MFSA MALTA FINANCIAL SERVICES AUTHORITY

Proposed Claims Handling Practices Guidelines

21 November 2025

Contents

Triq l-Imdina, Zone 1 Central Working District, Birkirkara CBD 1010
+356 2144 1155
communications@mfsa.mt
www.mfsa.mt

1. Applicability

This document is aimed at:

1.1. Persons authorised to carry on the business of insurance under the Insurance Business Act (Cap.403), including a European Insurance Undertaking which has established a branch in Malta in exercise of a European right in terms of the European Passport Rights for Insurance and Reinsurance Undertakings Regulations (Legal Notice 399 of 2015) with the exception of undertakings and protected cell companies whose business is restricted to Reinsurance, and/or affiliated re/insurance business (captives);

1.2. Third country insurance undertaking which has established a branch in Malta pursuant to article 11 of the Insurance Business Act (Cap.403);

1.3. Persons enrolled under the Insurance Distribution Act (Cap. 487) to act as insurance brokers, insurance agents, and insurance managers, which have been vested with delegation of authority with respect to claims handling and/or processing; and

1.4. Personal Lines insurance products which are designed to protect an individual from losses related to property loss, and liability. Commercial lines insurance covering business and commercial risks, and long-term business of insurance are outside of scope of this document.

2. Scope

2.1. The manner in which policyholders' claims are managed by insurance undertakings and insurance intermediaries vested with delegated authority in claims handling and/or processing (herein referred to as "Regulated Persons" or "the Company") is a key determinant of how such entities are perceived by their clients. In a highly competitive insurance market, excellence in claims handling often serves as a primary differentiator among market participants.

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The Malta Financial Services Authority (MFSA) has observed, through various channels, a growing volume of anecdotal feedback and consumer opinion—particularly on social media—regarding the quality of claims handling by insurance providers. These observations are further supported by data submitted through the Conduct Related Data Returns on complaints, which insurance undertakings are required to submit to the MFSA on an annual basis. A substantial proportion of complaints received by the Authority pertain to claims-related issues.

Additionally, the MFSA has conducted a number of supervisory inspections focusing specifically on claims handling practices. Feedback from within the insurance industry has also highlighted concerns in this area.

The purpose of this document is to outline the Authority's expectations regarding claims handling practices in respect of personal lines insurance products. It is intended to serve as guidance to assist Regulated Persons in meeting their regulatory obligations, including the obligation to treat clients fairly, honestly, professionally, and in accordance with their best interests.

2.2. This document sets out the best practices that Regulated Persons engaged in the provision of personal lines insurance are expected to follow when handling insurance claims submitted by policyholders. The objective is to ensure that all claims are managed in a manner that is fair, transparent, and timely.

2.3. The provisions contained herein are not intended to replace or supersede the internal Key Performance Indicators (KPIs) that Regulated Persons are expected to establish and maintain in relation to claims handling. Rather, this document considers the organisational culture, resourcing, operational frameworks, and procedural structures that support the delivery of an effective and high-quality claims handling function.

2.4. This document further seeks to encourage the broader adoption of digital technologies by Regulated Persons, with the aim of enhancing operational efficiency, minimising delays, and improving the overall client experience. The implementation of end-to-end digital claims management solutions has the

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+356 2144 1155
communications@mfsa.mt
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potential to streamline the claims process, reduce administrative burdens, and address common inefficiencies such as extended waiting times and excessive documentary requirements.

2.5. The contents of this document are aligned with the MFSA supervisory priorities for the period 2023–2025, which include Digital Finance, Governance, Risk and Compliance, and Consumer Protection.

2.6. For ease of reference, this document is structured in two parts. Part I addresses the roles, responsibilities, and internal control frameworks applicable to the claims handling function. Part II focuses on the claims handling process itself, outlining both general principles and product-specific considerations relevant to the operational aspects of claims management.

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+356 2144 1155
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PART A

3. Roles, Responsibilities, and Internal Controls

3.1. Board of Directors and Senior Management

3.1.1. The Board of Directors of the Insurance Undertaking is expected to ensure that a culture of service excellence and a client-centric approach to claims management is embedded within the organisation's strategic priorities. This cultural commitment should be clearly articulated, documented, and effectively implemented across the business. The Board should recognise claims handling as a critical function within the Regulated Person's operations.

3.1.2. In formulating the business strategy and corresponding budgets, the Insurance Undertaking shall give due consideration to the ongoing development and enhancement of its claims handling capabilities. This includes ensuring the allocation of adequate human resources and the establishment of a robust and scalable claims management infrastructure, proportionate to the volume and complexity of the insurance business underwritten.

3.1.3. The Board of Directors shall ensure that the governance framework governing the Regulated Person's claims handling function is consistent with the expectations set out in this document, as well as all applicable laws, regulations, and industry best practices.

3.1.4. The Board of Directors shall collectively bear responsibility for the effective oversight of the Insurance Undertaking's critical functions, including claims handling. Such oversight must be demonstrable and supported by appropriate governance structures and reporting lines.

3.1.5. Regulated Persons are required to establish and implement clear, effective, and proportionate claims handling policies and procedures that uphold the principles of fairness, transparency, timeliness, and positive client outcomes. These procedures must also provide for appropriate oversight and monitoring

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of any outsourced claims handling activities, ensuring that such arrangements meet the same standards as internal processes.

3.2. Quality Service Charter

3.2.1. The Board of Directors and Senior Management of Regulated Persons are expected to establish, approve, and implement a formal Quality Service Charter, which must, at a minimum, set out the following:

a) The Regulated Person's commitment to delivering high standards of service to clients, including the establishment of service levels that align with reasonable client expectations;
b) A clear summary of the claims handling process, including indicative timelines (where such timeframes are within the Regulated Person's control) across key stages of the claims lifecycle. This should cover, but not be limited to:
    - Responding to client queries;
    - Scheduling inspections, where applicable;
    - Issuing offers for cash settlements or total loss, once determined;
    - Processing claim payments once all necessary documentation is received and agreed upon, or upon acceptance of the Regulated Person's offer;
c) Defined procedures for effective communication and engagement with policyholders and other relevant stakeholders throughout the claims process; and communication and engagement processes with clients and other relevant stakeholders and
d) A reference to the Regulated Person's complaints handling process, including guidance on how clints may lodge complaints.

3.2.2. A concise version of the Quality Service Charter, highlighting the core service commitments and key timeframes (where applicable), shall be made publicly available. This may be achieved through publication on the Regulated Person's website and/or by providing the Charter to clients as part of the policy documentation. The Quality Service Charter must be reviewed and updated

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regularly to ensure it remains accurate, relevant, and reflective of the Regulated Person's current practices and regulatory obligations.

3.3. Human Resources

3.3.1. Regulated Persons shall ensure that the claims function is adequately and appropriately resourced with personnel who possess the necessary skills, qualifications, and experience, commensurate with the size, nature, and complexity of the insurance business undertaken.

3.3.2. Regulated Persons are expected to establish and maintain effective succession planning and staff retention strategies to ensure the ongoing availability of suitably qualified and experienced personnel within the claims function. These measures should support the continuity and operational resilience of the claims handling process.

3.3.3. Regulated Persons shall implement procedures to ensure that the processing of claims is not disrupted or delayed due to the unavailability of individual claims handlers, including during extended absences. Adequate handover, delegation, or backup arrangements must be in place to safeguard service continuity.

3.3.4. All personnel directly involved in claims assessment, including internal claims handlers and assessors, must be provided with adequate and ongoing training. Such training should address both technical aspects of claims evaluation and the legal and contractual frameworks applicable to insurance claims, including the interpretation of policy wording and consumer protection requirements. Where external professionals, such as appointed loss adjusters or surveyors, are engaged, Regulated Persons shall take reasonable steps to ensure that such individuals possess the necessary expertise and competence to perform their duties effectively and in line with applicable standards.

3.4. Digitalisation

3.4.1. Regulated Persons are encouraged to adopt digital solutions and innovative technologies to facilitate the delivery of efficient, effective, and timely claims

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services. This may include, where appropriate, the use of dedicated client portals or other digital interfaces that enhance accessibility and transparency for policyholders.

3.4.2. Regulated Persons are encouraged to implement and maintain robust IT systems specifically designed for claims handling. Such systems should enable the efficient analysis of data and support the generation of accurate and timely reports, including management information and other regulatory reporting requirements.

3.4.3. Regulated Persons should seek to phase out legacy systems and reduce reliance on manual processes to the greatest extent possible. The objective is to achieve a high level of automation and system integration, consistent with current technological standards and prevailing market practices.

3.4.4. Regulated Persons are expected to establish and maintain effective communication infrastructure with policyholders and relevant insurance market participants. Such systems should be compatible with up-to-date technology standards and data interface protocols to ensure seamless information exchange and improved service delivery.

3.5. Internal Processes and Procedures

3.5.1. Regulated Persons shall establish and maintain effective internal processes and procedures to monitor claims settlement outcomes. This monitoring should cover, inter alia, settlement timeframes, claim categorisation, complaint trends, claim costs, and other relevant performance metrics.

3.5.2. As part of their ongoing compliance and internal audit monitoring framework, Regulated Persons are expected to periodically assess the effectiveness of their claims handling processes, procedures, and internal controls. Such assessments should assess whether claims are being managed in a manner that ensures:

- The delivery of fair outcomes to clients;
- transparency in decision-making;

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- the timely settlement of valid claims; and
- adherence to all applicable legal and regulatory requirements.

3.5.3. It is considered sound governance practice for the findings of such assessments to be documented within compliance and/or audit monitoring reports submitted to the Board of Directors and/or Senior Management, thereby supporting their oversight of the quality and integrity of the claims handling function.

3.5.4. Regulated Persons shall establish a comprehensive set of KPIs to measure the effectiveness and efficiency of their claims handling operations. These KPIs should be aligned with the principles of fairness, transparency, and timeliness, and must support the achievement of positive client outcomes. KPIs should also incorporate, where applicable, feedback from clients and third-party claimants involved in the claims process. The results of KPI monitoring should be reviewed regularly and included in compliance and/or internal audit reports submitted to the relevant internal governance committees of the Regulated Person.

3.5.5. For the avoidance of doubt, KPIs that focus exclusively or primarily on average claims cost, without incorporating other critical aspects of the claims settlement process, or which are otherwise inconsistent with the expectations set out in this document, shall not be deemed sufficient to meet regulatory requirements.

3.5.6. Regulated persons are expected to retain adequate records of all meetings, communications, and other relevant documentation generated during the course of the claims process, as part of a comprehensive and auditable client file.

3.5.7. Insurance intermediaries who have not been formally delegated authority for claims handling or processing shall not engage in any part of the claims management process, other than providing assistance to clients in completing and submitting claim forms.

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3.6. Service Level Agreements (SLA) with Third Party Service Providers

3.6.1. To fulfil their obligations in ensuring fair, transparent, and timely claims settlement, Insurance Undertakings are required to establish clear, comprehensive, and enforceable SLAs with all third-party service providers engaged in the claims handling process. Such SLAs must clearly delineate expected service standards and performance metrics. Furthermore, Insurance Undertakings shall implement robust oversight mechanisms to continuously monitor adherence to these agreements and promptly initiate appropriate corrective actions where deviations or deficiencies are identified.

3.7. Post Claims Feedback

3.7.1. Regulated Persons are encouraged to implement structured post-claims feedback mechanisms, such as client satisfaction surveys, as part of their ongoing assessment of service quality and client experience. The objective of these exercises is to:

- Assess the client's perception of the claims handling process;
- Assess whether the service provided met reasonable client expectations;
- Identify opportunities for improvement in claims handling procedures, communication practices, and client support and
- Support the Regulated Person's alignment with the principles of fairness, transparency, timeliness, and client-centricity as outlined in this document.

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+356 2144 1155
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PART B

4. General Principles – Claims Processing

(Applicable to all Personal Lines Insurance Claims)

4.1. A Regulated Person is expected to handle all claims in a fair and professional, transparent, and timely manner in accordance with the best interests of its clients.

4.2. A Regulated Person is expected to provide reasonable guidance to help a policyholder make a claim and to provide appropriate and regular information on its progress.

4.3. A Regulated Person is expected not to reject a claim on unreasonable grounds.

4.4. Notifications of Claims

4.4.1. Regulated Persons shall promptly acknowledge receipt of any claim, and in any case no later than three (3) days from the date of receipt. Upon obtaining all necessary supporting documentation to their satisfaction, Regulated Persons shall commence the assessment and processing of the claim without undue delay.

4.4.2. Upon acknowledging receipt of a claim, Regulated Persons are expected to provide the policyholder with relevant contact details to facilitate ongoing communication and enquiries. Wherever practicable, this should include direct contact information for the individual assigned to handle the claim. Additionally, Regulated Persons should refer the policyholder to the Quality Service Charter, as outlined in Section 3.2.2 of this document.

4.4.3. Regulated Persons shall ensure that all communications with clients and other relevant stakeholders are conducted in a timely, efficient and responsive manner. This includes, but is not limited to:

- responding to general enquiries;
- Managing claims-related correspondence; and

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+356 2144 1155
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- Addressing requests for call-backs or follow-up communication.

4.4.4. Regulated Persons are expected to request any additional information or documentation required to assess and process a claim promptly and at the earliest reasonable stage of the claims lifecycle, where such requirements are reasonably foreseeable. These requests should be comprehensive and clearly communicated, with a view to avoiding unnecessary delays and minimising potential client dissatisfaction. However, this does not preclude the Regulated Person from requesting further supporting documentation at a later stage of the claims process, where such documentation is reasonably necessary to substantiate or validate the policyholder's claim.

4.5. Status Updates

4.5.1. Upon receipt of all necessary supporting documentation, Regulated Persons are expected to maintain proactive and ongoing communication with the policyholder regarding the status of their claim. Status updates shall be provided at regular intervals, the frequency of which should be commensurate with the nature, complexity, and anticipated duration of the claim, and whenever there is a material development in its progress.

4.5.2. Regulated Persons shall ensure the availability of accessible, user-friendly communication channels through which policyholders may obtain timely updates on the status of their claims. These channels may include, but are not limited to, electronic mail, SMS or other forms of text messaging, secure online client portals, mobile applications, or in-app notifications.

4.5.3. In circumstances where a claim is subject to dispute or requires extended review, Regulated Persons shall notify the policyholder in writing without undue delay. Such notification must clearly state that the claim is under further investigation or review, outline the reasons for this, and explain the implications for the anticipated processing timeline. This measure is intended to manage client expectations, promote transparency, and reduce the risk of dissatisfaction or complaints stemming from perceived inaction.

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Where a claim remains under investigation for an extended period, Regulated Persons are further expected to issue periodic written updates to the policyholder. These updates should confirm whether the investigation remains ongoing and, where feasible, provide an indicative timeframe for when a decision may be expected. It must be made clear that any such timeframe is subject to change depending on the circumstances of the case.

This requirement shall not apply in cases involving suspected fraud or similar misconduct, where the provision of such information may compromise the integrity of the investigation.

4.6. Market Values

4.6.1. Regulated Persons are expected to provide clear and proactive guidance to policyholders regarding the importance of accurately valuing the insured risk, in order to minimise the risk of over-insurance or under-insurance. Such conditions may result in disputes at the claims stage regarding the appropriate market or replacement value of the insured asset. Accordingly, at the application or underwriting stage, and at each policy renewal, Regulated Persons shall advise policyholders on:

- the importance of maintaining insurance coverage that reflects the accurate market value of the insured risk on an ongoing basis, particularly at renewal; and
- the potential consequences of both over-insurance and under-insurance, including the impact these may have on claims settlements.

4.6.2. In the the interest of promoting transparency and achieving fair client outcomes, Regulated Persons who recommend a revised sum insured at renewal are encouraged to present this information in a clear and comparative format. This should include:

- The current sum insured and the associated renewal premium; and
- The recommended revised sum insured along with the corresponding adjusted premium.

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+356 2144 1155
communications@mfsa.mt
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This information should be displayed side-by-side to assist clients in understanding the impact of the revised valuation on both premium levels and coverage. Where a recommendation is made regarding the sum insured, it must be clearly stated that the proposed figure represents the estimated market value, or where applicable, the replacement value of the insurable risk, assuming it is in a reasonable state of repair at the time of assessment.

This approach supports informed decision-making and helps to manage client expectations, thereby reducing the likelihood of disputes during claims settlement.

4.6.3. Where insurance intermediaries act on behalf of Insurance Undertakings in advising clients on the valuation of insurable risks, Insurance Undertakings are expected to ensure that such intermediaries are made fully aware of, and comply with, the expectations set out in this section. Insurance Undertakings shall retain overall responsibility for ensuring that advice provided on their behalf reflects fair, accurate, and transparent market value guidance, in line with the standards outlined in this document.

4.7. Payment of Claims

4.7.1. In accordance with the principles of fairness, transparency, and the delivery of positive client outcomes, Regulated Persons are expected to ensure that policyholders are offered an adequate and reasonable settlement during the final stages of the claims process.

4.7.2. Where a final decision is made to settle a claim, either partially or in full, or to reject a claim in whole or in part, and the proposed outcome does not align with the policyholder's expectations or demands, Regulated Persons shall provide a clear and comprehensive explanation in writing. This explanation must detail the rationale, policy interpretation, and supporting evidence used in arriving at the final settlement position.

4.7.3. Once the policyholder (or their authorised insurance intermediary, as applicable) has accepted the settlement offer and submitted the relevant

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+356 2144 1155
communications@mfsa.mt
www.mfsa.mt

discharge form and/or any other required documentation, Regulated Persons shall ensure that the claim is settled within fifteen (15) working days. For the avoidance of doubt, Regulated Persons may discharge payment directly to third-party service providers, such as motor repairers or healthcare institutions, where this is provided for under a SLA or policy arrangement.

4.7.4. In cases where claims are payable on a reimbursement basis and an offer has already been accepted, Regulated Persons shall reimburse the policyholder within fifteen (15) working days from receipt of the original invoices or bills.

4.7.5. Claims must be assessed and settled in a timely manner and shall not be unreasonably delayed or withheld pending the resolution of other outstanding claim components arising from the same incident, such as bodily injury, loss of use, or loss of income. Where liability has been accepted and the quantum of property damage or motor-related losses has been determined, Regulated Persons are expected to proceed with settlement of these components without undue delay, in line with the fair treatment of claimants and the avoidance of unnecessary hardship.

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+356 2144 1155
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5. Motor Claims Processing

5.1. Own Damage Claims (Policyholder)

5.1.1. Upon receipt of the final surveyor's report or the definitive claims assessment from the in-house claims reviewers, Regulated Persons shall communicate the decision, whether approval, offer, or rejection, to the policyholder or their duly appointed insurance intermediary without undue delay. All such communications must be provided in writing.

5.1.2. Communications conveying approval or offer to the policyholder must disclose the methodology applied in determining the scale of betterment, market value, salvage deductions, and any partial settlement where applicable. In cases of rejection or partial settlement, the rationale and grounds for declining the original claim shall be clearly documented and communicated.

5.1.3. Upon request by the policyholder, Regulated Persons are required to furnish copies of pertinent excerpts from the claims assessment or survey report, including recommendations made by the surveyor or in-house assessor. Access provided shall be strictly limited to information relevant to the repair estimate of the insured risk and shall exclude any confidential information, such as details pertaining to suspected fraud or ongoing investigations. Provision of such information must not prejudice any ongoing investigative processes.

5.1.4. In instances where the insured risk is declared as beyond economical repair or a total loss, Regulated Persons must, upon policyholder request, provide relevant extracts from the claims assessment or survey report and assessor recommendations. Such information shall include itemised repair estimates alongside the pre-accident market value, wreck value, and proposed cash settlement amount.

5.1.5. In cases of beyond economical repair or total loss, Regulated Persons shall afford policyholders the option to waive retention of the wreck deemed irreparable.

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5.1.6. Where the policyholder appoints a surveyor to assess the current market value of the insured risk, Regulated Persons shall duly consider the surveyor's report in any total loss or beyond economical repair settlements arising within twelve (12) months from the date of such inspection.

5.1.7. In the event of a road traffic accident involving two or more vehicles insured by the same Regulated Person, the Regulated Person is expected to take prompt and proactive measures to resolve the claim internally, provided the incident circumstances are not excessively complex or contested. This internal resolution process should leverage the Regulated Person's unique position to ascertain facts, determine liability, and expedite settlement, thereby minimizing procedural delays common to inter-insurer claims. Such handling must uphold the principles of fair, consistent, and diligent treatment of all customers.

5.2. Third-Party Motor Claims

5.2.1. Regulated Persons shall assess and respond to third-party claims in a prompt, fair, and impartial manner, particularly in circumstances where liability is reasonably clear. Third-party claimants must be kept informed of the progress and outcome of liability assessments through clear, timely, and transparent communication.

5.2.2. In cases where an at-fault policyholder fails to report a motor accident to their insurer, Regulated Persons are required to:

- issue a written notification to the policyholder, reminding them of their contractual obligation to report the incident in accordance with the terms of the insurance policy; and

- clearly outline the importance of full cooperation and the potential legal and regulatory implications of continued non-compliance.

Where the policyholder fails to submit the required claim without valid justification and does not respond within ten (10) calendar days from receipt

Triq l-Imdina, Zone 1 Central Working District, Birkirkara CBD 1010
+356 2144 1155
communications@mfsa.mt
www.mfsa.mt

of the notification, the Regulated Person is expected to proceed in accordance with the provisions of A*rticle 15 of the Motor Vehicles Insurance (Third-Party Risks) CAP. 104.*

Under no circumstances shall Regulated Persons delay the processing or settlement of valid third-party claims, nor deny liability solely due to the non-reporting or lack of cooperation by their own policyholder.

5.2.3. Upon receiving a third-party claim accompanied by the necessary supporting information and documentation from the third party, Regulated Persons are expected to schedule a vehicle inspection without undue delay, and in any case no later than seven (7) working days from the date of receipt. The purpose of the inspection shall be to assess the extent of damage and determine the necessary scope of repairs. This process is intended to minimise disputes regarding claim quantum and facilitate timely resolution of third-party claims.

5.2.4. Where a Regulated Person elects to settle a third-party claim on a *without prejudice* basis, such a claim shall be treated as any other settled claim for the purposes of policy administration. Consequently, the loss of No-Claims Discount and any applicable benefits (e.g., replacement vehicle entitlement) shall be applied as if the claim had been formally lodged by the policyholder.

5.3. Car Hire – Third Parties

5.3.1. Where a third-party claimant is entitled to compensation for the hire of an alternative vehicle during the period their own vehicle is undergoing repairs, and liability has been accepted by the Regulated Person, the Regulated Person shall be required to clearly specify, in its offer of settlement, the information necessary to determine the amount of rental compensation payable.

5.3.2. The calculation of reasonable compensation for the hire of an alternative vehicle shall commence from the first day the third party's vehicle is deemed not roadworthy and not road legal, or, where the vehicle remains roadworthy and road legal, from the first day the vehicle enters repair.

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5.3.3. Upon acceptance of liability, Regulated Persons shall be expected to authorise compensation for the hire of an alternative vehicle from the first day the third-party vehicle is declared not roadworthy and not road legal, irrespective of whether the vehicle is subsequently deemed a total loss or beyond economical repair.

5.3.4. The duration for which the hire cost of a replacement vehicle is to be computed shall be based on the recommendation of a motor vehicle surveyor or an assessment conducted by the Regulated Person's in-house assessor. This shall include a reasonable allowance for additional days to accommodate unforeseen delays beyond the control of the third-party claimant, including but not limited to the unavailability of necessary repair parts.

Where the damaged vehicle is classified as a *'grey import'* and the required parts are not readily available in Malta, the Regulated Person may, at its discretion, opt to reimburse the cost of the required parts and associated shipment fees in cash, instead of facilitating procurement. In such cases, the Regulated Person shall not be liable for the cost of replacement vehicle hire for the period that would have otherwise been required for part delivery and completion of repairs.

5.3.5. Regulated Persons shall regularly review and update the standard cost scales for replacement vehicle hire, to ensure that compensation to third-party claimants remains fair and reflective of prevailing market conditions, including cost fluctuations arising from inflation and increases in transportation expenses.

5.4. Type of Repairs

5.4.1. Regulated Persons, including their appointed surveyors or assessors, shall be expected to undertake an objective evaluation of each vehicle when determining the appropriate type of replacement parts to be used. In making such assessments, due consideration shall be given to the overall condition of the vehicle, including its upkeep, maintenance history, and mileage. In the case of vehicles aged five (5) years or older, the use of non-original equipment

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+356 2144 1155
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manufacturer (non-OEM) parts or second-hand replacement parts may be considered, provided such assessment is conducted in a manner that is fair and reasonable.

5.4.2. Where a decision is made to proceed with non-OEM or second-hand replacement parts, Regulated Persons shall offer the policyholder or third-party claimant the option to elect for original (OEM) parts instead, subject to the payment of any additional cost representing the difference in value (betterment).

5.5. Co-operation between Regulated Persons (Recoveries)

5.5.1. Regulated Persons shall be expected to engage in proactive and constructive cooperation in the resolution of disputes relating to liability and settlement recoveries. Such cooperation is necessary to ensure that such disagreements do not result in undue delays or detriment to policyholders.

5.5.2. Where liability has been clearly established and mutually agreed upon, but recovery payments remain outstanding, Regulated Persons shall be required to refund or reinstate any applicable policy excess, deductible, or No Claim Discount (where relevant), without undue delay.

5.5.3. Regulated Persons shall be expected to process and settle recovery requests submitted by other Regulated Persons in a timely manner, provided that liability has been clearly determined and agreed, and that all required supporting documentation, including substantiation and quantification of the amounts claimed, has been duly submitted.

6. Health Claims Processing

6.1. Health insurance claims often involve complex procedures due to the use of medical terminology, the requirement for specific documentation, and varying coverage conditions. Recognising the stress that may accompany medical situations, Regulated Persons are encouraged to provide dedicated client support, such as helplines or designated claims handlers, to assist claimants

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+356 2144 1155
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in understanding their coverage, interpreting billing items, and navigating the claims process. This support should aim to facilitate a smoother experience for claimants and offer clarity and reassurance during what is often a difficult time.

6.2. In instances where claims are partially settled, owing to the application of sub-limits, exclusions, policy limits, or incomplete documentation, Regulated Persons shall be required to provide a clear, written explanation for the decision. Such communication must outline the reasons for any deductions, distinguish between admissible and non-admissible amounts, and reference the specific policy terms or clauses applied. Explanations shall be presented in plain language, avoiding unnecessary technical or legal jargon, to ensure transparency and comprehensibility for the claimant.

6.3. Regulated Persons shall ensure that claimants have timely and convenient access to the applicable "*table of fees*" or tariff schedules, which set out the reimbursable rates and coverage limits for services such as hospitalisation, surgical procedures, and specialist consultations. References to the relevant fee schedules shall also be included in claim settlement correspondence, particularly where a claim is partially approved. These tables are expected to be reviewed and updated on a regular basis to maintain accuracy and relevance.

6.4. Regulated Persons shall publish, in a clear and accessible manner, the basis upon which reimbursement claims are assessed and settled. This shall include details of the reimbursement methodology used and must be made available to policyholders via the Regulated Person's website.

6.5. To promote fairness, transparency, and objectivity in claims processing, Regulated Persons are encouraged to utilise independent review mechanisms, both medical and cost-based, when evaluating claims. The adoption of such mechanisms supports evidence-based decision-making and may contribute to the reduction of disputes between claimants and Regulated Persons.

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+356 2144 1155
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7. Travel Claims Processing

7.1. Regulated Persons shall manage travel claims with a client-centric approach, particularly in distressing or urgent circumstances such as medical emergencies, theft abroad, or travel disruptions. In all instances, clients must be provided with clear, compassionate guidance throughout the process, including situations where coverage is not in place and clients are required to bear costs personally.

7.2. Emergency support and related assistance services may be outsourced to third-party service providers, who may further subcontract such services. Insurance Undertakings are required to establish comprehensive and well-defined SLAs with these providers and ensure that such SLAs are actively monitored for compliance and performance.

7.3. Regulated Persons, including their distributors, must confirm that policy terms and conditions are clearly communicated directly to the insured, with particular attention to coverage limitations concerning pre-existing medical conditions. In cases where the insured is covered under a group tour policy and the tour operator acts as the Tied Insurance Intermediary (TII), the TII shall be obligated to inform each insured party of the relevant terms and conditions and to explain the consequences of non-disclosure, especially in relation to pre-existing medical conditions.

7.4. Regulated Persons shall ensure that the procedures for validating claims related to lost or stolen items, including any requirements for original purchase receipts, are transparently disclosed to clients both at the point of sale and during the pre-claim stage.

7.5. Recognising that travel claims may be submitted long after the acquisition of items and that original receipts may not reasonably be available, Regulated Persons shall not rely exclusively on original receipts as the sole acceptable evidence of ownership or value. Alternative forms of proof shall be considered. The request for documentation must be reasonable, as imposing unreasonable demands for evidence that clients cannot be expected to retain

Triq l-Imdina, Zone 1 Central Working District, Birkirkara CBD 1010
+356 2144 1155
communications@mfsa.mt
www.mfsa.mt

may result in unwarranted claim denials or delays, which contravenes the principles of fair, transparent, and timely claims handling.

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