OUR COMPLAINTS HANDLING POLICY

Customer satisfaction is our top priority. LPH Insurance Brokers LLC is fully committed to address any concerns our clients may have, and we strive to bring the best possible resolution to our clients' concerns and ensure compliance with the applicable laws and regulations

OBJECTIVE

Objective of this Policy is to;

- Improve customer confidence in the health insurance market;
- Improve customer confidence, satisfaction and loyalty in respect of market participants;
- Promote the dealing by companies with customer dissatisfaction in a swift, effective and fair manner;
- Provide a clear escalation process regarding complaints received both internally and externally.
- Use complaints to enhance procedures and correct procedural or policy deficiencies.
- To allow customers to report instances where parties are not complying with the Health Insurance Law.

COMPLAINTS PROCEDURE

DEFINITION OF COMPLAINT

Any expression of dissatisfaction by a customer, potential customer or other business partner or any regulatory body made to the Company directly or indirectly which is related to the product or services provided by the Company or which is related to an employee of the Company or provided by another business partner of the Company.

What is not a Complaint – Any expression of dissatisfaction concerning denial of coverage which is clearly not covered under the policy or where the cost of claim exceeds the monetary limit under the terms of the policy are not complaints. However, where the complaint relates wholly or in part to vague wording or unclear definitions in the policy wording, terms and conditions or table of benefits, it will be considered as a complaint.

COMPLAINT LOGGING

A Complaints Log will be maintained by the Company with all complaints clearly logged, with the following
details;

- Name of complainant
- Name of patient (where applicable)
- Date of complaint
- Name of staff member receiving and registering the complaint
- Name of staff member to whom the complaint has been directed
- Identification of a repeat complaint (that is a repeat of an earlier complaint made by the same complainant)
- Policy detail (if an existing insured member) including Policy Number, Member Number, Company name (if a corporate scheme)
- Category of complaint
- Detail of the complaint
- Source of complaint (telephone, email, personal visit, online facility, via a third party, etc.)

COMPLAINT OWNERSHIP

Following employees have the overall responsibility for the Complaint:

- Ms.Jitta Phone: +971 26666348, Email: jitta@libertyinsurance.ae

The owners report to the Managing Director (MD). Any escalation if required shall sent to Mr. Thayakath Asabulla Sidhik,
who can be reached at Telephone no: +971 26666348 and Email
ID: sidhik@libertyinsurance.ae Complaints cannot be handled by the person about whom the complaint is made nor by a department which is the subject of the complaint.

COMPLAINT CHANNELS

Clients can file complaint on our website or as set out in our Complaint Procedure. We encourage the Client to raise the Complaint by filling in and submitting the Complaint Form published on our website. We also accept complaint received by phone, email or in person. We do have the capability to communicate with our clients in English, Arabic, Hindi, Tagalog and few other Indian languages. Our Complaint policy and procedure is publicized for clients on our Company's website: www.libertyinsurance.ae, in Health Insurance Proposal documents and in our Office.

CATEGORIES OF COMPLAINT

All complaints must be categorized in the Complaints log as relating to one of the following:

- Advice provided or product suitability
- Accuracy of documentation provided
- Delays in process (issue of quotations, response to correspondence etc.)
- Administrative or operational process or procedures (i.e. a complaint about the process itself rather than the implementation of it)
- Service provided by advisers, staff or departments (efficiency, attitudinal, behavioral, knowledge)

REPORTING

A monthly report of the complaints received and their status of ongoing Complaints is to be submitted to the Managing Director. An annual report should be submitted each year to Dubai Health Authority, Health Funding Department, no later than 7th January each year. This report should meet the following key performance indicators (KPIs).

- TAT by number of days to complaint resolution or point of referral to third party deliberation.
- Number of complaints outstanding at end of each calendar month
- Number of complaints unresolved after 15, 30 and 90 days at the end of each calendar month.
- Number of complaints escalated for outside deliberation or arbitration.

- Complainant satisfaction with outcome of internal dealing with the complaint using a scoring system
  (1=fully satisfied, 2=largely satisfied, 3=largely unsatisfied, 4=completely dissatisfied).
- Number of complaints by category.
- Number of complaints fully upheld.
- Number of complaints partially upheld.
- Number of complaints denied (prior to any external escalation).

STAFF TRAINING

Company has a Training and Competence Scheme to ensure that;

- a Complaint is treated fairly and efficiently, consistent with this Policy and values which are designed to ensure that our business activities and decision-making are carried out with integrity and in an open, transparent and honest manner;
- all Health Insurance Representatives in our Company and all employees working at Health Insurance Department shall be trained, competent and shall be aware of the required standards, processes and procedures to be followed by a Health Insurance Representative. Company shall give training to all new joinee and monthly update trainings to all working at Health Insurance Department, on all aspects – policy, premium, claims, handling, standards, procedures and processes
- Only employees having experience and competent to be certified as Health Insurance Representative will be allowed to handle Health Insurance. Company will be regularly monitoring the performance of each Health Insurance Representative and any certified Health Insurance Representative who falls short of the standards required by the Company, will have their work monitored and all recommendations reviewed by a manager or other competent person designated by Company. Once such representative achieves competent status, monitoring will cease.
- Competence of each approved Health Insurance Representative will have to be maintained and updated against the background of changes in the marketplace, in products, regulation and
  legislation.
- The training program is recorded in the company's Training Log, identifying the staff and the date of the training session. This will include general training plans of the Company with details like schedule of planned training courses, their objectives, content and target audience or the coming year as well as individual training and competence records for each Health Insurance Representative, which will include dates and details of all assessments, Individual Training Plans, remedial plans and training, results of tests or other assessments, training sessions attended, self-learning undertaken and any other matters pertaining to the individual Health Insurance Representative.

COMPLAINTS PROCESS FLOWCHART AND ESCALATION PROCESS

Complaints Process Flowchart is published on our website. Clients may lodge complaint on our website, by email, phone or in person. A written acknowledgement of the Complaint shall be sent within three working days of its receipt and will include a copy of our Complaints handling Procedure, telephone numbers and email ID of contact persons and expected TAT for complaint resolution. The assigned staff will make all required actions to resolve the complaint. Minor Complaints, which are mainly related to procedural, administrative or operational process will be resolved in 3 working days. Complaints like incorrect schedule of benefit, terms and conditions different from what has been sought for etc. which are of minor nature and requires less involvement from Insurer will resolved with 7 to 10 working days and we will keep the Complainant updated. Complaints relating to claims-approval delays/ denials, rejections, inappropriate claim settlement, delays in settlement etc. will be resolved in 21 to 30 days. Upon resolution, Complainant shall be notified and in the event Complainant is satisfied with the resolution, it will be recorded in the Complaint Log book and Complaint will be closed. During the resolution period, interim updates will be given explaining the status, why the issue is not solved and an indication of when a further contact or final response can be expected.

COMPLAINT REVIEW PROCEDURES

Complaint Log Book shall be reviewed by MD monthly, with specific attention to the unresolved complaints and
reasons for the same. MD will also look at the categories of the Complaints received and reasons of Complaints and how they were dealt with. Corrective action shall be suggested for implementation for Company's process and procedures, where Complaint is related to such procedural, administrational and operational matters within the Company, to avoid repetition of similar complaints in the future.