ADMINISTRATIVE SYSTEMS & STANDARDS

MMS administers many forms of creditor insurance requiring different schedules and processes and the appropriate details are set out in our contractual arrangement with each Client Company whose scheme(s) we administer.

There are however some basic standards that we apply to all our schemes and they are outlined below.

POLICY SERVICING (NEW BUSINESS & RENEWALS)

Policy Servicing is geared to a monthly cycle aimed at ensuring every transaction for the month is included in the commission and accounting runs for that month, and that these runs are then produced and issued as quickly as possible.

As you will see from the following, most daily and weekly processes are interrupted once each month whilst priority is given to producing and issuing all our accounting and commission statements.

For the purpose of differentiation the term 'non monthly business' is used below to refer to any policies where the premium is not collected direct from the customer by MMS.

MONTHLY NEW BUSINESS

Applications are received through the post or electronically. Paper based applications are checked and processed no later than 1 working day after being received and any errors are queried or returned if unacceptable. Once processed the applications are checked by an experienced staff member.

Electronic based applications are automatically checked by our systems on receipt. Applications can be forwarded to us 21 days in advance of the start date and a daily process separates the cases ready for processing.

Applications are then locked in batches for certificate issue.

NON MONTHLY NEW BUSINESS

Applications are normally received electronically and to ensure that we can issue certificates in acceptable time schedules, applications have to be sent to us regularly but at the latest applications have to be received by us on or before the 1st of the month following the start date.

Applications are processed and locked in batches for certificate issue.

CERTIFICATE ISSUE

All certificates are issued within 3 working days of processing and cases up to the last day on which business for the month is accepted, are issued within 2 working days.

The date of certificate printing is automatically recorded and all certificates are issued (posted) on the day they are printed. Provided, on any necessary investigation, we find that a certificate has been posted to the correct address we assume it is received 2 days after the date of printing. This date is used in evaluating cancellation. A copy of our complaints procedure leaflet is included with every certificate issued.

CANCELLATIONS

Where a cancellation is requested within 30 days of the Client receiving the Certificate (as defined above) we record the case as NTU (not taken up) and forward a full refund of any premium paid direct to the Client*. We do not make any charge for a cancellation in this category. The request for cancellation must be in writing and received by us within the 30 days. The request can come from the Client or the Client Company acting on their behalf

Once the 30 days has expired on monthly business a request for cancellation is processed and confirmed to the Client as no refund of premium would be applicable. For cancellation of non monthly business we require a written request from either the customer directly or via the Client Company. In acknowledging the request we will either forward any refund payable direct to the Client or credit it to the Client Company account for onward transmission to the Client depending whether the Client Company maintain the correct bank accounts to handle such monies.

All cancellation requests are processed within 3 working days of receipt and any refunds resulting therefrom are issued no less frequently than once each week.

Where cancellations are processed and refunded direct to the Client an advice of any refund paid will be forwarded to the Client Company and their account will be debited with the payment made effectively debiting them with any re-claw commission that is applicable.

**In some circumstances the refund goes to the financier.*

ARREARS LETTERS

The production of arrears letters is a fully automatic process that runs as part of the monthly premium commission payment run. They are always issued within 2 working days of production. They ensure the Client is fully aware that their cover may lapse and terminate due to non payment of premiums due.

MONTHLY PREMIUM COMMISSIONS

Monthly premium commission statements include all new business accepted and renewals received up to the last day of the calendar month.

Statements and payments are issued no later than the 10th of the following month. Depending where weekends and bank holidays fall they are generally issued earlier than the 10th.

NON MONTHLY ACCOUNTING

A full report and summary accounting is issued no later than the 24th of each month (usually issued by the 18th). It includes all new business and cancellations for the previous month.

RENEWAL PREMIUMS

Direct Debits for monthly premiums are collected on, or soon after, the 15th of each month, but Standing Order payments and cash receipts are accepted throughout the month.

REFUNDS (PAYMENT ERRORS)

Refunds generally apply where Standing Order payments have been made to us in error. They can sometimes include monthly premiums that it has been agreed that we will refund, although you would not expect monthly premiums to be refundable.

All such refunds are paid no less frequently than monthly usually directly following completion of the monthly premium commission run.

GENERAL ENQUIRIES

General servicing post is always responded to no later than 1 working day after it is received.

BENEFIT ALTERATIONS

Benefit alterations involve a change in premium and it is important in the case of Standing Orders not to cause confusion for the paying bank. It is also important in the case of Direct Debits to ensure the necessary minimum period of advice in accordance with the Direct Debit rules is provided to the Client. All alterations are actioned as quickly as possible allowing for these factors.

The effective date of a benefit alteration is the due date of the next premium received after the alteration has been actioned.

ANNUAL REVIEW

An Annual Review is produced on the first working day after the annual anniversary of the inception date of the policy. Further reviews are produced annually until the policy terminates.

The Annual Review provides the Client with full details of their policy i.e., the Terms & Conditions, type of cover included, monthly benefit (a detailed breakdown in the case of certain policies such as Keystone), annual cost and average monthly cost.

CLAIM FORM REQUESTS

Claim forms requested by lunch time are issued the same day, most of those requested in the afternoon are also issued the same day but requests later in the afternoon do not get issued until the next working day.

Every claim form issued is sent with a covering letter that requests that the Client has the form completed and returned to us and lists the extra information that should also be provided.

NEW CLAIMS

A new claim is created by the return to us of a fully completed claim form. New claims are actioned on the day they are received.

If a claim form is acceptable then it is evaluated, a computer claim record is created, any enquiries to Doctors, Employers or other third parties are issued and the claim is

acknowledged to the Client. The acknowledgement to the Client informs them we are issuing third party enquiries and a decision cannot be made until we receive all the information we need. The acknowledgement also reminds the Client of any information outstanding from them and asks them for any further information required from them as a result of the evidence contained in the claim form and not available at the time of issue of the claim form.

Any delay extending our original estimation of the claim investigation period is generally due to evidence from third parties such as Doctors or Employers not being forthcoming. We maintain a strict automated diary system to chase any outstanding evidence and always keep the Client informed in writing of any action we take to chase up such evidence so that they are fully aware of their claim progress.

Once all the required evidence and information is to hand a decision is taken on the validity of the claim in accordance with the terms of the cover provided.

Because of the type of cover we administer a claim decision does not involve negotiation on amount and consequently we do not get involved in "offers to settle". A claim is either accepted or declined dependent on a comparison of the Insured Person's circumstances and the cover terms.

Where it is necessary to decline a claim we write to the Client confirming the decision and setting out the reasons, with clear reference to the appropriate cover terms as to why it is necessary for us to come to that decision.

From the date of receipt of the last piece of required evidence it takes a maximum of 3 working days for us to either issue a decline letter to the Client or alternatively confirm an approved payment within our computer system. In the case of payment the approval will be timed to ensure that the actual payment is issued within 4 working days of receipt of the last piece of evidence.

CLAIMS PAYMENTS

Claims payment "runs" are actioned a minimum of twice weekly.

A claims payment run includes all payments approved since the last run and up to the minute before the run.

As a result of the claims payment run, individual cheques are issued for each claim to either the Client or other beneficiary. Regardless of the direction of actual payment the Client is sent a payment advice fully detailing the payment made and either informing them that it is the last payment applicable to their claim or alternatively enclosing and asking for completion of an on-going form.

ON-GOING FORMS

On-going claim forms are issued as part of the advice of the previous payment. They are an abbreviated claim form required to obtain proof of continuation of a claim benefit situation. This enables us to give consideration to the processing of further payments under the intimated claim.

By the time they are issued they may need immediate completion or alternatively they may need completion at some point in the future. The advice to the Client enclosing the form tells them when to have it completed.

The return of an on-going form is chased 15 days after the point at which it should be completed.

If it is not returned within a further 15 days the claim is closed and the Client is informed accordingly.

GENERAL ENQUIRIES

General investigations are commonly part of the initial underwriting of a claim, but they do also arise if new or different evidence arises from an on-going claim form.

We follow the same basic format of attention and follow through on all enquiries in that we allow an initial 15 days for a response following which we chase the enquiry and then allow a further 15 days for the response to be returned. The Client is again kept fully informed in writing of the action we are taking so that they are always aware of their claim status.

Although we undertake to do the work necessary in obtaining evidence wherever possible, it is the responsibility of the Client to provide the evidence required. On the rare occasions we are unsuccessful in obtaining the evidence required we write to the Client and pass to them the responsibility for following up the response on the basis that the claim can not otherwise proceed. If we still do not get a reply we remind the Client after 15 days and then 15 days thereafter advise them that the claim is closed.

Where the contents of any enquiry result in the issue of a further enquiry it would be dealt with on either the date of receipt, or the next working day.

CLAIM EVALUATION

The decision on whether to pay or decline a claim is always a 3 tier process to ensure that the most accurate and fair evaluation possible is reflected in the decision taken. We are obliged to quickly and firmly decline all claims that are outside the terms of the cover provided and equally quickly pay any claims within the terms of the cover. As administrators we have no financial interest in the result of the claim and can pay full attention to the factual evaluation of the circumstances related to the cover terms.

DATA FILES

We retain all business and claims files for a minimum of 5 years and can consequently always handle any query or complaint that may arise in respect of any case that we administer.