 44% disagree and 7% neutral.

For the statement regarding the service, consistently follow up of garages in relation to vehicles under repair, 67% of respondents disagreed, 27% agree and 6% neutral. This indicates that most respondents disagree with fast service in relation to this and also shows the least mean next to bid process. For the statement on surveyors' punctuality to see the damaged vehicle, the view of respondents, as it is shown clearly in the table, 50% disagree, 44% agree and 5% of them are neutral. In regard to surveyor's carefulness to see damaged vehicles to avoid re-survey 51% of respondents agreed; 48% disagreed. When respondents asked whether the claims settlement or payment process is reasonably fast or not, 48% of respondents agree, 42% disagreed and 10% neutral. On the other hand, the last question is asked to assess the overall claims staff activity; 52% of respondents disagreed with the prompt activity; 47% agreed.

4.2.3. Perception on customers' awareness of motor policy

The researcher prepared six questions to examine the overall view of respondents in relation to their awareness of motor policy terms and conditions and the effect on motor claims process. Accordingly, the responses regarding the policy related matters are summarized as follows:

Table 4.5. Responses in relation to customers' awareness on motor policy

Ser No	II. Customers' Awareness of Policy		Frequency					Mean	S.D
			SD (1)	D (2)	N (3)	A (4)	SA (5)		
11	I was well aware regarding the policy terms when I entered to the contract.	**No.**	11	27	11	43	25	3.37	1.30
		%	9	23	9	37	21		
12	I already agreed on the compulsory excess own damage	**No.**	6	42	14	47	8	3.07	1.11
		%	5	36	12	40	7		
13	I was aware about the contribution and average in case of claims while underwriting.	**No.**	21	46	19	30	1	2.52	1.08
		%	18	39	16	26	1		
14	I agreed with the value(Sum insured) of the vehicle at acquisition of the policy.	**No.**	4	7	3	62	41	4.10	0.95
		%	3	6	3	53	35		
15	I informed all the truth about the use of the vehicle insured to the company at the time of underwriting.	**No.**	4	7	4	61	41	4.09	0.96
		%	3	6	3	52	35		
16	Overall, my awareness of the motor policy made things easy in the process of claim.	**No.**	16	40	1	37	23	3.09	1.41
		%	13	34	1	32	20		
Aggregate mean								**3.37**	

Source: Own Survey, 2019

For the question raised to assess their awareness about the motor policy terms and conditions they bought, 59% of them agreed as they know well the policy; 32% of them didn't agree and 9% are not sure. For the question raised to assess respondents' awareness and their agreement of excess upon contract, 47% of respondents said agree; 41% disagree and 12% are not sure. The mean(3.07) indicates that it is in a low agreement. For the question raised to measure their awareness about the contribution & average in case of claims 57% of the respondents were disagreed, 27% agreed and 16 are not sure. This indicates that greater numbers of customer respondents are not aware about the contribution & average in case of

claims. 88% of the respondents agreed for the question raised to know their agreement about the sum insured at the time of contract 3% are not sure and 9% of them are disagreed. This indicates strong agreement among the respondents. 87% of the respondents agreed that they told all the truth regarding the use of the vehicle at the time of underwriting; 9% disagree and 3% are not sure.

The question was raised to measure respondents' awareness to the motor policy affects motor claims process in general, 52% of the respondents don't believe that their awareness to the policy didn't make the claims process fast; and 48% of them agree and 1% neutral.

4.2.4. Perception of customers on competency of service providers

The researcher tried to examine customers' view towards the competency and efficiency of service providers through seven questions. Accordingly, the answer of the respondents on this matter is presented as follows:

Table 4.6. Responses in relation to competency of service providers

Ser. No	III. Competency of Service Providers		Frequency					Mean	S.D
			SD (1)	D (2)	N (3)	A (4)	SA (5)		
17	The company selects garages with better standard.	No.	8	38	6	42	23	**3.29**	**1.30**
		%	7	32	5	36	20		
18	Garages and workshops are punctual to deliver.	No.	23	45	--	39	10	**2.64**	**1.36**
		%	20	38	--	33	9		
19	Dealers provide Spare parts promptly and sufficiently.	No.	29	37	5	38	8	**2.91**	**1.33**
		%	25	32	4	32	7		
20	Garages and workshops are reasonably fast to repair.	No	17	40	5	46	9	**2.99**	**1.27**
		%	15	34	4	39	8		
21	Garages are equipped with skilled manpower.	No.	17	29	18	44	9	**3.08**	**1.23**
		%	15	25	15	38	8		
22	Traffic polices and other governmental offices are fast enough to provide relevant documents in relation to the accident.	No.	19	34	--	46	18	**2.93**	**1.39**
		%	16	29	--	39	15		
23	Overall, performance of claims providers are reasonably fast.	No.	13	47	--	49	8	**3.01**	**1.24**
		%	11	40	--	42	7		
Aggregate mean								**2.97**	

Source: Own Survey, 2019

Regarding the company's selection of better standard garages, the larger number of respondents (56%) agreed, 39% disagreed and 5% are not sure about the garages standard. For the questions raised to measure garages and workshops punctuality to claims processing time, most of the respondents(58%) disagree with and 42% agreed. Questions also forwarded to respondents regarding availability of spare parts; 57% disagreed, 39% agreed and 4% are not sure. The mean is 2.91. This implies that most respondents believe that the process is highly affected by the shortage of spare parts. When the respondents asked about the garages speed to repair vehicles, 49% of them disagree and 47% of them agree. 4% are not sure about the efficiency of garages. 46% of the respondents believed that garages have skilled manpower; and 40% of them disagree with the competency of garages manpower and 15% are neutral. For the question about the performance of Traffic police and other governmental offices to issue necessary documents in relation to accident for claims process; 54% of the respondents agree with fast service and 45 disagree. In general, most of the respondents (51%) disagree with the promptness of service providers and (49%) of them agreed.

4.3. Data Analysis Using Inferential Statistics

4.3.1. Assumptions of Multiple Regression Analysis

Multiple regression is not just one technique but a family of techniques that can be used to explore the relationship between one continuous dependent variable and a number of independent variables or predictors (usually continuous)(Pallant, 2005). Accordingly, the researcher used this technique in order to understand how well a set of variables is able to predict a particular outcome and to identify the relative contribution of each of the variables. Furthermore, it helps to make collinearity diagnostics and to check the normality of distribution of data as well.

4.3.1.1. Multi Colliniarity Diagnosis

Multi-colliniarity is a problem that occurs with regression analysis when there is a high correlation of at least one independent variable with a combination of other independent variables. Sometimes, it will be difficult to identify the unique contribution of each variable in predicting the dependent variable, when variables are highly correlated. Collinearity diagnostics' is part of the multiple regression procedure that can help the researcher to pick up on problems with multi-collinearity that may not be evident in the correlation matrix.

Under collinearity diagnostics, two values are given: Tolerance and VIF. Tolerance is an indicator of how much of the variability of the specified independent is not explained by the other independent variables in the model(Pallant, 2005). If this value is very small (less than 0.10), it indicates that the multiple correlation with other variables is high, suggesting the possibility of multi-collinearity. The other value given is the VIF (Variance Inflation Factor), and a VIF value above 10 indicates the presence of multi-collinearity.

Table 4.7 below indicates amounts of Tolerance and VIF (Variance Inflation Factor) of the given independent variables, which is obtained from 'collinearity diagnostics' performed by SPSS. Accordingly, there is no multi-colliniarity among independent variables (competency of claims staff, customers' awareness to the policy and competency of service providers). Because, tolerance amount for all variables is greater than 0.10 and VIF is also less than 10.

Table 4.7.Collinearity Statistics

Model	Tolerance	VIF
Competency of Claims Staff	0.205	4.880
Customers' awareness to the policy	0.854	1.171
Competency of service Providers	0.194	5.161

Source: Own Survey Result (*2019)*

4.3.1.2. Normality Test

In a normal probability plot of the regression standardized results that were requested as parts of the multiple regression analysis lie in a regularly straight diagonal line from bottom left to top right. This would suggest no major deviation from normality. Accordingly, the below probability plot indicates that the requirement is satisfied and there is no major deviation from normality.

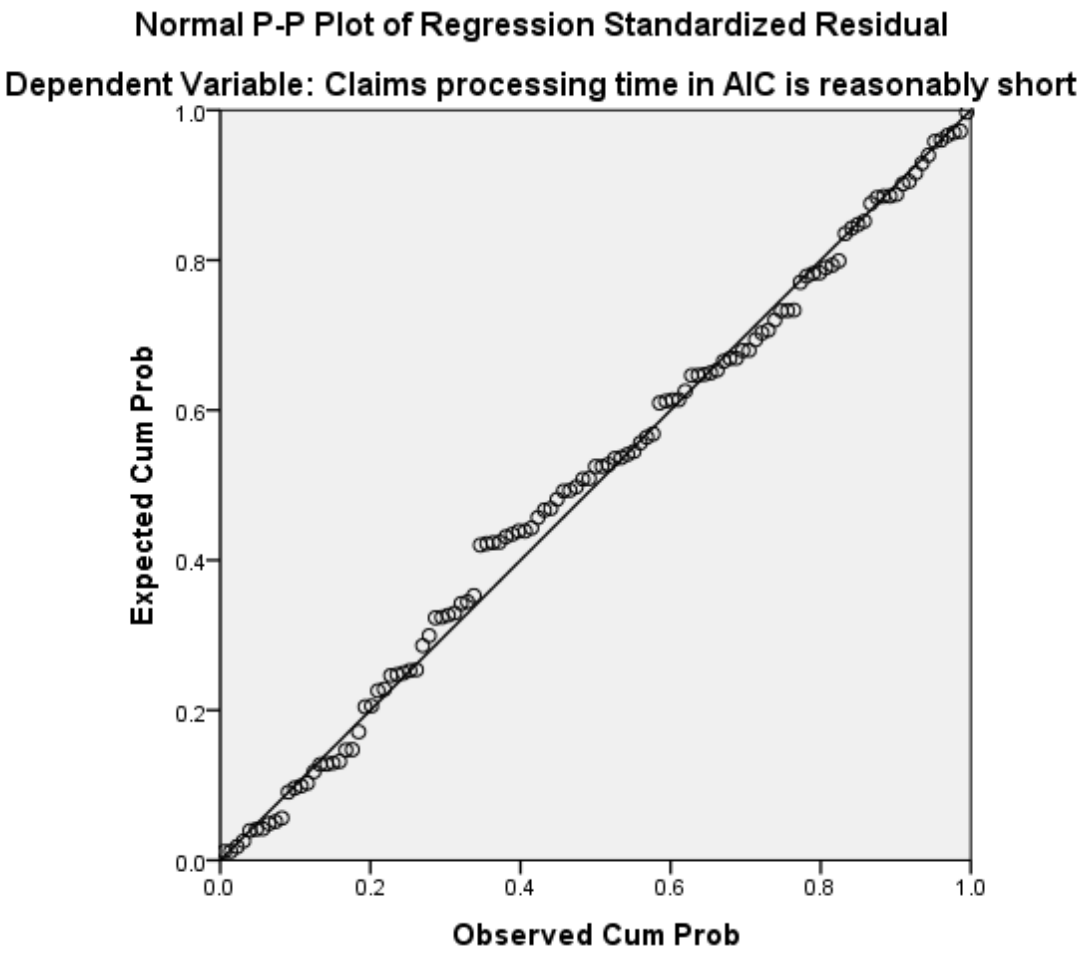


Chart 4.2. Normal P-P Plot of regression

Source: Own Survey Data (2019)

4.3.1.3. Regression Model Performance

A linear model using regression analysis is used to determine how well the model fits the data. R-squared (R^2) summarizes the proportion of variance in the outcome that can be accounted for by the explanatory variables. It is the percentage of the dependent variable variation that a linear model explains. As shown on Table 4.8, the model summary of regression results indicates that the adjusted R square (regression coefficient) is 0.811 which indicates that 81.1% of the variance in claims processing time can be explained by the three variables (Competency of claims staff, Awareness of policy and Competency of Service Providers). However, the rest 18.9% variance in claims processing time is due to other factors which are external to the stated variables. The findings of regression are presented in subsequent section.

Table 4.8.Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.903[a]	.816	.811	.58784

a. Predictors: (Constant), claims staff, customers' awareness, service providers

b. Dependent Variable: Claims processing time in AIC is reasonably short

Source: Own analysis result (2019)

Analysis is conducted to measure the effect of the magnitude of independent variables on dependent variable.

Table 4.9 demonstrates the Analysis of Variance (ANOVA), which is used in order to assess the statistical significance of the result. The highest F value and less significance value ($p<0.001$) indicate that the model reaches statistical significance and this tests the null hypothesis that multiple R in the population is equal to zero. $F = 166.801$, $p < .05$ (i.e., the regression model is a good fit of the data). Hence, the hypothesis that the three factors that affect motor claims processing time (independent variables) together will significantly explain the variance in motor claims processing time (dependent variable) is accepted.

Table 4.9.Analysis of Variance (ANOVA) for independent and dependent variables

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	172.918	3	57.639	166.801	.000[b]
	Residual	39.048	113	.346		
	Total	211.966	116			

a. Dependent Variable: Claims processing time in AIC is reasonably short

b. Predictors: (Constant), comp. of service providers, customers' awareness, comp. of claims staff

Source: Own analysis result (2019)

4.3.2. Factors affecting motor insurance claims processing time in AIC

The value of unstandardized coefficient beta (β) is used in order to find the contributions of each independent variable to dependent variable included in the model. The greater value of beta and less value of significant level ($p<0.05$) of each independent variable shows the strongest importance to the dependent variable (Pallant, 2005).

Table 4.10. Estimation Results of Regression Function

Variables	Unstandardized Coefficient Beta (β)	Standardized Coefficient Beta (β)	Sig.	t value
(constant)	-.420		.288	-1.459
Competency of Claims Staff	0.063	.472	.000	5.292
Customers' awareness to the policy	-0.006	-.018	.689	-0.401
Competency of service Providers	0.081	.463	.000	5.047

Note: The dependent variable is claim processing time

S*ource: Own analysis result (2019)*

As shown on above table, the coefficient of independent variables also revealed that competency of claims staff at p=0.000 and competency of service providers at p=0.000 are significant. This indicates that these two independent variables (competency of claims staff and competency of service providers) contributed a lot to the prediction of the dependent variable (motor insurance claims processing time). However, the other independent variable (Customers' awareness of motor policy)is not as such significant to the prediction of dependent variable since its significant value is greater than 0.05which is 0.689.

The β coefficient value indicates that a one-degree change in competency of claims staff and competency of service providers cause a variance of 6.3% and 8.1% degree of importance with regard to the processing time.

When t value is below 2, it indicates that the significance of independent variable to dependent variable will be generally low. Accordingly, as shown in the above table, customers' awareness to motor policy is -0.401 which is below 2, is insignificant to the dependent variable. Whereas the two variables(competency of claims staff and competency of service provider), are significant.

In regression, an interaction effect exists when the effect of an independent variable on a dependent variable changes, depending on the value(s) of one or more other independent variables. Thus, in a regression equation, an interaction effect is represented as follows:

$Y= \alpha+ \beta1X1+\beta2X2+ e$

Where;

Y is the predicted value of the dependent variable;

Alpha (α) is constant which is mostly denoted as 0.05;

X1=competency of claims staff, X2=competency of service providers

β1& β2 are regression coefficients for Competency of claims staff and Competency of service providers.

4.4. Testing Hypothesis

H1: There is a positive relationship between competency of claims staff and motor insurance claim processing time.

As it is shown on table above, the β coefficient value was computed as 0.063, which indicates that keeping other factors constant, a unit of change in competency of claims staff causes 6.3% improvement on motor insurance claims processing time. Besides, as it is shown on same table above, the statistic t value for competency of the staff was 5.292 at p value 0.000.

Based on the table and justification provided in the preceding paragraph, as β coefficient value is greater than 0.05, and t value which is 5.292 is greater than 2. Thus, we can conclude that competency of claims staff has significant influence on motor insurance claims processing time. This finding supports Hypothesis1 and it is accepted. The null hypothesis is rejected.

Even though the studies conducted for different companies, this finding is to some extent in conformity with the previous study conducted by Moltot Abiyo(2016) under the title 'Assessment of Challenges and Prospects of Motor Claims Management in Africa Insurance Company S.C. He summarized as major findings from customers that claims process doesn't meet customers' expectation; in case of investigation at site, on assessment of damage, on bid process, on approval of settlement and payment process. Generally, as his findings, regarding competency of claims service, claims staff lacks proper competency to deliver adequate service to the customers on time.

H2: There is a positive relationship between customers' awareness of motor policy and claims processing time.

Regarding the second variable, customers' awareness of the policy, as indicated on the table and justification provided the β coefficient value is less than 0.05, that is -0.006and t value-0.401 which is less than 2. Thus, it can be observed that, this hypothesis is rejected because it is not significant. Therefore, null hypothesis is accepted.

In this regard, a study conducted by Fasika Tatek, under the title assessment of factors affecting satisfaction of motor insurance customers: in selected insurance companies, under his findings awareness of contract positively affects motor insurance customers satisfaction. But have no such effect on the claim processing time.

H3: There is a positive relationship between competency of service providers and motor insurance claim processing time.

According to the greater β value which is 0.081, and the t-value greater than 2, the third hypothesis is also acceptable. Therefore, competency of service providers has a positive and strong relationship with motor insurance claims processing time. The β coefficient value computed indicates that keeping other factors constant, a unit of change in competency of service providers causes 8.1% improvement on motor insurance claims processing time which is better than previous variables. This finding shows that service providers have high impact on motor insurance claim processing time. Thus, the null hypothesis is rejected.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter is the final part of the study, which provides summary of major findings, conclusion, recommendation and limitation of the study.

5.1. Summary of Major Findings

This part of the study aims to summarize the finding and results that have emerged from the data analysis presented in Chapter Four. From the study, the following particular findings were observed:

- Customers' respondents towards the competency of claims staff of AIC with regard to quick service to accept customers' accident notification and verify the policy then acknowledge acceptance of their claim shows that the majority of respondents were agreed.
- Respondents' view towards the claims staff service with regard to creating awareness on the required documents at the beginning; prompt towing and inspection; surveyors punctuality to see the damaged vehicle; prompt assignment of surveyors; carefulness to see vehicles to avoid repetition is in a moderate agreement.
- Respondents' observation regarding bid process and consistency to follow up vehicles while at garages is low.
- Responses regarding the overall promptness of claims staff to make the process relatively fast are low as aggregate mean is 2.97.

As per the customers' perception, we can see that there is satisfaction gap between the intended and actual motor claims process due to claims staff performance, especially in areas of timely towing or inspection; bid process; in consistently follow up of vehicles in garages under repair and in settlement or payment process.

- Responses on customers' awareness to motor policy so as to be cooperative to facilitate motor claims process; most of them agreed as they know the policy well(Mean=3.37).
- Customers' response towards awareness of contribution in case of claim, it is low (Mean=2.52).

- Regarding the responses towards their awareness to agreement on sum insured at the time of contract and notifying the truth to the insurer is high(Mean= 4.1 & 4.09)

Overall, the perception of customers towards the effect of awareness of policy on motor claims process is in low agreement(mean=3.37)

- When we see the customers' responses regarding service providers, most of them agreed with better standard garage selection of the Company.
- Customers' response regarding garages and workshops are equipped with skilled manpower is low.
- The perception of customers with regard to punctuality of garages and workshops to deliver services and to the accessibility of spare parts to repair the damaged vehicles is low.

On the other hand, the customers' perception in regard to service providers indicated there is a customer satisfaction gap in areas of garages/workshops punctuality and promptness to deliver; unavailability of spare parts which affect the process incredibly can also affect the claims process of the company.

5.2. Conclusion

The aim of this study was to determine the main factors that affect motor insurance claims processing time in AIC, from the findings of this research, it can be concluded that from the three factors selected, (competency of claims staff, customers' awareness of policy and competency of service providers), two of them have strong correlation with motor insurance claims processing time. The findings illustrated in regression function shows that competency of service providers have high degree of importance to influence claims processing time.

Competency of service providers is most determining factor. As the result indicated, service providers' competency has a positive and strong relationship with claims processing time. On the other side, it was evidenced that customers' awareness of the policy has no significant effect on claims processing time.

As discussed in the literature, in the service industry like insurance, contact employees are the face of the organization, and can directly influence customer satisfaction which can determine productivity of the company as well. Thus, pieces of tasks in the whole claims process should be considered and handled carefully.

5.3. Recommendations

Based on the major findings and conclusions of the study, the following recommendations are forwarded to the management and other stakeholders.

- In claims process, some tasks that are identified as longer time processes have to be minimized as per their relevance for the case by avoiding unnecessary activities. In addition to this, claims frontline officers should notify every procedure first in order to save time and avoid unnecessary procedure; surveyors have to be carefull in estimation of values and be punctual as well. The management of AIC should provide intensive training on customer handling and related issues to claims staff to have customer focused view. Moreover, punctuality, accuracy and cooperation should be developed among the team. Claim Directorate of AIC should assign staffs who are responsible to see the availability of spare parts and their price as well as prices of used vehicles in the market so as to update underwriting staffs.
- From the finding, the number of customers who have no enough understanding of policy, compulsory excess and contribution on accident is considerably high. Even if, as shown above, it has no significant effect on the claims process, it is evidenced that claim handling of the insurance company is highly affected by the policy the insured have which is the result of quality of underwriting. Thus, underwriting staff need to be careful enough at the time of issuing policy; and the relevant information such as excess/deductible, and other endorsements should be clearly disclosed to the customer and briefly stated or attach on the policy as well, so as to avoid ambiguity and disagreement at the time of claim settlement. Furthermore, as vehicles value varies from time to time, sum insured should be updated on the policy upon renewal of policies and market values should be carefully stated on new policies. In addition to this underwriters should explain motor policy to customers as much as possible about the covers, exclusions and conditions.

- Claims Directorate should select best service providers that are garages, and external surveyors so as to build trust in the minds of customers. They should be checked annually as they are keeping the standards and expectations of customers. Since the effect of service providers is high to motor claims management the Company should organize by itself own towing vehicles, garages and supply of spare parts.

LIMITATIONS AND FUTURE RESEARCH

The activities of the study have been affected by the following problems that the researcher faced while undertaking the study. This study has limitation with regard to sampling method. The questionnaires were dispatched for those who came to branch offices, though it would be better to get the insights of those who left due to dissatisfaction. Lack of researcher experience might also consider as limitation.

It is recommended that a further study be conducted on the effect of price based competition in the insurance industry; assessment on the impact of fraud in motor claims on insurance companies and assessment on opportunity and challenge of compulsory third party insurance in the insurance industry.

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Annex I

St. Mary's University
School of Graduate Studies

Date: _____

Dear Participants,

I am a student of St. Marry University, School of Graduate Studies undertaking Master of Business Administration. As partial fulfillment of my study, I am conducting a research project titled '***Factors affecting motor insurance claims processing time in case of Awash Insurance Company S.C'***.

This questionnaire is aimed to gather relevant information that will be useful in the above mentioned research. I am pleased to inform you that, you have been selected as one of the respondents in this study. I, therefore kindly request your utmost cooperation in filling the questionnaire honestly and accurately. Please note that the quality of information you provide determines the ultimate reliability of the study.

If you are interested to have further information about this study or have any problem in filling the questionnaire, please contact me through:

Tel.: +251-911-478 848

Email: sosinalemmad@gmail.com

Note:-

- ✓ ***Please do not write your name.***
- ✓ ***Please put the tick mark (✓) on the appropriate space in the box to the point which mostly reflects your idea.***
- ✓ ***All information will be used only for academic purpose and treated confidentially.***
- ✓ ***Your honest and unbiased response will greatly contribute for the research to achieve its objective.***

Part 1: Demographic Information

Please put tick (✓) mark on the option that best describes you.

1. Gender

   ☐Male ☐ Female

2. Age

   ☐Below 25 ☐26-35 ☐36-45 ☐Over 46

3. What type of motor policy you have?

   ☐Private ☐Commercial

4. What is your client-ship/experience at Awash Insurance Company S.C.?

   ☐ Below 1 year

   ☐1- 4 years

   ☐5-10 years

   ☐Above 10 years

Part 2: Close-Ended Research Instrument for Data Collection

Directions: Please put tick (✓) in the appropriate place for each item to express your view and level of agreement with the statements.

Hint: Please use the following key for your information:

1 = Strongly Disagree (SD) ➔ if your level of agreement is very low in the measured attribute.

2 = Disagree (D) ➔ if your level of agreement is below average in the measured attribute.

3 = Neutral (N) ➔ if you are not so sure about the measured attribute.

4 = Agree (A) ➔ if your level of agreement is above average in the measured attribute.

5=Strongly Agree (SA) ➔ if your level of agreement is very high in the measured attribute.

S/No	Question Items	Rating Scales				
I.	**Competency of Claims Staff**	**SD (1)**	**D (2)**	**N (3)**	**A (4)**	**SA (5)**
1	The claims staffs are prompt to verify the policy and acknowledge the acceptance of claim notification.					
2	The claims staffs create awareness on required documents to process the claim at the time of accident notification.					
3	There is reasonably quick towing or inspection service.					
4	The bid process is prompt.					
5	Prompt assignment of surveyors to the damaged vehicle.					
6	There is consistent follow up of the case while at garage.					
7	Surveyors are punctual.					
8	Surveyors are careful to see the damage to avoid re-survey.					
9	Settlement process is reasonably fast.					
10	Overall, performance of claims staffs is reasonably fast.					
II.	**Awareness of Policy**	**SD**	**D**	**N**	**A**	**SA**

S/No	Question Items	Rating Scales				
		(1)	**(2)**	**(3)**	**(4)**	**(5)**
11	I was well aware regarding the policy terms when I entered to the contract.					
12	I already agreed on the compulsory excess own damage					
13	I was aware about the contribution & average in case of claims while underwriting.					
14	I agreed with the value(Sum insured) of the vehicle at acquisition of the policy.					
15	I informed all the truth about the use of the vehicle insured to the company at the time of underwriting.					
16	Overall, my awareness of the motor policy made things easy in the process of claim.					
III. Competency of Service Providers		**SD (1)**	**D (2)**	**N (3)**	**A (4)**	**SA (5)**
17	The company selects garages with better standard.					
18	Garages and workshops are punctual to deliver.					
19	Dealers provide Spare parts promptly and sufficiently.					
20	Garages and workshops are reasonably fast to repair.					
21	Garages are equipped with skilled manpower.					
22	Traffic polices and other governmental offices are fast enough to provide relevant documents in relation to the accident.					
23	Overall, performance of claims providers are reasonably fast.					
IV. Claims Processing Time		**SD (1)**	**D (2)**	**N (3)**	**A (4)**	**SA (5)**
24	Motor insurance claim process in AIC is reasonably short.					

Thank you for your patience and honesty to answer the research questions.

Thank you again for giving your precious time.

ቅድስት ማርያም ዩኒቨርሲቲ
የቢዝነስ ትምህርት ክፍል

የጽሑፍ መጠይቅ

ይህ መጠይቅ የተዘጋጀው በቅድስት ማርያም ዩኒቨርሲቲ የቢዝነስ ትምህርት ክፍል ለማደርገው የሁለተኛ ዲግሪ ትምህርት ማሚያ ጥናት ይሆን ዘንድ ነው፡፡ የጥናቱ ጥቅል ዓላማ በተሸከርካሪ አደጋ ወቅት የካሣ ጥያቄ አፈፃፀምን የሚያጓትቱ ጉዳዬችን ለመለየት ነው፡፡ በዚህም መሰረት አዋሽ ኢንሹራንስ ኩባንያ አ.ማ. ለጥናቱ ተመርጧል፡፡ እርስዎም የኩባንያው ደንበኛ እንደመሆንዎ በዚህ ጥናት እንዲሳተፉ ሲመረጡ የሚሰጡት ትክክኛ መረጃ ለጥናቱ ውጤታማነት በጣም አስፈላጊ መሆኑን በመገንዘብ መጠይቁን በጥንቃቄ እንዲሞሉ በአክብሮት እጠይቃለሁ፡፡ ተሳትፎዎ በእርስዎ በጎ ፈቃደኝነት ላይ የተመሰረተ ነው፡፡ በመጨረሻም የሚሰጡት መረጃ ሚስጥራዊነቱ የተጠበቀና እንደሚሆንና ለዚህ ጥናት እና ለትምህርታዊ ዓላማ ብቻ እንደሚውል አረጋግጣለሁ፡፡ የማንኛውም መልስ ሰጪ ማንነት በማንኛውም መልኩ የማይታተምና የማይሰራጭ መሆኑንም አረጋግጣለሁ፡፡ ጊዜዎን ሰውተው ስለሚያደርጉልኝ ትብብር በቅድሚያ አመሰግናለሁ፡፡

ሶስና ለማ
ስልክ፡- 0911 478 848

ማሳሰቢያ፡-

- በመጠይቁ ላይ ስም መፃፍ አያስፈልግም፡፡

- ትክክለኛ መልስ የያዘዉ አማራጭ ሳጥን ውስጥ የ √ ምልክት በማድረግ ይመልሱ፡፡

ክፍል 1፡ የግል መረጃ

1. ፆታ: ☐ወንድ ☐ሴት

2. እድሜ: ☐ከ 25 በታች ☐26-35 ☐36-45 ☐ከ 46 በላይ

3. የተሽከርካሪዎ የኢንሹራንስ አይነት:
☐ የግል ☐የንግድ

4. የደንበኝነት ዘመን:
☐ከ1 ዓመት በታች ☐ከ1-4 ዓመታት ☐ከ5-10 ዓመታት ☐ከ10 ዓመት በላይ

ክፍል 2፡ ይህ የመጠይቅ ክፍል ደንበኞች በአዋሽ ኢንሹራንስ ኩባንያ የካሣ ክፍያ አፈፃፀም ሂደት ርዝመት ላይ ያለውን ምክንያትና ሁኔታ ለይቶ ለማወቅ የተዘጋጀ ነው፡፡

እባክዎ ለሚከተሉት ጥያቄዎች በተሰጡት የመለኪያ መጠን በመጠቀም የ√ ምልክት በማስቀመጥ ያመልክቱ፡፡

1. በጣም አልስማማም
2. አልስማማም
3. እርግጠኛ አይደለሁም
4. እስማማለሁ
5. በጣም እስማማለሁ

ተራ.ቁ	ጥያቄዎች	ልኬት				
ሀ. የካሣ ክፍል ሠራተኞች ብቃት(Competency of Claims Staff)		1	2	3	4	5
1	የካሣ ክፍል ሠራተኞች ኢንሹራንስ መኖሩን አረጋግጦ የካሣ ጥያቄውን ለመቀበል ፈጣን ናቸው፡፡					
2	የካሣ ጥያቄውን ለማስተናገድ የሚያስፈልጉ መረጃዎችን እንዲያቀርቡ ከመጀመሪያው በዝርዝርና በፍጥነት ያሳውቃሉ፡፡					
3	የተጎዳ ተሽከርካሪ ለማንሳትና የአደጋውን መነሻ ለማወቅ አስፈላጊውን ምርመራ ለማድረግ ፈጣን ናቸው፡፡					
4	የጨረታ ሂደቱ ፈጣን ነው					
5	የሰርቨይ ባለሙያዎች በፍጥነት ወደ ተጎዳው ተሽከርካሪ ይላካሉ፡፡					
6	በጋራዥ በጥገና ላይ ያሉትን ተሽከርካሪዎች በፍጥነት እንዲጠገኑ ክትትል ያደርጋሉ፡፡					
7	በጥገና ላይ ያሉትን ተሽከርካሪዎች የሥራ አፈፃፀም ለመመልከት ባለሙያዎች					

ተራ.ቁ	ጥያቄዎች	ልኬት				
	በወቅቱ(በተጠየቁ) ጊዜ ለመገኘት ቀጠሮ ያከብራሉ፡፡					
8	ድግግሞሽን ወይም ምልልስን ለማስቀረት ጉዳቱን በጥንቃቄ ይመለከታሉ፡፡					
9	የክፍያ ሂደቱ ፈጣን ነው፡፡					
10	በአጠቃላይ የካሣ ክፍያ ሠራተኞች የአሠራር ሂደት ፈጣን ነው ፡፡					
ለ. የተሸከርካሪ ኢንሹራንስ ውል የመረዳት ሁኔታ(Awareness of Policy)		**1**	**2**	**3**	**4**	**5**
11	ውል ስገባ የተሸከርካሪ ኢንሹራንስ ውል ይዘቱን በደንብ ተረድቻለሁ፡፡					
12	በውል ወቅት የአደጋ መነሻ(Excess) መጠን ላይ ተስማምቻለሁ፡፡					
13	በአደጋ ወቅት መዋጮ (Contribution) እንደሚኖር በውል ወቅት ተረድቻለሁ፡፡					
14	በውል ወቅት ኢንሹራንስ በሚገባለት የተሸከርካሪ ዋጋ ላይ ተስማምቻለሁ፡፡					
15	በውል ወቅት የተሸከርካሪውን አገልግሎትና ሌሎች ተያያዥ ጉዳዬችን በግልፅነት ለኩባንያው አሳውቄአለሁ፡፡					
16	በአጠቃላይ ከውል ባለመረዳት ጋር በተያያዘ ጉዳይ የካሣ ክፍያ አልዘገየብኝም፡፡					
ሐ. ከኢንሹራስ ጋር የሚሠሩ የአገልግሎት ሰጪ ድርጅቶች ብቃት (Competency of Service Providers)		**1**	**2**	**3**	**4**	**5**
17	ኩባንያው የተሻለ ደረጃ ካላቸው ጋራዥዎች ጋር ይሠራል፡፡ ይመርጣል፡፡					
18	ጋራጮች ቀጠሮ አክብረው ያስረክባሉ፡፡					
19	መለዋወጫ አቅራቢዎች በቂ የመለዋወጫ አቅርቦት አላቸው፡፡					
20	ጋራጮች ተሸከርካሪዎችን ጠግኖ ለማጠናቀቅ ፈጣኖች ናቸው፡፡					
21	ጋራጮች ብቁ ባለሙያዎች አሏቸው፡፡					
22	የትራፊክ ፖሊስ፣ እና የተለያዩ የመንግሥት ቢሮዎች ከአደጋው ጋር የተያያዘና የሚፈለገውን መረጃ ለመስጠት ፈጣን ናቸው፡፡					
23	በአጠቃላይ ከኢንሹራንሱ ውጭ ያሉ አገልግሎት ሰጭዎች ፈጣን ናቸው፡፡					
መ. የተሸከርካሪ ኢንሹራንስ ሂደት የጊዜ ሁኔታ (Claims Processing Time)		**1**	**2**	**3**	**4**	**5**
24	በአዋሽ ኢንሹራንስ ኩባንያ የተሸከርካሪ ኢንሹራንስ የካሣ ክፍያ ሂደት ፈጣን ሊባል የሚችል ነው፡፡					